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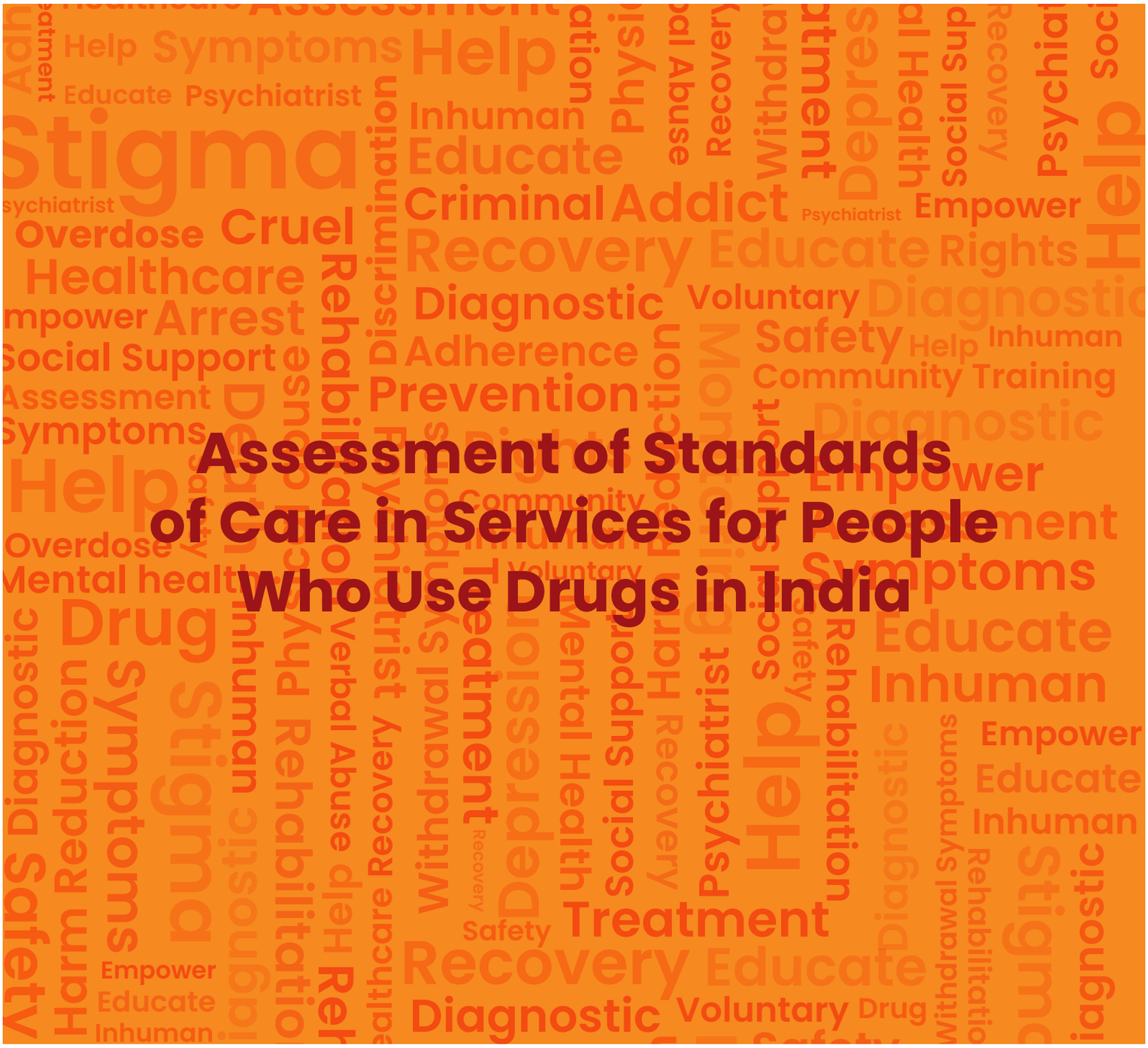

Assessment of Standards of Care in Services for People Who Use Drugs in India

Indian Drug Users' Forum
The voice of the drug using communities from across the country

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Foreword

Drug use is a health problem affecting individuals, their families and society at large. Drug use is now recognised as an illness like other chronic non-communicable diseases such as diabetes or hypertension. People who use drugs (PWUD) require treatment from health professionals, as well as care and support of caregivers and society members. Scientific research has shown that treating addiction can lead to improved outcomes not only for the individuals but also for society at large.

However, there is no single approach to the treatment of addictive disorders. Some emphasize on medical approach, while others emphasize psychological or social approaches in helping PWUD. Unfortunately, PWUD are also subjected to physical violence and torture in the name of providing treatment. An important lacuna in the provision of treatment and care for PWUD is a lack of standardisation of the treatment process and approaches available for PWUD for treating addiction.

The present document looks at existing models and modalities of treatment followed for providing care and support for PWUD in India, and the standards followed in various addiction treatment facilities in India. The report also provides recommendations on how the existing standards can be improved. Based on our experience we realise that punitive treatment does not only treat addiction it violates human rights and reinforces the stereotypes against PWUD.

This document is produced with a hope that it would prove useful as an effective tool for advocating for the rights of PWUD to access evidence-based treatment anchored on the principles of human rights and justice. I am also hopeful that this document can be useful to policymakers and programme planners of India in improving the standards of the addiction treatment facilities.

Tushar Palorkar
Acting Chief Executive
Alliance India

Message

As the President of the Indian Drug Users Forum (IDUF), I welcome the opportunity to write this preface on behalf of my community. IDUF is a national peer-based organization that works to defend the rights of people who use drugs and to address stigma and criminalization. The findings from the "Assessment of standards of care in services for people who use drugs in India" are of huge significance for our community – especially those who remain beyond the reach of the prevention, treatment and care services and has left many of us fighting for survival. It is the time that drug control and human rights system cease to behave as if they are in parallel universes.

No drug law, policy, or practice should have the effect of undermining or violating the dignity of any person or group of persons - including especially people who use drugs in treatment, deaddiction and/or rehabilitation centers. Further, we believe that a person's involvement in drug-related criminality affects the enjoyment of some rights and specifically engages others. In no case are human rights entirely forfeited as also reinforced under the recently launched International Guidelines on Human Rights and Drug Policy (March 2019) by the UNDP, UNAIDS and the World Health Organization. With specific reference to drug dependence treatment; the International Guidelines on Human Rights and Drug Policy highlight that "the right to health as applied to drug policy includes access to evidence-based drug dependence treatment on a voluntary basis".

In accordance with their right to health obligations, it also recommends that governments should "ensure the availability and accessibility of drug treatment services that are acceptable, delivered in a scientifically sound and medically appropriate manner, and of good quality (that is, with a strong evidence base and independent oversight). This study by India HIV/AIDS Alliance is timely and also compliments some of the key findings of the "Magnitude of Substance Use in India" (February 2019) study conducted by the Ministry of Social Justice and Empowerment, Government of India. It presents an opportunity for policy makers to identify and address key issues of people who use drugs to ensure the prevention, treatment and care efforts in India are further strengthened through "meaningful involvement of people who use drugs".

Moses Zofaka Pachuau
President
Indian Drug Users Forum (IDUF)

Abbreviations

SUD	Substance Use Disorder
DAC	De-Addiction Centre
DDAP	Drug De-Addiction Programme
DTC	Drug Treatment Clinics
HIV	Human Immuno-deficiency Virus
IRCA	Integrated Rehabilitation Centre for Addicts
MHCA	Mental Healthcare Act
MoH&FW	Ministry of Health and Family Welfare, Government of India
MSJE	Ministry of Social Justice and Empowerment, Government of India
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
OST	Opioid Substitution Therapy
PWUD	People Who Use Drugs
TI	Targeted Intervention
WHO	World Health Organization

Contents

This document is a product of *Global Fund Regional Harm Reduction Advocacy in Asia project* (2017-2020) that involves 7 countries in Asia (India, Vietnam, Indonesia, Cambodia, Thailand, Nepal, and the Philippines). The project aims to maximize the impact of investments that help break the cycle of transmission among people who inject drugs in concentrated epidemics by addressing legal, policy and health system barriers that hinder necessary outreach and coverage of essential services. Strategic engagement of the key stakeholders from relevant government ministries, UN agencies, civil society organisations and community networks working on harm reduction for PWIDs is critical to achieving increased access to HIV and Harm reduction services.

Background

Substance use disorders (SUD) are serious health issues, with a significant burden on the affected individuals and their families. There are also significant costs to society including lost productivity, crime and lawlessness, increased healthcare costs, and various negative social consequences. According to global estimates, there are 2.3 billion alcohol users and 271 million illicit drug users (1,2). The global disease burden attributable to illicit drugs and alcohol use disorders is estimated to be 10.9% and 9.6% of Disability Adjusted Life Years (DALY) caused by mental illness and SUD (3). Opioids alone are responsible for around 76% of deaths due to drug use disorders, which includes overdose-related deaths as well as deaths due to infections caused by unsafe injection practices (4).

In India, the recently conducted national survey on the magnitude of substance use in India, 2019, reported alcohol (14.6%) as the most commonly used substance in the past year. This was followed by cannabis (2.8%) and opioid use (2.1%) (5). It was estimated that there are about 57 million people suffering from alcohol use disorder, 7.2 million people with cannabis use disorder, and 7.7 million people with opioid use disorder. Similarly, it was estimated that there are around 850,000 people who inject drugs in India. Thus, a large number of people are affected by substance use disorder in India.

The management of substance use disorders has evolved over time, with a change in the understanding of 'causation' of substance use disorders as well as with advancement in medical science which brought forward more effective treatment options. The understanding has shifted from attribution of 'cause' of substance use disorder to religious-moral degradation followed by social deviation and later to biological factors. The current conceptualization of SUDs relies heavily on a bio-psycho-social model, with biological factors understood to be playing a distinct and important role in the development of addiction as well as relapse once the individual has attained remission from the use of substances (6). The treatment, accordingly, has undergone changes over the years. With various parallel schools of thoughts existing for explaining SUD and guiding the treatment, treatment centres that follow different treatment strategies often co-exist with each other in a region or country. It is important to ensure that basic standards are laid down for these centres to follow and provide optimal care and support to individuals suffering from SUD.

Response to the problem of substance use disorder in India

In India, different players and institutions provide treatment for substance use disorder. The Drug De-addiction Programme (DDAP), Ministry of Health and Family Welfare (MOH&FW), Government of India, supports Drug 'De-addiction centres' (DACs) established in Government hospitals (7). Through this programme, around 122 DACs have been established throughout the country. These DACs are run by the

departments of psychiatry in medical colleges or in general hospitals at district levels. Additionally, the Ministry of Social Justice and Empowerment (MSJE), Government of India, supports Non-Governmental Organisations (NGOs) to provide prevention, treatment and rehabilitation services to people who use drugs. As per available MSJE reports, there were more than 400 NGO-run centres called as 'Integrated Rehabilitation Centre for Addicts' (IRCAs) throughout the country.

The third group is the private sector. There is no data on the nature and extent of services provided by the 'private sector'. Additionally, the private sector is not a homogenous entity – this includes private doctors, including private psychiatrists, providing treatment as well as many private entities who run 'Rehabilitation Centres'. Even among these private DACs, there is no uniformity – some are operated by NGOs, some by faith-based organisations, others are operated by 'recovering drug users'. Similarly, there is no uniformity in the infrastructure, staffing and the type of services available with these centres.

Quality of healthcare

Quality of care is described as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (8). It includes both preventive and treatment or curative services, both community-based and facility-based services and is for individuals as well as for the population.

Elements of healthcare quality

The seven elements or characteristics of health care quality as mentioned by the World Health Organization (WHO) (8) are as follows:

- **Equity:** The quality of health care should not vary according to personal characteristics such as gender, race, ethnicity, geographical location and socioeconomic status
- **Effectiveness:** Health care services should be based on scientific knowledge and evidence-based guidelines
- **Safety:** Health care service should minimize harm, including preventable injuries and medical errors, to the patient
- **Efficiency:** Health care should maximize health resources and reduce wastage
- **People-centeredness:** Health care services should respect and respond to the patient's preferences, needs and values. Health care should have (i) 'Continuity' of services from illness prevention to palliation and between different levels of care (Ex: Primary care to specialist care), have (ii) 'Co-ordination' across different care settings and have (iii) 'Comprehensiveness'.
- **Timeliness:** There should be minimal delay in providing and receiving services
- **Integration:** There should be co-ordination between the various facilities and providers

Factors influencing the quality of health care

There are various factors that can influence the quality of health care (9).

- **Patient-related factors:** These include the understanding capacity of patient, patient education, patient's attitude, behaviour, patient's responsibility, patient's involvement and co-operation and type and severity of patient's illness

- **Provider-related factors:** These include personality of provider, knowledge, and skills of provider, quality of education provided by medical universities, provider's job satisfaction and motivation (depends further on multiple factors like pay, working environment, managerial leadership, organisational policies, co-workers, recognition, job security, job identity, and chances for promotion)
- **Environmental factors:** Manpower, financial resources, quality of medical instruments, strength of referral system, support services, effectiveness of the management, flexibility of national policies to adapt to national circumstances, collaboration between organisations.

Importance of Quality of health care

Poor quality of care can lead to wastage of time, resources, money and cause more harm to patients (8,10). When people perceive poor quality of health care being provided, they change treatment settings (for example, preference of private hospitals over public hospitals), or even travel long distances, sometimes even across the border, if it is affordable, to get a good quality of health care (11). This trend is not only present among affluent people, but also among the less affluent population. This also results in loss of daily wages caused by long-distance travel, which in turn can lead to serious financial loss to the family and even to poverty. Not providing quality services at the right place and at the right time, not only increases the economic burden on a family but also leads to wastage of time and wastage of human resources. The poor-quality care disproportionately affects the more vulnerable population of society, not only due to health costs during illness but also due to the long-term disability, impairment and lost productivity caused by the harms of poor health care (8).

Apart from these negative effects on the patient's family, poor quality of health care also can lead to harm to the patient directly. For example, based on the 2016 Global burden of disease study, it has been found that, out of the 8.6 million excess deaths in Lower and Middle-Income Countries (LMICs), that were amenable to health care, around 58.3% (5 million excess deaths) was due to poor quality care, i.e., the patient had used the services, but died due to poor health care quality and 46.1% (3.6 million excess deaths) was due to non-utilisation of available health care (12). Also, if people are not treated with proper dignity and respect by providers, people would avoid future treatment with such providers, leading to wastage of intervention, even if it is safe, effective and widely available (13). Poor quality of health care leads to significant economic impact, not only for the individual but also for health systems and community. For example, some admissions as in-patients could be avoided if given proper quality care at the proper time for the less sick patients. More intensive health care can be then utilized for sicker patients (8). This is especially useful in resource-poor settings like India.

Standards of Care for Treatment of People Who Use Drugs

Though there is a large number of people who use drugs (PWUD), the number of people who receive treatment for substance use disorder is very less. Globally, it is estimated that only one out of six PWUD receive treatment (4). The recently conducted national survey on the magnitude of substance use in India reported that only one in thirty-eight individuals with problem alcohol use has received any form of treatment, while in the case of illegal drugs, one in four individuals had received any form of treatment (5). Thus, there is a huge gap in the number of people who need treatment and those who receive them. Data on the quality of treatment received by persons suffering from substance use disorders, especially from lower- and middle-income countries, is lacking. However, there have been reports of human rights violation, torture and involuntary detention in some drug treatment centres across the world, including from India (14,15). While on one hand, there is a huge treatment gap, on the other hand, the treatment received by those with the disorder is also not equal, with some receiving good evidence-based treatment and some facing human rights violation in the name of treatment at drug treatment centres. Hence, it is not only necessary to fill the treatment gap by making the services accessible, but it is also necessary to have minimum standards that must be followed to make treatment services more effective, evidence-based and of good quality.

The UNODC and WHO have jointly published a document 'UNODC-WHO International Standards for the Treatment of Drug Use Disorders' that is undergoing field testing in various countries (16). The document lays down several principles that need to be followed irrespective of the treatment philosophy followed in a particular jurisdiction. It is also stated that any treatment for substance use disorder should 'meet the common standards of all health care':

- Be consistent with the UN Declaration of Human Rights and existing UN Conventions
- Promote personal autonomy
- Promote individual and societal safety

Principles for treatment of substance use disorder

The various principles laid down in the document on international standards for the treatment of drug use disorders by WHO and UNODC[1] are as follows:

1. Treatment must be available, accessible, attractive and appropriate

Drug use disorders can be treated effectively if people have access to a wide range of services for drug use. The services range from outreach, screening, and

[1] *https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP4_V1601463.pdf*

brief interventions, inpatient and outpatient treatment, medical and psychosocial treatment, long-term residential treatment, rehabilitation, and recovery support services. Furthermore, these services must be available in different geographies with minimal barriers that can affect accessibility. The services should offer social support and protection, and general medical care along with addiction treatment.

2. Ensuring ethical standards of care in treatment services

This principle lays emphasis on respecting the individual's autonomy in the treatment of drug use disorders and following the universal ethical healthcare standards. Thus, the treatment should ensure the well-being of the individual, ensure non-discrimination and remove the stigma. The decisions on treatment initiation and cessation, the modality of treatment should be made by the individual to the extent of her/his capacity to do so. Treatment should be provided after getting consent from the individual. Punitive, humiliating and degrading interventions should not be used on the individual in the name of treatment.

3. Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services

Drug use disorders should be seen as health problems rather than criminal behaviour. Even when PWUD are imprisoned, they should be provided treatment for their drug use. There should be a close collaboration with the criminal justice system to encourage treatment for drug use disorders instead of punishment.

4. Treatment must be based on scientific evidence and respond to the specific needs of individuals with drug use disorders

Only those approaches that have been found to be scientifically effective or agreed upon by the international body of experts must be used to treat drug use disorders. The duration and intensity of the interventions must be in line with evidence-based guidelines. Existing interventions should be adapted to the cultural and financial situation of the country without undermining the core elements crucial for effective outcomes.

5. Responding to the needs of specific populations

Several subgroups of people with drug use disorders have specific needs. Working with these groups like women who use drugs and young people requires treatment planning and services that considers their unique vulnerabilities and needs.

6. Ensuring good clinical governance of treatment services and programmes for drug use disorders

Treatment policies, programmes, procedures, and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and the target population. Service organisation should be responsive to the service user's needs and should have a variety of measures to support their staff and encourage them to provide good quality services.

7. Treatment policies, services, and procedures should support an integrated treatment approach, and linkages to complementary services must be constantly monitored and evaluated

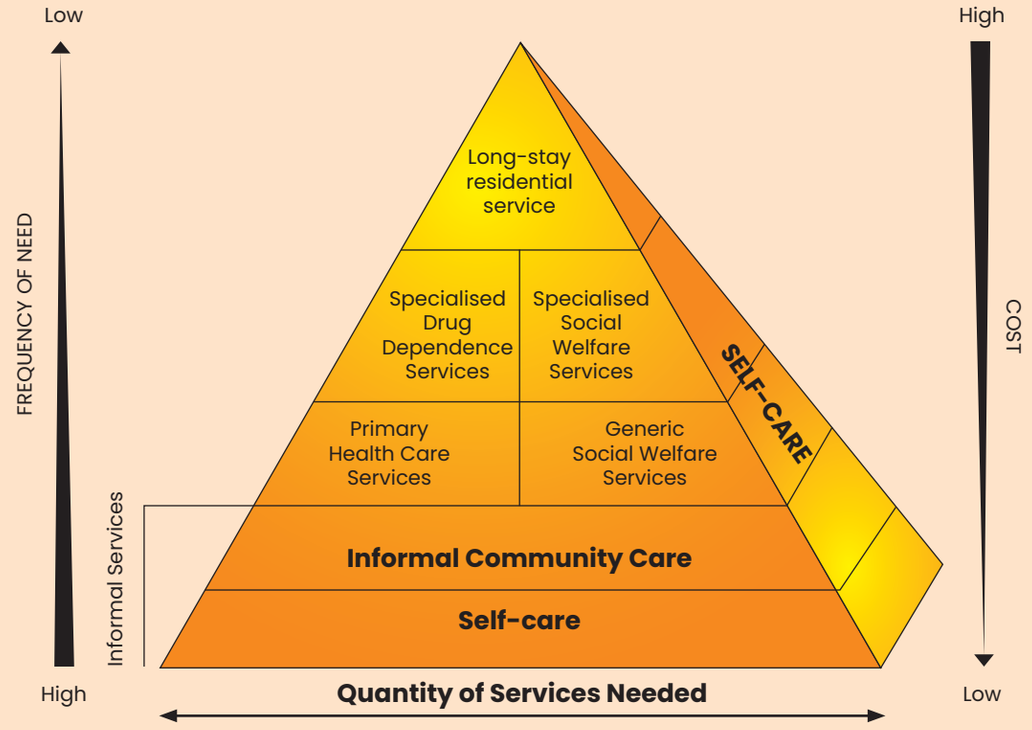
The treatment system for drug use disorder should include mental health care, social services, other specialist health care services, etc. The treatment system must be constantly monitored, evaluated and adapted.

Integrating various treatment services for drug use disorders

It is important to recognise that individuals using psychoactive substances are at different stages. Some individuals may be at the lower end of the drug use disorder spectrum; they may have initiated drug use recently and would have suffered minimal damage in terms of occupational, social and familial problems. Others may have a severe degree of drug use disorder with several years of drug use, multiple drug use, unemployment, homelessness, and other drug-related complication.
The service organisation pyramid of different treatment services shows that most treatment services are required at levels of lower intensity which can help people in the early stage of their drug use disorder. Providing low-intensity treatment services can prevent individuals from developing more severe drug use disorder.

The low-intensity treatment services are also less cost-intensive and resource-intensive compared to other specialised services required for individuals at later stages of drug use disorders.

Figure: Service organization pyramid for substance use disorder treatment and care



Examining Existing Standards of Care for Treatment of Substance Use Disorder in India

As mentioned earlier, there are three distinct agencies that provide treatment and services for SUD. These include – Ministry of Health and Family Welfare, Ministry of Social Justice and Empowerment, and Private Sector. The National AIDS Control Organisation also provides services for a particular subset of PWUD – people who inject drugs (PWID). The documents on standards developed by these agencies were examined and compared with the standards recommended by the international agencies to understand the standards of care for PWUD followed in the centres supported by the three agencies.

A. Government Drug De-Addiction Centres (DACs)

After the recommendations of a Cabinet subcommittee, the "Drug De-addiction Programme (DDAP)" was launched by MoH&FW in 1988 for treatment provisions of individuals with SUDs (DDAP, 2017). The program initially started with the establishment of 30 bedded "De-Addiction Centres (DAC)" in six premier institutes for providing inpatient treatment to patients with substance use disorder. Subsequently, the program was further expanded in other medical colleges and district hospitals in various states with the plan of one-time funding for the establishment of the centre, and recurring costs to be borne by the respective states. The "DACs" of north-eastern states were fully funded centrally, as were the six premier institutes. Currently, there are a total of 122 DACs supported or established through the DDAP, which includes 43 fully funded centres in the North East (7).

While there is no ongoing programme of monitoring the functioning of DACs, on a few occasions, monitoring and evaluation exercises have been carried out by DDAP, MoH&FW. Some of the constraints in the functioning of DACs noted in these evaluation exercises included:

- There was mostly no provision of funding for providing services through the state governments for the DACs (except for north-eastern states that were receiving a recurring grant from the Central government).
- Low priority was accorded to drug dependence treatment services by the hospital authorities. Trained doctors were not available in many of the centres, neither was there any dedicated support staff (nurses/counsellors).
- Very few patients were accessing services and even those accessing services were not retained in treatment. Record maintenance was inadequate. Most of the medicines required for treatment were usually not available. Psychosocial interventions were often not provided. Community-based activities were lacking.

Thus, these evaluation exercises demonstrated that the model of service delivery – based on an inpatient setting of care with infrastructure support by the central government and which was dependent upon state government support for the continuation of services – was met with only partial success. Hence, there was an urgent need for strengthening the Drug De-addiction Programme of MoH&FW in India.

Standards of care for De-addiction Centres

A document titled 'Minimum Standards of Care for the Government De-addiction Centres' was developed by NDDTC, AIIMS for the DDAP, MoH&FW in 2009 (17). This document had sections on services, infrastructure, staff, training, and Monitoring and evaluation. The document was authored by experts in the field of substance use disorder.

In terms of **service**, the document advocated for the provision of both outpatient and inpatient services. Medications for both short-term withdrawal management was deemed to be as essential. The centres were to strive for getting medicines for the long-term treatment of SUDs. Similarly, emergency and laboratory services for SUD were to be integrated within the mainstream services available in the hospital. Basic psychosocial services were to be provided in outpatient and inpatient settings. The section on **infrastructure** has recommended the type of rooms/areas required to run inpatient and outpatient services as well as the space required for each room/area.

Other overarching issues and principles have also been laid down in the document. This includes accreditation of the centre, ensuring that the services at the centre are compatible with existing healthcare services available in the hospital, and develop policies that are sensitive and compatible with the local culture. The document has also mentioned that the services should be provided with due consent from the patient, and the privacy and confidentiality of the patient must be maintained.

Observations

The document has very well laid emphasis on both outpatient and inpatient services. Additionally, it has focused on the need for both short-term and long-term pharmacotherapy for SUD. There is more focus on the infrastructure, staff, and training. Though various services are mentioned, they are not detailed out in terms of how these services would be provided and operationalised. There is also mention of the need to maintain confidentiality and privacy of the patient, as well as consent to be obtained from the patient.

Furthermore, the patient or the end-user appears to be a passive recipient of the services rather than an active stakeholder. There are no mechanisms laid down that ensures how these standards would be followed, and who would monitor the compliance with the standards. There are no details on the penalties for non-compliance with the standards or incentives in case the centre exceeds the minimum standards laid down. Without such a mechanism, any document would remain a mere document without any real value in terms of implementation of the standards recommended.

There have been no further evaluations of the DACs conducted after the publication of the standards document. These evaluations would have provided an assessment of the extent to which the DACs follow these standards.

B. Integrated Rehabilitation Centre for Addicts

Integrated Rehabilitation Centre for Addicts (IRCAs) is funded by the MoSJE and is operated mainly by the NGOs. There are close to 400 IRCAs spread throughout the country. The IRCAs aim to help PWUD achieve total abstinence. The approach followed for ensuring total abstinence is 'Whole Person Recovery' (18). This approach, as described in the minimum standards document, seeks not only to make a person drug free but also help them to:

- Deal with personality defects
- Strengthen interpersonal relationships
- Develop work ethics and financial management
- Crime-free life
- Healthy recreational activities

The means to achieve this is by inpatient stay for an initial period of 30 days followed by outpatient follow-up and aftercare. In some cases, the duration of stay may exceed two months. The thirty-day period is spent on initial medical detoxification and psychological interventions.

Standards of care for IRCAs

The Ministry has prescribed standards to be followed in the NGOs running IRCAs in the form of a document titled 'Minimum Standards of Services for the programmes under the scheme for prevention of alcoholism and substances (Drugs) abuse'. The revised manual was published in the year 2009 (19). The document recommends standards for various schemes for substance use problem funded by the ministry, including Awareness-cum-Deaddiction camps, and Prevention of alcoholism and drug abuse at the workplace. Chapter two covers standards for IRCAs, while chapter five covers responsibilities of staff and code of ethics to be followed in IRCAs.

The chapter on standards for IRCAs mentions providing detoxification through a 'rights-based approach' to 'make withdrawals safe and comfortable'. However, there is no further elaboration of what this actually means and how it translates into everyday practice. There is also mention of management of withdrawal symptoms through medications though the protocols for the same are not provided or referenced. The psychological services, however, are extensively detailed in terms of the number of sessions, types of sessions (individual, group, family, re-educative, etc.). Similarly, the document also lays down the frequency of follow-up visits that an individual must undergo after he is discharged from IRCA, and also mechanisms of follow-up and contacts. There is an emphasis on record maintenance and means of verification of each of the activities carried out in the IRCA. The document also lays down standards for infrastructure, amenities and food served to patients.

The fifth chapter on the code of ethics for staff and rights of patients mentions the provision of treatment without discrimination with respect to the type of drug being used or the route of use of drugs. The chapter also clearly mentions

- No use of corporal punishment for any misbehaviour of clients
- No denial of food as means of punishment
- No discrimination against individuals who are HIV positive
- Confidentiality of the patient's information

Observations

The document not only lays down standards for IRCAs to follow but also spells the aims, objectives and the modality of treatment to be followed for PWUD. In this regard, it is noteworthy to mention here that the focus of treatment is inpatient followed by aftercare in OPD. Many patients who do not have severe forms of addiction (and form large chunks of patients with addictive disorders) and do not require inpatient care would then be left out of the treatment. Similarly, pharmacotherapy is emphasised for the short-term treatment of withdrawals. There is less emphasis on medicine use for long-term treatment. Much emphasis is on psychological interventions for short as well as long-term management of addiction. The mechanism to ensure that these standards are followed is not clearly spelled. As is the case with DACs, here too, the document follows a 'top-down' approach – the end-user seems to be a passive recipient of services, rather than an active stakeholder in treatment. However, one major problem in the document is the use of various terms that are clearly pejorative and are objectionable in current times. The document contains terms such as 'addicts', 'alcoholics', 'indemnity', etc. which have been removed from the scientific literature on PWUD.

There have been few formal assessments conducted to ascertain whether and to what extent IRCAs follow the standards laid down in the document on minimum standards. The Regional Resource and Training Centres (RRTCs) are expected to monitor IRCAs in their region with regards to adherence to the standards. There are no monitoring reports available in the public domain, and hence, the adherence to standards cannot be commented upon. The Ministry has also conducted accreditation of IRCAs based on the standards laid down in the document, and about 50 centres have been assessed for suitability of accreditation. However, most reports are not available in the public domain.

The executive summary of one undated report of an evaluation exercise conducted by an agency commissioned by MSJE, Govt of India, is available online (20). While the agency claims to have interviewed 370 'centre managers' and 7700 beneficiaries (including 'inmates, relapse and rehabilitated patients'), the detailed methodology, including how the centres were sampled, how were the respondents such as 'relapse' and 'rehabilitated patients' selected is not provided. The detailed report is also not available. As a result, the findings of the study cannot be entirely relied upon. The executive summary reports that most centres follow the laid down guidelines and most 'inmates' reported satisfaction with the treatment provided.

C. Opioid Substitution Therapy (OST) centres supported by National AIDS Control Organisation

Injecting drug use is contribute highest prevalence of HIV due to the sharing of needles and syringes. Though National AIDS Control Organisation (NACO) is not directly involved in 'treatment' of PWUD, as Opioid Substitution Therapy (OST) under NACO is provided from the purview of HIV prevention through reduction or cessation of injecting behaviour. However, OST also has benefits in terms of being a treatment strategy for opioid dependence as well. Hence it is briefly covered here.

The most evidence-based treatment for opioid dependence is opioid agonist maintenance treatment also known as opioid substitution therapy (OST). *OST has been included in NACP III as an essential intervention component for people who inject drugs*. OST offers people who are opioid dependent an alternative, prescribed medicine, most typically methadone or buprenorphine. OST is effective in enabling people to reduce or cease injecting drug use, greatly reducing their risk of HIV infection.

The NACO has a mandate of providing HIV prevention, treatment and care for the general population as well as population groups at risk of HIV. One of the high-risk groups is People Who Inject Drugs (PWID). NACO has adopted a harm reduction strategy for the prevention of HIV among PWID. Apart from needle syringe programmes implemented exclusively by NGOs, OST forms an important HIV prevention intervention programme supported by NACO. This is because almost all PWID in India use opioids and are dependent on opioids (21).

OST is an essential component of the HIV prevention strategy of NACO, since its inception in the third phase of the National AIDS Control Programme (NACP-III) in 2007 (22)his/her family, and the society. Injecting drug use (IDU. While the OST centres were initially run by NGOs implementing Targeted Intervention (TI) projects, most of the NACO OST centres in the country currently are located in Government hospitals that provide OST services through a collaborative public health model (23). In this model, the OST centre is located within the government hospital and is manned by a full-time staff comprising of a doctor, a nurse, a counsellor and a data manager. The staff of the OST centre works under the direct supervision of a designated 'nodal officer', who is a full-time employee of the hospital. The OST centre is linked with an IDU-TI located in the vicinity of the hospital for the initial referral of PWID clients to the centre, as well as field-based follow-up and advocacy. These centres cater to PWID exclusively and provide only outpatient-based OST for opioid dependent PWID. The OST medicines are dispensed daily to the PWID clients registered with the OST centre. Currently, there are more than 250 OST centres in the country supported by NACO, operating through either the NGO or the collaborative public health model, catering to more than 20,000 PWID (24).

Observations

NACO has well-developed guidelines and standard operating procedures for the implementation of OST programme. The Standard Operating Procedure (SOP) on OST has been developed in 2009 and has not been updated further, while the practice guidelines have been undergone revision in 2014 (25, 26). A situation assessment of OST centres carried out in 2012 showed that by and large, most centres adhered to the standards prescribed by NACO in implementing OST, including opening timings, dispensing timings, recruitment procedure, assessment, dispensing as well as the provision of ancillary services (27). The clients also reported improvement while on OST in terms of reduction in opioid use, withdrawals, craving, side effects, regularity, missing doses, and improvement in psychosocial status. Majority of the clients were satisfied with the treatment services being provided in the OST centres. There were some areas of concern in terms of dosing of buprenorphine, training of staff, and reportage of withdrawals by OST clients.

D. Private Sector

Though the private sector is not an 'addiction treatment programme' as is the case with the three programmes mentioned above, they form a major component of addiction treatment systems in India. They have also mushroomed as the centres established under the above three programmes are not sufficient to cater to the large population of substance users in need of treatment. There is no documentation of the number, type of private sector or their functioning. However, anecdotal understanding suggests that this is not a uniform sector. At present, most of these centres are not regulated by any of the governmental agencies. Some state Governments (such as Punjab) have enacted rules for compulsory licensing to operate addiction treatment centres.

There is great variation among the private sector providing addiction treatment services. At one extreme, addiction treatment is provided by psychiatrists, and at the other extreme, there are individuals with no qualification or experience in addiction treatment who run 'rehabilitation centres'. The psychiatrists provide outpatient as well as inpatient services with major focus on medical model of treatment. Some psychiatrists also provide long-term medications, including OST or opioid dependence. Most of the 'rehabilitation centres' have set up inpatient facilities. There are also reports of inhuman treatment in such centres, including resorting to physical and verbal abuse. However, these are anecdotal reports appearing in lay media, and one does not know the quality of treatment provided to patients admitted in such centres. A peer-reviewed article reported verbal abuse, physical abuse and torture by the staff of the private run centres in the state of Punjab (28).

Thus, to understand the actual status of the treatment services being offered by the private de-addiction centres currently, a rapid, dipstick assessment was planned to be conducted as part of this activity.

Assessment of private centres

The overall aim of the assessment was to understand the existing status of treatment services offered in drug treatment centres not funded by a government agency

(private centres) and further to draw recommendations towards standards of care based on this study. The specific objectives were: 1) To assess the nature and type of services provided for treatment of substance use disorders in drug treatment centres that were not supported by any Government agency, and 2) To assess satisfaction among recipients of addiction treatment services in drug treatment centres that were not supported by any Government agency.

The assessment was cross-sectional, qualitative in nature, which was conducted at different geographical locations. It was planned to do a purposive sampling of centres and clients through personal contact of the data collection team, and members of the Indian Drug Users Forum (IDUF) network. Different geographical locations were targeted to understand the situation across the country. Five states were covered in the assessment – Maharashtra, West Bengal, Tamil Nadu, Assam, and Uttar Pradesh. In-depth interviews were conducted with the centre staff or centre in-charge as well as with the clients who had taken treatment within the past one to two years. A total of 15 centres were accessed and one staff from each of the centre was interviewed. Similarly, 25 clients from across the five states were interviewed.

The assessment areas covered in the interview were as follows:

Interview of centre staff

- Infrastructure and amenities
- Staffing, qualifications and experience
- Treatment philosophy and modality, duration, locus, etc.
- Rights of clients in the treatment centres

Interview of clients (last treatment experience)

- Background and drug use details
- Details of centre – amenities, staff, etc.
- Treatment modality, duration, experience
- Rights (& violation of rights)

The data obtained from the qualitative interviews of the centre staff as well as interview of clients regarding their last treatment experience was analysed qualitatively. Initially, codes were developed after reading each interview, and themes occurring through these codes were identified.

Salient findings – interview with centre staff

All the 15 centres were private facilities, of which one was a private hospital. Most of the centres had inpatient settings only. Very few centres had outpatient services. Most centres claimed to have facility for 25 to 30 clients at any given time. There was no facility for women and children in most centres. Most of the centres were run by “recovering drug users”, i.e., drug users who had become abstinent. Most of the centres also had a part-time doctor, including a psychiatrist. Most centres provided counselling through either “recovering users” or “senior clients of the centre”.

Staff in most of the centres had a positive attitude towards people who used drugs. Most of the staff believed that medicines were not necessary for recovery and the treatment they recommended was useful as they themselves came out of addiction through that method. One of the staff mentioned – "*If chronic users like me could go through painful ways of healing all other drug users also needs to go the hard way*".

Staff at most centres claimed to follow Therapeutic Community (TC) or 12 step facilitation (Narcotics Anonymous/Alcohol Anonymous) for treatment of substance use disorders. Medicines were used in almost all centres for withdrawal management. However, no centre used medicines for long term management of substance use disorders. Almost all centres claimed that they involved family in the treatment process. Most centres provided treatment for three to six months period.

Most centres claimed that they used to admit unwilling clients also. Many centres provided 'pick-up' service from the client's home, which they called as "Rescue facility" or "Crisis management". For this, the centre staff used to take consent of family in almost all cases, while some centres also ask family members to inform the local police and submit a copy of the FIR to the centre. "*Family informs local police and submits a copy of the FIR to the centre*" – one of the staff at a centre mentioned. After admission, the client cannot decide to leave the treatment and only family can terminate treatment prematurely. Many centres denied any physical abuse of the clients. However, some staff did accept verbally abusing the clients.

Salient findings – In-depth interview with clients

Most of the clients reported being admitted for multiple substance use like heroin, cannabis, alcohol and sedatives. All the clients had the last treatment experience within the past one year. Almost all were admitted to private centre.

Most clients reported that there were around 30 – 35 clients at a time in the centre. Many clients perceived the rooms to be clean. However, it was found that they cleaned the rooms themselves. Many clients reported inadequate space. Counselling used to be held either in terrace or common hall. Many clients also perceived the toilets to be clean. However, again the toilets were cleaned by the clients themselves. Beds were not available in many centres and the available mattresses also had to be shared with other clients. Food was perceived to be satisfactory by most clients. Few recreational materials were available for the clients – In most cases, TV was the only recreational material, but for that too, access was restricted. In some centres, there were outdoor activities in the form of volleyball and football.

Most of the clients reported that the centres where they were admitted used to be run by "ex-users". Also, the majority of the staff in these centres were either ex-users or senior clients. The part-time doctor was available in most centres. Most of the clients were admitted for 3 months. Few were admitted for even one year. Even though symptomatic medications were given to manage withdrawals, it was inadequate in most cases. However, some clients felt that "*suffering withdrawals is part of improving motivation*". No medications were given on a long term basis or post-discharge of the clients. There were no investigations being done either before or after the

patients were admitted, even though there was a tie-up with local hospitals for the treatment of comorbid medical problems. Most of the clients reported being provided counselling at the centres, with some also reporting professional counsellors. Twelve-step based counselling was provided in many centres.

A good number of clients reported being admitted without their will to the private centre. Almost all reported pick-up facility in the centre. One of the clients reported - "*I went to sleep and the next day before I woke up, they came to pick me up. They allowed me to consume the last piece I had with me*". The majority of the clients could not leave treatment before completion of the required duration, except in cases when the family consented. Most of the clients were provided access to family, but only after the initial few weeks and it was also for a limited duration only.

Most of the clients reported having experienced verbal abuse at the centres. However, some felt justified to receive the same. One of the clients reported - "*Yes, sometimes, a small bit of verbal abuse is necessary for the treatment of old junkies like us.*" A modest number of clients also reported getting physical punishment at the centres. For example, one of the clients mentioned - "*The kitchen in-charge wanted me to bring a tub full of water which I denied and told him that I have not come here to work, he slapped me and forced me realise that I am unworthy of anything and staying in the outside world.*" Almost all reported witnessing physical punishment to others in the form of beating, locking up in room, standing under scorching sun, standing up for hours, not being allowed to talk, not being allowed to meet family, not being given food, chained, made to sit on brick or glass. Some were denied smoking as a sort of punishment.

The overall experience was not good for many clients. Few clients had mixed feelings and reported that some elements in the centre helped them to cope and stay sober. Very few had a good experience at the centres. Clients reported – "*It was like, that it was just a business to earn money*". Some felt that "*People who think they can torture others should be punished*".

Observations

- There is a huge market of private de-addiction centres in India. At each city visited by the team, the centre staff, as well as client, reported that there were around 50 to 75 such private drug treatment centres in total in that city. Based on the study, each centre had around 25 to 30 clients at any given point of time. So, in one city there was an average of 1250 to 2250 clients being admitted at such centres at any given point.
- There is a very limited choice for treatment by the patients in private deaddiction centres. Most of the staff were recovering drug users themselves and did not have any training related to substance use disorder management. They had the attitude that since they had been able to suffer and come out of addiction, other clients should be able to do the same. This shows that treatment at these centres is mainly based on recovering drug users' experience rather than actual expertise or evidence.

- Even though most of the centres were run by recovering drug users themselves, there was gross human rights violations in the centre including both physical as well as verbal abuse. Most of the centres admitted the patients without their consent and there was almost nil option of premature termination of treatment by the patient themselves.
- Doctors visited many of these centres and even psychiatrists were part of most centres. Even though there are medications to reduce the discomfort of patients during withdrawal, most of the centres either did not give the right type of medicines or in right doses for withdrawal management. Long-term pharmacotherapy is not used in majority cases, though almost all clients were heroin users for a long time and had multiple admissions before. Opioid Substitution Therapy is the recommended treatment in such cases. However, this was not available or provided in these centres.
- Human rights violation was acceptable to some of the clients. Beating and violence was considered to be the only treatment known and the only treatment available for most clients. The family was an active partner in the admission and discharge or release of the clients. There was even support from the local law enforcement authorities.
- There are also some positive aspects in the treatment at these centres like withdrawals are being managed with medications, and some form of counselling, structuring of daily activities and acceptance of one's problem is provided in these centres.

Laws and Regulation of Addiction Treatment Facilities in India

The Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 governs the cultivation, sale, transport, and use of psychoactive substances listed under the act as narcotic drugs or psychotropic substances. The Act has strict provisions of imprisonment and fines for those contravening the law, including for those using the narcotic drugs and psychotropic substances. However, the Act has also provided for use of narcotic drugs and psychotropic substances for scientific and medical purposes. Many pharmacological agents such as opioids and benzodiazepines used for treatment of drug use disorders fall under the list of narcotic drugs and psychotropic substances. Further, the Act permits the Government to establish as many centres as required for treatment of drug use disorders.

There is no specific law for regulation of addiction treatment facilities in India. The Government hospital-based DACs are attached to the larger hospital and are recognised as such by the Government as these are Government hospitals. The other entities such as IRCAs run by NGOs do not have a separate registration; they are usually registered as NGO or a society under the Society Registration Act of the state where these NGOs are located. The private 'Rehabilitation' centres are also registered similarly. Some private centres run by medical professionals, including psychiatrists, are covered under the Clinical Establishment Act, 2010 (29). While the Clinical Establishment Act, 2010, covers all those institutions that provide treatment of any illness, abnormality, etc. in any recognised system of medicine established by a person or group of persons, there is no specific mention of substance use disorders in the Act.

The recently enacted, Mental Health Care Act, 2017, purports to fill this gap. The Mental Healthcare Act (MHCA), 2017 is enacted with an aim to improve care and treatment for people affected by mental illness in India. The Act has included substance use disorder (SUD) specifically in the definition of mental illness itself (30). However, some of the phrases used in the definition such as "abuse" are not clear, as the current classificatory systems of mental illnesses do not have any diagnostic category termed 'abuse'. Another important issue is the lack of clarity on which categories of SUD would be covered under MHCA. Simple reading of the text of the Act seems to suggest that SUD is a single entity for the purpose of this law. In such case, many provisions of the act such as supported admission (admission without consent) that are meant for treatment of people with severe mental illnesses with gross impairment, may become applicable to all types of SUD. This can create potential problems for addiction treatment providers.

There is also much good for patients suffering from SUD in the Act. The Act lays down various rights that include, among others, protection from cruel, inhuman or

degrading treatment in any mental health establishment. The Act also provides for the State Mental Health Authority (SMHA) to lay down standards to be followed in addiction treatment facilities in their respective state. Thus, the MHCA has the power to bring about significant changes in the functioning of the addiction treatment facilities in the country. However, much will depend on the way the minimum standards for addiction treatment facilities would be framed by the respective SMHAs. Delhi has already framed minimum standards for addiction treatment facilities operating in the National Capital Territory (NCT) of Delhi (31). The document lays down standards to be followed in various addiction treatment facilities such as those providing detoxification, long term care/rehabilitation and facilities treating patients with dual disorder of mental illness along with substance use disorder. However, much focus of the document has been on infrastructure, staffing and type of records to be maintained in the establishments. The document fails to lay down standards to be followed during the provision of treatment and care such as assessment, diagnosis, treatment, rehabilitation, etc. Yet, the existence of such a document would now force all existing addiction treatment facilities (both Government and private) to follow the standards laid down for the NCT of Delhi.

Discussion

The assessment of existing standards for the treatment of substance use disorders in India has interesting observations.

It is clearly established that a sizeable population in India is suffering from substance use disorders and need treatment. The recent national survey estimated more than seven crore (70 million) individuals to suffer from alcohol or other drug use disorders in India. However, very few individuals receive treatment, though they are desirous to quit their psychoactive substance use. Thus, there is a huge demand for the treatment of SUD in India.

The various ministries of the Government of India have been supporting and funding addiction treatment facilities across the country. Both facilities located in government hospitals along with other medical facilities, and those operated by NGOs are supported by different ministries. Thus, the government has aimed to provide treatment at different locations which an individual suffering from SUD would find comfortable in availing services. However, when one plots the number of individuals through the existing government facilities against the number of individuals requiring treatment, it is clear that the existing number of facilities is simply inadequate to cater to the existing demand in India. This is also the reason why private facilities are mushrooming in the country and seem to be very popular. The assessment of these facilities shows that the type of treatment provided in these centres are not superior to the treatment offered in Government-supported centres. Yet, these centres are always filled to capacity. This can be clearly explained to be due to a shortage of government facilities in the country.

The type of treatment offered in the country seems to be skewed towards inpatient treatment. The document on international standards for treatment and care of PWUD recommends the availability of a variety of treatment services for PWUD. As per the document, the most common types of services needed are informal community care, primary healthcare services followed by specialised drug dependence services. The top of the pyramid is occupied by long-stay residential services. In India, the opposite seems to be true. There are plethora of long-stay residential services, while the availability of SUD treatment in primary care services is minimal. Recently, the DDAP has initiated 'Drug Treatment Clinic' (DTC) in some Government hospitals (7). These clinics provide outpatient-based treatment for SUD with both short-term and long-term pharmacotherapy. Psychosocial interventions are also provided in these clinics.

Each Government department/Ministry has set its own standards that are expected to be followed by the facilities funded by the department. However, there are no well-formulated mechanisms to ensure that these standards are followed by these facilities. Some of the practices adopted in the standards do not seem to be in conformity with the recommended standards by international bodies/agencies.

Till now, most private centres were out of the ambit of any form of regulations. Several human rights abuses were found in the assessment conducted as part of this activity. These incidents occurring in different cities have also been covered by the lay press. Many individuals of SUD are forced to undergo involuntary treatment which is demanded and initiated by family members; the private centres are happy to provide this service to the family members. With the recently framed MHCA, private centres would also be required to follow the norms and standards laid down in the Act. However, much would depend on the rules that would be framed by the SMHA.

It is apparent that there is a dearth of trained staff working in many centres. The treatment of SUD is not formally incorporated in the undergraduate medical or in nursing curriculum. There are very few certificate courses offering training on psychosocial intervention for SUD. Untrained manpower working in clinics or centres offering treatment for SUD can cause more harm than good for PWUD. This can also deter PWUD from seeking treatment in the future if they relapse. An adequately trained manpower working on SUD will be able to provide treatment based on sound scientific principles.

Many family members and even PWUD themselves felt that involuntary treatment and human rights abuse is justified. Many individuals feel that this is the only form of treatment that can work in SUD. Many individuals also do not seek treatment as they are not aware that treatment is available for SUD as well. It is important to educate PWUD, families and the general public regarding the availability of treatment for SUD and that addiction is a treatable condition like any other chronic non-communicable disease.

There are no current mechanisms established by the government departments or ministries in-charge of addiction treatment where cruel treatment and abuse of rights can be reported. Creating such a mechanism will not only empower the individual who is subjected to cruel, inhuman treatment, but this will also act as a deterrent for other centres/facilities that employ such methods in the name of treatment.

Recommendations

Contextualising the standards of care for treatment of substance use disorders to the Indian setting

Keeping the above points in mind, the following recommendations can be drawn to improve the standards of treatment and services for individuals with SUD in India

A. Increase availability and accessibility of treatment services for PWUD

- Increase outpatient-based treatment for SUD in government hospitals. It is recommended that DTCs should be expanded to all the districts of the country, so that evidence-based treatment is available and accessible to every PWUD.
- There should be an increase in the number of treatment centres providing short-term inpatient care for SUD. The existing 500 odd centres (both government and NGO-based) are inadequate to cater to the vast number of drug dependent population in India.
- Increase the number of treatment centres providing short-term inpatient care for SUD

B. Capacity building in the area of SUD treatment in medical education

- Incorporate teaching on SUD treatment in undergraduate medical and nursing curriculum.
- Introduce certificate courses on training in the area of psychosocial interventions in SUD.
- Make training mandatory for the appointment of staff in addiction treatment clinics and centres.

C. Raise awareness on addiction treatment

- Launch mass media campaign to educate public about nature of addictive disorders (addiction is a mental health problem; addiction is a chronic, non-communicable disease) and availability of scientific treatment for addiction (addiction is treatable; addiction requires multi-pronged approach for treatment)

D. Regulate all addiction treatment facilities, including private centres

- There may be separate rules framed for the regulation of the treatment of SUD or a separate act on the treatment of SUD altogether. This act should make inhuman, cruel treatment of PWUD punishable offense. Treatment should be made voluntary and conditions where involuntary treatment is permissible, should be clearly spelled out. The rights of PWUD should also be clearly spelled out in the Act.

E. Develop a redressal mechanism for reporting cruel treatment and abuse of rights of PWUD

- Form a state-level committee comprising of representation from the social welfare department, health department, psychiatrists, NGOs working with PWUD, and most importantly PWUD themselves. This committee should be mandated to look into human rights abuse and cruel treatment meted out to PWUD in the addiction treatment facilities.

F. Ensure periodic monitoring of addiction treatment facilities for adherence to standards laid down in the law

- A system of periodic monitoring of addiction treatment facilities should be laid down by the department/ministries in-charge of demand reduction activities for SUD.
- An accreditation system must be established for the assessment of all addiction treatment facilities. An addiction treatment facility should be allowed to function only if it qualifies in the assessment performed by an independent agency.

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About Alliance India

Alliance India (India HIV AIDS Alliance) is a non-governmental organization which was founded in 1999 to support sustained response to HIV in India. We work in partnership with the Government of India, civil society and HIV communities to advocate and support the delivery of effective, innovative, community-based programmes at scale.

About Harm Reduction Advocacy in Asia (HRAsia)

Strengthening community advocacy and improving access to harm reduction services for People Who Inject Drugs (PWID) in Asia Pacific Region

Alliance India works with PWID community to build networks that engage with national and state-level governments, state and local law enforcement officials as well as health care workers to expand their understanding for the delivery of a comprehensive harm reduction package of services. We are the Principle Recipient (PR) for The Global Fund supported regional Harm Reduction Advocacy in Asia programme (HRAsia). It is a seven country Asia programme (2017-2020) that includes Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam.

Along with the in-country partners – KHANA (Cambodia), Rumah Cemara (Indonesia), Cebu Plus (Philippines), Ozone Foundation (Thailand) and SCDI (Vietnam), the programme is built on the capacities of four regional technical partners, namely Asian Network of People who Use Drugs (ANPUD), Law Enforcement and HIV Network (LEAHN), International Drug Policy Consortium (IDPC) and Harm Reduction International (HRI).

The programme aims to maximise impact of investments that help break the cycle of transmission of HIV among people who inject drugs (PWID) in concentrated epidemics by addressing legal, policy and health system barriers that impedes access to services. The programme also aims at strengthening community systems and increasing the evidence for advocacy.

The project aims to:

- Create a platform for strategic engagement with regional mechanisms as well as national governments on legal and policy reform to support harm reduction interventions.
- Convene national and regional level policy dialogues with policy makers from relevant government ministries (Social Justice and Empowerment, Health etc.) on harm reduction policy, programme (increase domestic funding) and legal issues (arrest and incarceration); transition strategies for international donors and the issue of sustained funding for harm reduction in the region.
- Strengthen community systems of PWUD and civil society organisations implementing harm reduction to meaningfully engage in dialogue with key stakeholders for a sustained HIV and drug use response.
- Generate strategic information to shape advocacy for a health and rights based harm reduction response – policy and operations research will provide national stakeholders in focus countries and regional institutions with information to improve policy and programmatic responses to HIV and drug use.

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