

**DRAFT MEGHALAYA STATE POLICY ON DRUG ABUSE**

**DEPARTMENT OF SOCIAL WELFARE  
GOVERNMENT OF MEGHALAYA**

## **Draft Meghalaya State Policy On Drug Abuse.**

**I. APPROACH:** Pragmatic approach through the (i) Study conducted by NEIDAC – Social Welfare in 2009. (ii). Discussions with key informants (people using drugs), service providers and functionaries of NGOs implementing drug abuse prevention programmes.

### **II. DEFINITION:**

The definition of drug abuse is varied and one single definition will not represent the extensive scale that drug abuse entails. Drugs are classified into licit drugs and illicit drugs; while licit drugs are legally allowed for consumption, illicit drug are not and they fall under the Narcotic Drugs and Psychotropic Substances Act (NDPS) of the Country.

The definitions of drug abuse can be classified into four main categories: public health definition, cultural or vernacular usage, medical definition, and the criminal justice definition.

The public health definition looks at drug abuse on two levels: the individual and the society, laying a lot of stress on the role of society. A recent development is the use of the term drug use and drug user, which is preferred by public health professionals who work in the field of HIV/ AIDS. The vernacular or cultural definition views drug abuse strictly as a personal behavioral problem. The medical term lays emphasis on the individual along in its definition of drug abuse. The criminal justice looks at drug abuse as a purely criminal activity whatever the definition of drug abuse may be, the subsequent result is the same; it causes social and health problems, unsafe sexual contacts, violence, deaths, accidents, suicides, physical dependence and psychological addiction.

For the sake of simplicity the Policy will use the term drug abuse in the entire document and will define drug abuse as follows: “Drug abuse is the uncontrollable, irrational/ excessive use of drugs that lead to physiological and psychological harm. It affects the central nervous systems (CNS), which produce changes in mood, levels of awareness or perceptions and sensations.”

This Policy will address drug abuse in a broad sense, including all form of substances that are addictive and that will fall in any of the following category:

- Stimulants: Amphetamines, Cocaine, Diet Pills (Anorectic Drugs), Methamphetamines.
- Depressants: Barbiturates, Benzodiazepines, Alcohol
- Hallucinogens: Psilocybin (“Shrooms”), DMT, LSD, Peyote and Mescaline, PCP
- Narcotics: Codeine, Heroin, Opium, Morphine
- Inhalants: Adhesive/Glue, Correcting Fluids etc.

### **III. RATIONALE**

Since balance and harmonious growth of individual and society depends on healthy physical and psychological well-being, it is necessary to lay due emphasis on the cause of ill health, social evils and other detrimental factors so as to ensure sound development, fullest satisfaction and maximum contribution towards oneself and society.

It has been recognized that the State has a vast pool of human resources with unique potentials. It shall be of immense pleasure/ happiness if they are properly nurtured, channelized and developed. It is necessary to devise plans and programmes to impart and sustain good habit, to be strengthened by ideal knowledge and suitable skills, and at the same time to see that human virtues and excellence are not hampered by and through drug abuse.

The Policy would directly contribute to personal welfare through effective decision making, positive attitude, healthy lifestyles, strong will power, self-control and its sustained effort and at the same time to ensure that skill and talents are not abused or ruined by unhealthy practices and behavior. It would indirectly contribute to social welfare, peace and prosperity.

This Policy stresses that beneficiaries and stake holders identify appropriate agencies/ institutions and machineries at different levels and of different capacities/ responsibilities dealing with the means, methods and strategies relating to identification of substance abuse and its related issues with their appropriate steps, development of human potentials, virtues and values, and in addition corrective and rehabilitating measures be devised, supported by recreational and vocational modes.

#### **IV. OBJECTIVES OF THE DRUG ABUSE POLICY**

1. To create awareness and educate people about the ill-effects of alcoholism and substance abuse on the individual, family, the workplace and society at large.
2. To provide for the whole range of community based services for the identification, motivation, counseling, de-addiction, after care and rehabilitation of addicts.
3. To alleviate the consequences of drug and alcohol dependence amongst the individual, family and society at large.
4. To set up separate treatment and De-addiction Centre separately for women and children.
5. To motivate and encourage stakeholders, i.e. community, parents, teachers, Government Departments, NGO. Etc., in the fight against drug abuse including alcohol.
6. To spell out clearly the role and responsibility of the various stakeholder in curbing/ minimizing drug abuse.
7. To have special programme targeting the High Risk Group – Commercial Sex Workers, street children, labourers in the coal mines, Truckers etc.
8. To advocate for the welfare of those suffering from drug abuse through inter sectoral linkages and networking for services related to this issue.

#### **V. MEGHALAYA SCENARIO:**

Drug use is a major problem in the State of Meghalaya. The entire State is facing the ramifications of drug use in various ways, affecting the health and development of the people manifold. The Department of Social Welfare Meghalaya supported a State Study conducted by North East India Drugs and AIDS Care (NEIDAC) in 2008-2009; this study revealed a huge increase in the number of drug users in the State, reaching a total of 17833 (this figure excludes alcohol users). Terming the disease of addiction as complex and vexing, the Study showed that drug addiction in the State is nor limited to a certain population or community but in fact crosses all cultures, socio economic level, gender and age.

Women and children seem to be worst affected, with no treatment facility available in the State for them; women suffer the disease in silence and children are totally unaware that their drug abuse is harming them. According to the Study the drugs mostly abused by children are inhalants. Inhalants can be of various types, common ones being volatile solvents, gases, aerosols and Nitrites. This form of drug abuse is common amongst street children and young adolescents in schools. Inhalants are abused to achieve an intoxicating effect and can cause serious harm to the user.

Cannabis is another drug commonly abused by children, more common amongst street children. Cannabis has been proved to lead children to experiment with drugs like heroin at a later stage. Awareness or educational programmes on drug abuse prevention is inconsistent and hence not very helpful for young adolescents who need such information on a regular basis.

Awareness about substance addiction that has been disseminated in the State through various mediums is not sufficient, since the problem is complex and does not seem to decrease. Addiction is understood differently by different sections of society which has resulted in discrimination of drug users, leading to a situation that gets worse instead of better.

The study conducted by NEIDAC – Social Welfare indicated that treatment works and will in a large way address the consequences of addiction, especially criminal related activity, and infection with diseases like HIV/AIDS. Education about drug abuse prevention is much needed so society is informed and can deal with the issue more comprehensively.

Given that the State is already swamped with alcoholism, wherein the disease is entering every fabric of society, the Department of Social Welfare felt that a State Policy on drug abuse must be in place to guide the entire State in addressing this problem meaningfully.

The Policy will give special reference to vulnerable groups like women, children, youth, sex workers; these groups being susceptible to drug abuse because of their surroundings, nature of occupation and a high level of curiosity and experimentation. The Policy will also give emphasis to intervention in prisons and the workplace.

**i) Children:** (According to the Child Labour ( Prohibition and Regulation) Act defines a child as any person who has not completed 14 years of age)

Children constitute the most vulnerable section of society. Disadvantaged children should have equal opportunities for optimum personal growth. To promote the overall well being of vulnerable children, prevent neglect, abuse and exploitation of children and to provide care and shelter for disadvantaged children is the responsibility of every society.

The right to protection, health care and education is to be addressed. The family plays the vital role of providing nurturance, emotional bonding and socialization to the child. The other important key stakeholders in providing care and protection to children are schools and the community.

Vulnerable group of children are those who have been abused and those living in the streets. Street children are the most vulnerable as there is no protection or supervised care from concerned adults. They are vulnerable to exploitation, violence and various forms of abuse. They do not have access to basic resources required for a healthy growth: proper nutrition, clothing, shelter and medical care.

Children are abused or neglected due to reasons like poverty, ignorance or lack of adequate resources. Abuse has a long term effect on the psyche of the child.

Drug abuse in street children is common. Childline, an NGO working with street children in Meghalaya states that there are 70 street children identified abusing *dendrite* and Ganja.

The common types of drugs abused by these children are:

1. Inhalants: Adhesives/ glues, Aerosols – paint sprays, hair sprays, deodorants etc, Solvents/ gases: nail polish remover, paint thinners, correction fluids.
2. Nicotine
3. Alcohol
4. Cannabis

The potent fumes of solvents can suppress the hunger, cold and loneliness of the street children. These children are vulnerable to being lured into drugs and also used for trafficking of drugs.

According to a Report on the Magnitude of the Problem of Drug Abuse in Meghalaya conducted by NEIDAC, there is a high prevalence of drug abuse among school children. The main Inhalant abused by children is Dendrite.

**ii) Young people/ adolescents:** (The World Health Organisation defines an adolescent as any person between ages 10-19)

The age of initiation of drugs is getting younger year by year. The Study conducted by NEIDAC indicated of Drug users to have started at an early age. Interviews with key informants of Drug Use and HIV/AIDS projects in the State reveal many drug users have admitted to have started experimenting with drugs at the age of 10-11 yrs old. The frightening truth is that till date young people in the State are yet to have a concrete source of information about drug use that will equip them in making well informed decisions. The sporadic awareness programmes done by civil societies although much appreciated, is yet to yield the desired impact. There is a need to develop a strategy that is State wide and sustainable, and which will ensure collaboration and accountability of other Departments in the State as well.

**iii) Women:**

Traditionally women appeared to be less susceptible to drug use and its related problems as per the societal perception. However our society is undergoing transition with changing roles, increased stress and alterations in lifestyles, bringing newer problems including drug abuse.

Drug using women are likely to be more stigmatized than their male counterparts because their activities are regarded by society as a 'double deviance' – deviance from both accepted social codes of behaviour and from traditional expectations of the roles of wife, mother and family nurturer. Drug abuse remains a hidden issue with these affected women not coming forward to access services and treatment because of the stigma and a lack of support services for them.

In Meghalaya, women abusing drugs can be college students, Female Sex Workers (FSW) and partners/ spouses of male drug users. Alcohol use is also very common among women in the State.

The predominant drugs of abuse are heroin, pharmaceuticals like cough syrup, tranquilizers and pain killers. At least 30% female users are injecting drug users.

Their sources of Income for drugs are: drug peddling, sex work, extortion, blackmail and other personal earnings or household incomes.

Personal and Social consequences: Female Drug users face violence from non-drug using spouses, male members of the family and spouses dissatisfied with the sexual relationship. There is little or no support from family and friends and many separate from their spouses.

Women drug users, who have children experience guilt from neglecting their children and families, suffer low self-esteem and feel like failures. Some of the female drug users' family are aware of these women being peddlers or sex workers but see them as bread earners and continue to force them to continue in such trades. Some women drug users who have separated from their spouses live outside their homes or in the streets with partners or "street protectors".

Some female drug users are supported by their mothers/ spouses in getting held and treatment. However there are certain issues which prevent women drug users from seeking treatment and these are – concern for their children being unattended at home, fear of exploitation, fear of withdrawals, lack of a supportive treatment environment and lack of awareness of treatment facilities.

**iv)Sex Workers:** addressing sex workers form an integral part in any drug abuse prevention programme. Meghalaya is not unfamiliar with sex workers; the state has been the presence of sex workers through various Intervention Programmes on HIV/AIDS by Meghalaya State AIDS Control Society and UNODC. A star observation from these

interventions is the high incidence of drug use by this section of the population. Sex workers here refer to both men and women sex workers. Drug users tend to sell sex to support their drug use and conversely, there also has been instances where sex work has lead to drug use due to the nature of the work and the environment the individual is in that incites drug use. The entire situation is muddled together, leading to serious ramifications like HIV infection, Sexually Transmitted Diseases and Hepatitis B and C, not to mention the colossal damage that comes from bringing up their children in such an environment where many sex workers have to fend for their children along without support from families or the spouse or partner.

**v) Prisons:** Although prisons are regarded as secured premises, incidents of drug use and drug smuggling in this area are immense. Many times the market for drugs is further expanded by the very smugglers/ peddlers that are confined there in the prisons. Drug users who are in prison for various crimes are the ready consumers. Drug smuggling in prisons must be addressed effectively so as to avoid this illegal practice.

**vi) Work Place intervention:** Drug use in any workplace has proved to be very irksome to any administration or management. Absenteeism and over burden of work on others results in inefficient performance, frustration and a team morale that is dismal. A work place intervention that will sensitise and provide mechanisms for treatment will be of immense help to the abuser and the people around him as well.

## **VI. THE THRUST AREAS IN THE POLICY:**

1. Primary Prevention: Awareness, trainings etc.
2. Secondary Prevention: Treatment
3. Tertiary: advocacy, addressing discrimination etc.

### **1. Primary Prevention:**

In this area the Policy is looking at disseminating correct information about drug abuse that will enable the individual to make well informed choices. This will be through awareness programmes via media, community groups and through Information Education

Communication materials. Inter sectoral collaboration will be the driving force behind these educational programmes keeping in mind that drug abuse is a widespread problem that requires intervention from all sections of the society.

## **2. Secondary Prevention:**

Counselling and referrals play an important role in the treatment of an individual abusing drugs. It is not always necessary that one who is abusing drugs needs to go for a full term rehabilitation programme. There are cases where the drug use habit has just started and effective counseling and a referral to a support group or regular counseling will help one to recover. Secondary prevention will deal mostly with motivation for treatment and to refer that patient to a treatment programme or to continue counseling as an out patient as aforementioned. Referrals also include ascertaining that the patient is assessed physically and psychologically and referred for further investigations should there be a need.

Treatment is and will continue to be a priority in the State with regard to those who are suffering the disease. Rehabilitation centres will be established at least in all the districts and existing ones will be strengthened. Alternative drug treatment centres like Opioid Substitution Therapy is supported and Rehabilitation Centres run by private agencies is encouraged. The Department of Social Welfare will establish a Monitoring and evaluation group/ task force in the State which will look into the functioning of all the rehabilitation centres under the Department. Although Private rehabilitation centres does not fall under the direct supervision of the Department yet they will be scrutinized if and when the committee does receive a report from Patients of any mal practice. Centres providing OST must have accreditation from the National Accreditation Board of Hospitals and Health Care Settings (NABH).

## **3. Tertiary Prevention:**

For any effort in addressing the issue of drug abuse it is always vital that individuals who are affected by this disease are not stigmatized or discriminated upon since this will lead to their denial of the problem and subsequent refusal for treatment. The State therefore recognizes all groups and networks that are formed by individuals having the problem of drug abuse, and will support their efforts provided these groups are legally registered

with the State, have active bank account and are implementing activities that are related to the issue. The State also recognizes Support Groups, forums or networks of civil societies that addresses the problem of drug abuse collectively. In this section the Department will make efforts in working with other Departments, agencies, civil societies in combating the problem of drug abuse.

## **VII. STRATEGY:**

### **1. PRIMARY PREVENTION:**

Primary prevention will include education about issue of drug abuse to the entire State with special focus on vulnerable groups like children, young people and people living in high risk areas. High risk in this case would imply those areas where the environment is very prone to drug abuse eg. Coal mining area and the periphery, national highways...

#### *a) General:*

Information Education and Communication (IEC) materials that are based on local needs, language and culture should be developed by the Department of Social Welfare. IEC can come in the form of booklets, posters, hoardings, calendars and through the electronic media. IEC is necessary for mass awareness and the same can also be developed specifically for the vulnerable groups. The Department should identify experts to design the IEC so as to avoid any mis-communication to the receiver.

Communities can take the lead in organizing awareness programmes in their localities.

#### *b) Adolescent:*

- Introduction of Life Skills education in Educational Institutions: Through the inter sectoral approach, life skills education can be taken up by related departments like the Department of Education such as DERT. It is vital that Life Skills education be made mandatory in the school curriculum. Life skills education classes need to be given the same importance as other subjects and must be taken by a teacher who is trained in this subject. The State Education Department should include a mandatory chapter on drug abuse and its consequences in all aspects for classes. 7-12.

- Available resources like the National Service Scheme, Nehru Yuva Kendra, Meghalaya Bharat Scout and Guides can be capacitated in providing trainings and education on drug abuse so as to reach a larger student community.
- Educational Institutions can also support anti drug clubs that may be started by students either in each class or at the school level.
- Special attention must be given to the surrounding areas of the Schools/ Colleges. School/ College authorities and the local Police together must be vigilant to control drug peddling.
- Anonymous Surveys could be conducted in Schools and Colleges to ascertain the level of drug use in the Institution and to provide appropriate and adequate help when necessary.

*c) Children:*

Life Skills education can also be started for Children from the age group of 11 to 14 years old (classes 6-8). It is imperative to note here that the contents/ material to be taught is different from the High and Higher Secondary Level.

*d) Street Children:*

Education about the consequences of drug abuse must be provided to children living in the streets. Aside from the Street Children specific IEC, direct awareness programmes accompanied by counseling is vital for any impact to be attained. Addressing the immediate needs of the street children is however more crucial; hence the intervention for street children should also include provision of basic needs like shelter and food.

*Women:* An Awareness package that is continuous and has content that encourages women to seek treatment and for community and women at large to understand that drug abuse can affect women too and hence treatment must be provided for women as well.

e) Sex Workers:

Linkage with Meghalaya State AIDS Control Society is vital to make education on drug abuse for Sex workers effective. Through the Targeted Interventions for Sex Workers, Drug Abuse education programmes will be incorporated that will help sex workers to be linked with Rehabilitation Centres and After Care Centers, aside from receiving awareness about the disease of addiction.

## **2. SECONDARY PREVENTION:**

Rehabilitation Centres must have an attached counseling unit to cater to counseling and referrals. The unit should be supported by a separate team of counselors, Outreach workers and Doctor who are well trained in this aspect. The unit should create a strong link up with related services like the Vocational Centres, ART Centres, ICTCs, Civil Hospitals private clinics/ diagnostics clinics, HIV + networks, Drug Users Network, Alcoholic Anonymous groups etc. The same unit can also stretch services to high risk groups like sex workers, street children, schools etc by conducting sensitization programmes and discussions with them frequently.

Secondary prevention will also look at conducting Detoxification camps and providing primary health care to people abusing drugs; which will be done via the counseling and referral unit.

### **a) Corresponding approach in secondary prevention:**

#### **Harm Reduction:**

A comprehensive harm reduction package as an intervention in the prevention, treatment and care of Injecting Drug Users, which is aimed at preventing, slowing down and reversing the HIV/AIDS epidemic among IDUs is being supported by Agencies like World Health Organisation, United Nations Office of Drugs and Crime, UNAIDS. The country as a whole is implementing harm reduction programmes under the aegis of the National AIDS Control Organisation. The Department of Social Welfare in its effort to protect Drug Users in the State have the legal and moral right to treatment and to protect themselves from disease that they may contract during their drug using period.

Recognizing that addiction is a disease in itself and that recovery is slow if not guaranteed, and that diseases like HIV, hepatitis kills the patient faster than the disease of addiction itself, it is important that Harm reduction programmes in the State be encouraged and supported.

Harm Reduction is a multi pronged programme especially design for Injecting drug Users to minimize the risk of being infected with HIV and in infecting others. The aim of harm reduction is to keep drug users alive, well and productive until treatment works or they grow out of their drug use and can be reintegrated into society.

**Harm reduction has 2 main approaches:**

1. The Needle Syringe Exchange Programme: Wherein used syringes are being exchange for new ones. This has immensely helped IDUs in protecting themselves and others from HIV infection.

2. The Opioid Substitution Therapy (OST): OST involves replacing an IDU's drug of use (opioids such as heroin) with a medically safe drug or the same opioid in a safer mode of administration under medical supervision (in India the medical drug is Buprenorphine).

OST has been found to be very effective in the treatment of Drug users and in diverting their unsafe lifestyle to a safer more productive one.

It should be important that such programmes need to be accredited by the National Board of Hospitals and Health Care Settings (NABH). Drug abuse programmes is integrated into the harm reduction approach and can be an effective approach to those who are still using and who are not interested in treatment.

**b) TREATMENT**

Treatment facilities need to provide all possible medical and psychosocial therapies. Currently rehabilitation centres often do not provide adequate medical treatment for withdrawal symptoms, and this needs to be addressed so that drug users do not suffer needlessly. The Detoxification phase should be as painless as possible with provision of adequate and appropriate medication along with psychological support.

Treatment providers should ensure the highest level of skill and professionalism with all therapeutic and medical staff equipped with sufficient training and experience.

The welfare of the recovering user should always be of paramount importance. A process to monitor and take corrective action needs to be introduced to safeguard the interests of drug users undergoing treatment and ensure cases of ill treatment and abuse does not arise.

With various rehabs and treatment centres existing in the state, a minimum standard of care and treatment needs to be in place. While it is important that users have access to a wide range of treatment options, care should be made to ensure all the physical and psychological needs of users are met.

As the disease of addiction has a great impact on the family of the user, treatment should also include members of the family. Involvement of the family in the therapy process can greatly increase the chances of a successful treatment and rehabilitation.

With drug use increasing among young people and women, there is an urgent need to set up dedicated treatment facilities or integrated treatment for minors and women in existing facilities.

***i) Drug Abuse treatment in children***

Drug Abuse treatment in children has to be multi – dimensional.

The best option for treatment is rehabilitation of the child in his own family environment. Short term institutional care can be considered as an option, when other alternatives are being explored. Vulnerable children like street children and those who are not in a position to access treatment fall under the Juvenile Justice Act 2000 (Children in need of care and protection) (Juveniles in Conflict with Law). For these children, the Act provides for their support and care. Children's homes established under this Act can provide institutional care for these children with drug abuse problems.

For those children who can afford treatment, treatment centres for children below 18 years can be established by NGOs experienced in the treatment of drug abuse.

Treatment centres for drug abuse in children should look into the needs of these children. Hence treatment should comprise of:

1. Detoxification: treatment of withdrawals and medical complications.
2. Psychological assessment and support.
3. Family therapy (to bring about an enabling home environment)
4. Recreational activities
5. Re-integration of children into the family and community
6. Nonformal education/ skills
7. After-care.

The treatment centre should have an environment that substitutes the care of a family environment to meet the physical, psychological and emotional needs of the children. The infrastructure of such centres should be child friendly with the staff taking on roles of parent figures. Other children take on roles of siblings, thus providing a “family” structure and environment.

Guidelines and criteria for setting up treatment centres for Drug Abuse in Children should be in keeping with the JJ Act 2000.

*ii) Day Care Centre for Street Children.*

A day care and night shelter for street children should be in place in areas where Street children are present. Aside from being a safe place for the street child to be in, the centre will serve as a direct link with the street children for awareness and treatment for those into drug abuse.

### ***iii) Treatment for Women Drug Users:***

Women can be seen as being involved with drugs from three perspectives:

1. Women non-drug users with drug abusing families or partners
2. Women who consume drugs
3. Women who are involved in the production/distribution of drugs.

The needs of Women Drug users:

- Existing services are not adequate and these services need to be scaled up.
- Employment and shelter
- Proper and easy accessibility of treatment to be made available
- Re-integration into society

### **Treatment Model for Women Drug Users**

The Treatment should be a multi-cause interactive model which is gender based and gender sensitive. The model should meet the needs of these women such as medical care for Detoxification and Treatment of medical complications, counselling, family therapy, ancillary services, transportation, child-care, housing, legal assistance, jobs/ vocational training, acceptance of children in the treatment programme, attention to pregnant women drug users and economic rehabilitation.

### ***iv) Prison Intervention:***

- Prison staff must be sensitized and trained in drug abuse consequences and other effects.
- Skills in detecting drugs in smugglers must be a mandatory training.
- Prisons should have sniffer dogs to detect Drugs from prisoners, visitors or any suspect.
- Prisoners who are drug abusers must be sent for de-addiction.

## **Treatment for prisoners abusing drugs:**

### **Treatment Facilities for Drug Abusers in the Jails:**

1. Detoxification
2. Rehabilitation

#### 1. Detoxification:

This can be carried out under the supervision of the Jail Doctor. A separate detoxification room can be allotted in which the newly admitted Drug users can be kept for detoxification. The period of detoxification is for 15 days.

#### 2. Rehabilitation

Drug users who have been discharged from detoxification can then be transferred to the Rehabilitation section of the Jail. This is a section which houses only Drug users as there is a need to segregate them from the rest of the prisoners. This is necessary so as to be able to carry out the required rehabilitation programmes for the drug users. Secondly the Drug users need to be segregated so as to prevent them from interacting with prisoners who have committed heinous crimes.

Rehabilitation can be based on the “Therapeutic Community’ Programme. This is a peer-led, mutual self-help, social learning model of recovery. The aim is to inculcate value or principle based lifestyle changes recognizing that a drug user’s personality undergoes changes as a result of his addiction.

The negative features of this altered personality are focused on for change through emphasizing the development of these principles. The essence of the Therapeutic community is mutual self-help through sharing a person’s recovery, growth and privileges. It is a community that provides a supportive environment through peer support.

Day activities are structured so as to inculcate discipline in the lives of the drug user. These activities include Counselling (Group and one-to-one), education through sessions on issues of drug abuse, coping skills, relapse prevention etc., recreational activities and income-generation activities.

Drug users who have been discharged from the Jails can be referred to NGOs/ Support groups like Alcoholics Anonymous and Narcotics Anonymous Group for After-Care.

v) **Work Place Intervention:**

It is a well recognized fact that at any given time there are a number of alcoholics/ drug dependents in any Government/ Industrial organization. Some of them may have serious problems adversely affecting the individuals' performance at work which further leads to degeneration of his entire life. Drug Abuse (including alcohol) is a progressive disease and like any other disease, the earlier it is identified and treated, the greater the chance of recovery. When an individual's drug use affects his/ her job performance, treatment becomes necessary. The threat to one's job security amounts to crisis. Given a chance to improve performance and resolve crisis, employees are more apt to take up the assistance offered. Workplace Intervention for people abusing drugs is called the Employee Assistance Programme (EAP) i.e., to assist the Employee in getting treatment, subsequent recovery and therefore leading to satisfactory Job Performance.

**a) Identification of Treatment Centres:**

The State Government may identify at least 2(two) centres to refer the employee under the Employee Assistance Programme, for Treatment, Counselling and Rehabilitation.

**b) The Identified Centre should provide the following services:**

- 1) Consultancy.
- 2) Training & Education for Employees.
- 3) Assessment and Referral Services.
- 4) Effective treatment facilities.
- 5) After Care Programme and Family Therapy.

**c) Advantages of the Programme indicate the following:**

- 1) Referrals are based on a decline in job performance.
- 2) Individual Counselling.
- 3) Family Counselling.
- 4) Referral and subsequent admission.
- 5) Follow up.

#### **d) Special Leave:**

It is proposed that employees under the EAS, be granted special leave to undergo treatment and counselling. However, all medical expenses are to be borne by the individual.

### **3. TERTIARY PREVENTION:**

The concept of addiction being a disease is still not widely known or accepted by many sections of society. Various large and influential bodies of society often deny the drug users' right and need for specialized and appropriate treatment and often disregard basic human rights in their dealings with users.

Advocacy needs to be a collaborative activity and strengthened across all concerned stakeholders in society, including law enforcement agencies and the people who are affected by drug use. A central or apex body would be invaluable to initiate and coordinate advocacy efforts to achieve wide and effective coverage. This body could also look into matters of discrimination, maltreatment and harm caused to drug users, with the rights of users kept at the highest priority.

Advocacy efforts need to be based on a clear understanding of addiction (as a disease as defined by World Health Organisation and various national Medical Associations).

The widely acceptable definition of health is that given by the WHO in the preamble of its constitution, according to World Health Organisation, "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease." In recent years, this statement has been amplified to include the ability to lead a 'socially and economically productive life'

Everyone has the right to life, liberty and the security of person.

As addiction compromises all the above tenets, appropriate and sufficient measures are needed to allow drug users enjoy this right.

Drug users can be incarcerated for long periods for consumption or possession of tiny amounts of narcotics. Drug users are regularly denied due process in the handling of criminal cases against them. They are often subject to widespread discrimination and stigma, marginalized by society, and denied access to basic services. They are vulnerable to a particular kind of torture as their addiction can be used against them as an instrument of coercion in police interrogations.

The right to health includes the right to obtain health services without fear of punishment – impossible to achieve under the drug law regime. As the UN Committee on Economic, Social and Cultural Rights has stated, policies that “are likely to result in.... unnecessary morbidity and preventable mortality”, are breaches of governments’ Obligation to respect the right to the highest obtainable standard of health.

There is a particularly important need to address stigmatization of, and discrimination against, injecting drug users as barriers to the right to health and other human rights.

For example:

- Drug users are often stigmatized and are vulnerable to repressive treatment by the criminal justice system. Often, drug addiction is treated primarily as a matter of criminal law rather than a health issue.
- Discrimination against drug users can hinder HIV prevention efforts: people will not seek HIV counseling, testing, treatment, and support if this means facing discrimination,
- Lack of privacy or confidentiality, alienation or in some cases, the threat of incarceration.
- Lack of human rights protection makes it more difficult for drug users to cope with HIV/AIDS. Where drug addiction is met with HIV transmission, those affected can be doubly stigmatized and may suffer discrimination at multiple levels.

### **VIII) STUDY AND RESEARCH:**

The State of Meghalaya is yet to have a consistent research programme on drug abuse. The approach towards treatment and prevention programmes has always been based on loose information and observations that lack a concrete system of follow up or assessment. Research must be promoted among agencies recognized by the Government and also by State Government.

Agencies/ Departments alike. The State must plan to conduct researches/ survey on a regular basis. This will help in effective planning of programmes and to have an authentic knowledge of the drug abuse scenario in the State always. These researches must be continuous with old surveys renewed and studied again.

Topics can range depending on the need and requirement for such research. Some mandatory studies that need to be done include:

- a) The market and production of illicit drugs in the State.
- b) Drug trafficking and its nexus with other illegal activities like arms smuggling within the state or inter State.
- c) Rehabilitation/ drug treatment, impact on recovery and relapses.
- d) Effectiveness of the Mechanism for testing for drugs and precursors and the technology involved.
- e) Impact of harm reduction on drug abuse.

### **IX. Capacity Building and Training**

Training and capacity building for the various stakeholders in the fight against the menace of drug abuse is essential to equip them with skills and knowledge in dealing with this issue.

Hence, the various stakeholders namely NGOs, Community Based Organisations (CBOs), Faith Based Organisation (FBOs), Parent, Teachers, Heads of various Departments, Administrators, down to the level of the grassroot workers namely ASHA & Anganwadi Workers, needs Training for prevention, early detection, referral, counselling etc.

The Education Department firstly could make Drug Awareness an Integral part of the school curriculum and students must be equipped with life skills to enable the temptation/peer pressure to try drugs, and its harmful effects.

Drug Awareness could also be part of the Training Curriculum in the various Teachers Training Courses. It must also form part of the curriculum for Training of the ASHA worker under Health Department and Anganwadi Worker under Social Welfare Department.

It is equally important to train the various Head of Departments and sensitize them on the various aspects of drug abuse.

Training must be in place on detoxification and overdose management for Doctors and paramedical staffs in Government and private run health Institutions/ Hospitals.

Capacity Building is very essential to enhance the efforts in drug abuse prevention and treatment programmes. Being a complex disease, it is only right that the persons involved in addressing it must be qualified and sensitive to the issues that are associated with this disease. Certain departments like the Police, Customs, have trainings on drug law enforcement in their training curriculum. While Central agencies have specific training centres e.g, for Doctors – National Drug Dependence Treatment Training Centre (NDDTTC) of the AIMS and for NGO personnels – the National Institute of Social Defence (NISD); the State has no facility for trainings as such.

The State must look into having training centres available whereby regular trainings can be held and can be accessed easily by the personnels of NGIs, Doctors, Nurses etc in the treatment and prevention of drug abuse.

A nodal agency like the Department of Social Welfare can be identified wherein the following responsibilities are expected:

1. Formulation of training objectives for various target groups.
2. Design training programmes/ develop manuals that can be related to locally.
3. Documentation of best practices, innovations in treatment, and anything related to drug abuse which will contribute to the state and country's effort to check the disease.
4. Prepare training materials.
5. Conduct Training of Trainers (TOTs) and related training programmes regularly or on a need based.

## **X) POLICY IMPLEMENTATION & CO-ORDINATION MECHANISM**

Substance Abuse is a Multi – Dimensional Problem which requires a Multi-Sectoral Approach. For effective Policy Implementation, a Multi-Sectoral Convergence, Collaboration, Co-ordination and Linkage is imperative.

Firstly, there is a need to identify the various Stakeholders who can be partners in implementing the Policy at the State Level, District Level, Block Level and right down to the Community Village Level.

Secondly, it is important to identify the role and responsibilities of each stakeholder to effectively implement the Policy.

Thirdly, it is vital to work out an effective co-ordination mechanism between the various stakeholders for effective Policy implementation.

### **A. Various Stakeholders for Policy Implementation**

- ❖ At the Government level, besides the Social Welfare Department, the different Departments of the Govt. who can be partners in implementing the Policy are:
  - Education Department.
  - Police Department.
  - Sports & Youth Affairs Department.
  - Health Department.
  - Meghalaya AIDS Control Society.
  - Directorate of Information & Public Relations.
  - Industries.
  - Horticulture.
  - Civil Defence & Home Guards.
  - Registrar Co-operative Societies.
  - Employment & craftsmanship.

At the Non Government level:

- ❖ NGOs working in the field of Drug Abuse, Voluntary Organisation etc.
- ❖ Youth Organisation, Women's Organisation.
- ❖ Faith Based Organisations.
- ❖ Teacher/ Lecturers.
- ❖ Parents/ Guardians.
- ❖ Drug User's Network.

For implementing the Policy, the various stakeholders need to converge, collaborate, co-ordinate and maintain a link with each others. This could be done by forming Committees at different levels where members could meet and chalk out programmes and review implementation of the Policy.

**At the State Level:** The State Level Co-ordination Committee on Drug Abuse has already been constituted with the Minister I/c. Social Welfare as its Chairman. The line Departments and NGOs working in the field are also members of the Committee. No such Committees have been constituted at the District Level, Block Level and Community/ Village Level.

**At the District Level:** The District Level Co-ordinations Committee on Drug Abuse with the Deputy Commissioner as Chairman and the line Departments at the District Level, NGOs, Teachers etc. at the District Level could be constituted for implementation and review of the Policy. Likewise,

**At the Block Level:** The B.D.O as Chairman and line Departments Officers and NGOs etc. as members could be constituted to form the Block Level Co-ordination Committee on Drug Abuse.

At the Village/ Community Level: The Committee could be constituted with the Headman as Chairman, Teachers, AWW, AWM, ASHA, NGOs at the Village Level, Youth Organisation, Women's Organisation etc. as members.

## **B. Multi-Stake holders Role and Responsibilities**

At the State Level, the Director of Social Welfare is the Member Secretary of the Committee at the State Level.

The Social Welfare Department is to play the leading role in convening the committees at the State Level and right down to the Village/ Community Level. The Department is also to liaise with the members in chalking out the strategies to implement the Policy and also to follow up and review the action taken by the respective members.

**Education Department:** The DERT in the Education Department has a wide outreach across the State covering even the remotest village. Schools are the first start in creating awareness on Drug Abuse.

Contents on substance abuse, identification of students abusing drugs, counselling skills etc. could be incorporated in the curriculum as part of the Training for Teachers to enable the teachers to create awareness, early identification and referral.

As part of the school curriculum, students could be taught like skill education on substance use for raising awareness as well as empowerment.

**Police Department:** The Police Department could also include substance abuse Awareness Programmes in their curriculum for training Police Functionaries and officials.

As the Policy emphasis on the Harm Reduction & Demand Reduction and not on the Supply Reduction, the implementation of the NDPS Act by the Police Department and issues related to it would be beyond the purview of this Policy.

**Sports & Youth Affairs Department :** This Department dealing with youths could play a significant role in implementing the Policy, Awareness Campaign through Sports and other recreational activities could be organised, setting up more recreational centres for youths, encouraging youths to take up sports and recreation, mobilizing and involving youths in various social activities etc.

**Health Department:** The Health Department could take up issues relating to the treatment of substance abusers. Doctors stationed in CHCs, PHC, and the Civil Hospitals need to be skilled in administering detoxification services and in overdose management. Civil hospitals in all Districts should have a unit/ wing for detoxification and the emergency team should be trained in managing overdose cases.

The Health Department could co-ordinate with the Social Welfare Department in awareness camps, detoxification camps and other activities in the State.

The Health Department could also play a leading role in training of its functionaries and its officials with the objective of strengthening their comprehension of drug abuse.

**Directorate of Information & Public Relation:** This Department could take the lead in publishing of IEC materials in all the Regional Languages.

#### **Meghalaya AIDS Control Society**

The Society is already implementing various schemes and projects for substance abusers linked with HIV/ AIDS.

The Programmes/ activities could be further intensified to cover maximum area possible with special focus on High Risk Areas.

#### **Industries/ Horticulture, Co-operative Societies/ Employment & Craftsmanship, KVIC**

So far, the above mentioned Departments have been left out of the ambit of the substance abuse but it is felt necessary to also rope them in the for the Rehabilitation and Social Re-integration of the recovering addicts.

These Departments could provide gainful employment and help in the rehabilitation of the addicts. The various schemes and self employment opportunities could be given preference to this section of the society.

The role and responsibilities of the NGOs, Voluntary Organisations, Faith based Organisations etc. would be defined more clearly depending on the objectives, target group etc.

C. The Committees at the State Level right down to the Block/ Village Level would be responsible to work out an effective co-ordination mechanism i.e, frequency of meetings, agendas, action to be taken by each Department/ member, follow up and review of the programmes and activities.

**D. Monitoring & Evaluation**

Monitoring will be done in two levels, internal and external.

Internal monitoring: The District level Coordination Committee and the State Level Coordination Committee will have the added responsibility to carry out monitoring of drug abuse prevention programmes in the State. The process will have the District Level sharing the reports with the State level coordination committee. Any pertinent issues, concerns arising from the District will be address together with the State Committee. Monitoring will be done twice a year.

Powers and Function of the District Level Coordination Committee:

Powers and Function of the State Level Coordination Committee:

External monitoring: Every once a year, the Department will provide for external evaluation and monitoring of the drug abuse prevention programmes in the State. The External team will assess the programmes under the Primary Prevention, Secondary Prevention and the Tertiary Prevention and provide guidance and recommendations to the quality and progress of these programmes.

Documentation: State Level data is very vital to understand the progress of work done and the current scenario of drug abuse. Social Welfare can be the nodal agency to consolidate data on the drug abuse prevention programmes of the State which can be accessed by the public/ stakeholders for reference and knowledge.

A separate unit of experts in technology and documentation can be established to help this process move smoothly. It is advised that a software be developed for this data collection which will increase the efficiency of the team.

**Department like Police and Custom (Supply) will continue to follow their guidelines in supply reduction.**