

Drug Policy in India: Key developments since the UNGASS 2016

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Introduction

In March 2019, member states are expected to take stock of commitments made in the 2009 United Nations Political Declaration and Plan of Action on ‘International cooperation towards an integrated and balanced strategy to counter the world drug problem’ at the ministerial segment of the 62nd Session of the UN Commission on Narcotic Drugs (CND). It represents an important opportunity to review progress to date and to set meaningful goals for future drug policy. Although no comprehensive review has yet been undertaken by the CND, the International Drug Policy Consortium (IDPC) has conducted assessments of progress over the past decade both at the global level and at the regional level in Asia.¹ Following the ‘Drug Policy in India’ briefing paper by IDPC in 2015,² this paper outlines the key drug policy developments in India since the UNGASS Outcome Document was adopted in 2016, which highlights health and human rights concerns in relation to both drugs and drug policies. These concerns include the themes of availability and access to controlled medicines, evidence-based treatment for drug dependence, measures to minimise “the adverse health and social consequences” of drug use including overdose deaths and transmission of HIV, viral hepatitis and other blood-borne diseases (which are referred to as part of a range of ‘harm reduction’³ measures in this Paper), interventions to address the specific needs of children and youth, and proportionate responses in the criminal justice system.⁴

The 2016 UNGASS on the world drug problem

On 19 - 21 April 2016, world leaders met at the 30th Special Session of the United Nations General Assembly in New York (UNGASS) and adopted a consensus agreement on drug policy known as the “UNGASS Outcome Document”. Notable features of the UNGASS Outcome Document include expansion of the range of global drug policy objectives from supply reduction, demand reduction and international cooperation to incorporate a set of broader objectives encompassing public health, human security, social and economic development, and human rights. In addition, member states reaffirmed the health- and welfare-oriented aims of the international drug control treaties, and agreed that measures to control drugs would be taken in full conformity with “all human rights, fundamental freedoms, the inherent dignity of all individuals and the principles of equal rights and mutual respect among States”.⁵

At the UNGASS, the most senior delegate representing India, the Minister of Finance, affirmed the country’s commitment to addressing the ‘world drug problem’ within the framework of the international drug control treaties and the flexibilities contained therein. The Minister further assured the gathering that India has adopted “a public health approach” towards drugs and is working to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, including for

“palliative care, pain relief and opioid substitution therapy for cancer patients and drug-abuse victims” by removing regulatory barriers.⁶

India’s Legal Framework on Drug Control

Drug control in India rests on two main legislations – the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act), which was enacted pursuant to the international drug control treaties – namely, the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol amending the 1961 Single Convention on Narcotic Drugs, 1961 (1961 Convention) and the Convention on Psychotropic Substances, 1971 (1971 Convention) and subsequently, the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (1988 Convention) – as well as the Drugs and Cosmetics Act, 1940 (DC Act), which regulates the import, manufacture, distribution and sale of medical drugs, devices and cosmetics. The latter not only regulates drugs used in modern allopathic medicine, but also those used in indigenous systems of medicine including Ayurveda, Siddha and Unani, as well as Homeopathy.

Both laws are supported by subordinate or ‘delegated’ legislation, in the form of ‘Rules’ which prescribe in detail the procedure for implementing the principal Act. The NDPS Act is supplemented by the NDPS Rules, 1985, which have been amended from time to time, other subject-specific Rules under the NDPS Act such as the NDPS (Execution of Bond by Convicts or Addicts) Rules, 1985 or the NDPS (National Fund for Control of Drug Abuse) Rules 2006 as well as the various orders and notifications issued by the Central Government. Legal apparatus at the State level includes State NDPS Rules and Excise Laws, which deal with ‘intoxicating drink and drugs’. The DC Act is supported by the Drugs and Cosmetics Rules, 1945 (DC Rules).

Issues of drug use, dependence and harm reduction overlap with various other laws, which will be described further in the Paper.

Access to narcotic and psychotropic medicines

The mandate of international drug control treaties, i.e. ensuring availability of narcotic drugs and psychotropic substances for medical and scientific use while prohibiting non-medical and non-scientific use is reflected in the NDPS Act, which “prohibits, controls and regulates” narcotic drugs and psychotropic substances, with permissible activities taking place only for medical and scientific aims.⁷ Yet access to opioids for medical use, in particular, for alleviation of pain was restricted and posed a major concern for palliative care in the country.⁸ After years of advocacy and litigation for access to morphine for cancer patients, the palliative care community succeeded in convincing policy makers to lobby for legal reforms.⁹ Consequently, the NDPS (Amendment) Act, 2014 was adopted, which places the need for “ensuring availability of narcotic drugs and psychotropic substances for medical and scientific use” as an unequivocal aim of the NDPS Act, alongside “preventing ‘abuse’ and illicit traffic”.¹⁰

New procedures for essential narcotic drugs

In May 2015, more than a year after the NDPS (Amendment) Act, 2014 was adopted to improve medical access to opioids, the Central Government notified six drugs as ‘essential narcotic drugs’ including morphine, fentanyl and methadone.¹¹ While the notification does not disclose the reasons for these drugs being classified as ‘essential narcotic drugs’, it is widely known that morphine is in demand for pain relief and palliative care, while methadone is needed for opioid substitution treatment (OST) for people dependent on opiate drugs such as heroin as well as for the treatment of pain.¹²

On the same day, the Central Government notified the NDPS (Third Amendment) Rules, 2015,¹³ thereby creating a separate system for the possession, transport, sale, purchase, consumption and use of essential narcotic drugs, which applies uniformly across the country. Consequently, the legal procedure for providing OST using methadone is now different from that

using buprenorphine. Prior to 2015, the provision of methadone required multiple licenses from multiple agencies, but now it can be administered at a medical facility – whether in the public or private sector, which is certified as a ‘Recognised Medical Institution’ by the State Drug Controller in the concerned state.

Though intended to establish a simplified system for procuring opioid medicines, the amended procedures have not scaled up or improved access for patients.¹⁴ In the context of drug dependence and harm reduction, access to methadone treatment is still poor and restricted.¹⁵

Legal controversy surrounding buprenorphine

India has been providing OST using buprenorphine for nearly a decade, as part of the National AIDS Control Programme. Access to this government-sponsored treatment is however, limited to people who inject drugs, leaving out millions of opioid dependent persons who are non-injectors.¹⁶ The problem, which became acute in the state of Punjab, led medical practitioners and psychiatrists working in the private health sector, to prescribe and dispense buprenorphine to non-injecting opioid dependent patients, whose numbers were increasing day by day.¹⁷ Though scheduled as a psychotropic substance under the NDPS Act, the medical use of buprenorphine for treating opioid dependence is well recognised nationally and internationally.¹⁸ State law enforcement agencies however, invoked the NDPS Act against doctors, accusing them of engaging in the ‘unauthorised’ possession, sale and distribution of buprenorphine,¹⁹ even though the NDPS Act allows “medical use” and does not prescribe any license for using psychotropic substances, which are governed by the DC Act and the DC Rules.²⁰

Buprenorphine is listed in Schedule H1 of the DC Rules²¹ and can be sold at a pharmacy on prescription.²² It can also be supplied to registered medical practitioners, hospitals and nursing homes against a signed invoice, a record of which is to be preserved for 2 years.²³ Since the said conditions were complied with, it is difficult

to justify the actions of the Police in prosecuting private medical practitioners as alleged ‘drug offenders’.²⁴

The reason for the controversy appears to be a two decades-old letter, by which the Drug Controller General of India (DCGI) had granted approval for the manufacture of sublingual buprenorphine tablets for the domestic market.²⁵ The said document, which was re-circulated by the DCGI in 2010 for the buprenorphine - naloxone fixed dose combination, stated that the preparation “shall be supplied only to the designated De-addiction centres set up by the Govt. of India funded by the Ministry of Health and Ministry of Social Justice & Empowerment and hospitals with De-addiction facilities”.²⁶ Since there is no clarity on whether ‘de-addiction centres’ refer to residential facilities or also include OPD-based clinics, the expansion of OST services using Buprenorphine has been slow in the country.²⁷

The DCGI document, which is evidently inconsistent with the DC Act and DC Rules has been challenged in several petitions filed by medical practitioners before the High Court of Punjab and Haryana, with the intention of confirming the legality of qualified psychiatrists to prescribe and dispense buprenorphine to opioid dependent patients in private clinics. It is unclear whether the controversy will settle anytime soon.²⁸ The perception that buprenorphine is a ‘legal fix’ and a ‘habit forming drug’ has only compounded the problem of restricted access to OST in the state of Punjab. In the meantime, the suffering of patients, who are denied treatment as well as doctors, who are apprehended for providing treatment, has not been acknowledged.²⁹

New substances under control

Since 2015, 29 new substances have been brought under the purview of the NDPS Act. All the newly added substances are scheduled under the international drug control treaties except ‘catha edulis or khat leaves’³⁰ and ‘tramadol’,³¹ which have both been notified as psychotropic substances in India. In 2017, the Delhi High Court upheld the inclusion of ketamine as a psychotropic substance, though it had not been

included under the 1971 convention.³² In doing so, the Court interpreted section 3 of the NDPS Act, which authorizes the Central Government to add or omit from the list of psychotropic substances on the basis of (i) evidence of ‘abuse’ or scope of ‘abuse’ of a substance, and (ii) changes in international conventions in respect of that substance, in a manner that makes consideration of international scheduling decisions optional. Unlike ketamine, whose medical use in India was scant, tramadol is used extensively in the health sector for treatment of pain. In addition, its use in the long-term management of opioid dependence has been under review in India.³³ The decision to notify tramadol under the NDPS Act has left the medical fraternity concerned,³⁴ though its impact on access by patients will be known only after some time.

Cannabis for medical use

The legally-recognised use of narcotic drugs and psychotropic substances for medical and scientific purposes has assumed importance in recent times with growing interest in medicinal cannabis policies and practices in India and abroad.³⁵ In some ways, terms such as “medical marijuana” or “medicinal cannabis” are a misnomer in India, as cannabis is not treated as a single substance under the NDPS Act. The cannabis plant, its parts and products are classified as different substances attracting different penal consequences. The NDPS Act distinguishes between the “cannabis plant”, “ganja” [flowering or fruiting tops of the cannabis plant without the seeds and leaves], “charas” [separated resin or hashish], “medicinal cannabis” [extract or tincture of hemp] and “bhang” [the cannabis leaf] – the latter not being included in the Act. While scientists talk about compounds such as cannabinoids and their subclasses, for example-delta-9-tetrahydrocannabinol (THC), cannabidiol (CBD), and cannabinol (CBN) and their therapeutic potential, the NDPS Act does not describe cannabis in these categories. Therefore, proposals to allow access to medical cannabis will need to take account of the specific categorisation of various components of cannabis under the NDPS Act.³⁶

Moreover, medical use of cannabis is already

permitted under the NDPS Act, which empowers State Governments to regulate “cultivation of the cannabis plant, production, manufacture, possession, sale, purchase, consumption or use of cannabis” for “medical and scientific purposes” by framing by-laws or rules. Most states have a regulatory framework in place in the form of ‘State NDPS Rules’, but only on paper. As an example, under the Maharashtra NDPS Rules, 1985, a doctor who wishes to possess ‘ganja’ for use as an ingredient in any medicine or sell medicines containing ‘ganja’ on prescription can submit an application to the Collector (officer in charge of administration of a District), who, after making inquiries and obtaining the approval of the State Commissioner of Prohibition and Excise, may grant a license specifying the quantity of ‘ganja’ that the doctor may possess.³⁷ Similar provisions exist in other States³⁸ but there is no official account of their use or implementation.

The confusion in policy is compounded by the absence of studies on cannabis and cannabinoids in modern medicine in India.³⁹ In this respect, the Central Government has reportedly asked the Council of Scientific and Industrial Research (CSIR), a government agency for research and development, to study the medicinal properties of the cannabis plant.⁴⁰ Further still, the State of Jammu and Kashmir has granted a license for the cultivation of cannabis for research purposes to the Indian Institute for Integrative Medicine (IIIM), Jammu.⁴¹

It is important to note that ‘ganja’ and ‘bhang’ are on the ‘list of poisonous substances’ under the DC Act and can be administered in Ayurvedic, Siddha and Unani medicine.⁴² Yet, in response to a question in Parliament about whether there were any clinical trials being conducted on the therapeutic effects of cannabis on cancer patients, the Minister from the Ministry of Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy (AYUSH) replied in the negative on 4 January 2019.⁴³

Besides medical and scientific use, the cultivation of cannabis may also be allowed for industrial or horticultural purposes, in accordance with article 28 of 1961 Convention and section 14 of

the NDPS Act. This provision too, has come into the spotlight recently, with the Government of Uttarakhand – a hilly State in northern India – issuing a proposal to allow industrial hemp in the State.⁴⁴ It is unclear if, and how many such licenses have been granted for cannabis cultivation in the State.

Drug dependence treatment

Moving towards outpatient services

Services for drug dependence treatment in India have largely been provided as in-patient, residential facilities known as “Drug De-addiction Centres”. The Ministry of Social Justice and Empowerment (MoSJE) has been supporting “Integrated Rehabilitation Centres for Addicts”, which cater to persons dependent on alcohol and drugs but not tobacco. The MoSJE estimates that there are 400 such centres in the country, where a person undergoes detoxification, rehabilitation and recovery so as to become “drug free, crime free and gainfully employed.” The duration of stay in the centre varies and can be anywhere between 1 to 3 months. The MoSJE is planning to convert the centres into treatment clinics that offer both in-patient and out-patient services.⁴⁵

The Ministry of Health and Family Welfare (MoHFW) also provides drug dependence treatment on an in-patient basis at government hospitals and medical colleges across the country. After taking note of the challenges in its drug de-addiction programme such as low patient uptake and poor functioning of in-patient services, the MoHFW announced a new scheme for Drug Treatment Clinics (DTCs) in government health facilities.⁴⁶ The DTCs operate as out-patient clinics that are integrated into the existing health system and will offer psycho-social support and pharmacological treatment, including for long-term management of drug dependence, free of cost.

The state of Punjab has led the way in mainstreaming outpatient treatment services for drug dependence. In 2018, the state government established Outpatient Opioid Assisted Treatment

(OOAT) centres in many districts with the aim of providing pharmacologically-assisted treatment such as OST using buprenorphine in community settings.⁴⁷ The Government of Punjab has also decided not to focus on arresting people who use drugs, and if arrested, to encourage them to seek treatment and immunity from prosecution under the law.⁴⁸

The growing support for outpatient clinics and pharmacologically-assisted treatment may have been aided by the 2014 amendments to the NDPS Act, which added the term ‘management’ to section 71(1) of the NDPS Act, thereby enabling OST and other harm reduction measures to be taken by the Government for the ‘treatment and rehabilitation’ of people dependent on drugs.⁴⁹

Drug dependence as ‘mental illness’

In 2017, India passed the Mental Health Care Act, 2017 (MHC Act), in order to protect the rights of persons with mental illness and promote access to mental health care. The MHC Act is in line with the UN Convention on the Rights of Persons with Disabilities and overrides the Mental Health Act, 1987.

The MHC Act addresses the issue of drugs to the extent that it defines mental illness as

a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of person, specially characterized by subnormality of intelligence.

It is unclear whether substance dependence per se qualifies as a mental illness or if the definition refers to comorbid conditions of substance dependence and other mental illness. If the former understanding prevails, then services for drug-dependence would fall under the MHC Act and the various protections that it accords to persons with mental illnesses would apply to people who

are dependent on drugs. These include the right to community-based care, protection against cruel, inhuman and degrading treatment, the right to be treated equally with a person with a physical illness, preservation of confidentiality and access to one's own medical records, the freedom to maintain personal contact and communication with others while in treatment, the right to grievance redressal and legal aid.⁵⁰ If applied, these provisions could transform the delivery of drug dependence treatment in the country, which has not been rights-based.⁵¹ In particular, inpatient facilities offering treatment for substance dependence would be treated as a 'mental health establishment'⁵² and required to comply with registration and other standards prescribed by the State Mental Healthcare Authority.⁵³ In this regard, the Government of National Capital Territory of Delhi became the first state in the country to formally notify minimum standards of care for 'Centres providing Substance Use Disorder Treatment and Rehabilitation' under the MHC Act.⁵⁴ It remains to be seen whether these regulations will help check the problem of unregulated drug de-addiction centres in the State of Delhi.⁵⁵

According to the MHC Act, the government is required to take measures to reduce the stigma attached to mental illness. In relation to drugs, this would mean a duty to alleviate the stigma associated with drug use and dependence. In addition, under the MHC Act, police officers have a duty to take a mentally ill person, found "wandering at large within the limits of the police station" or a person who, appears to be "mentally ill and incapable of taking care of herself" or "a risk to herself or others" on account of mental illness to a public health establishment.⁵⁶ Employed in the context of drugs, this would mean that the police should not arrest people who use drugs, but instead refer them to a health facility, since the MHC Act overrides existing laws including the NDPS Act.⁵⁷

While the benefits of applying the MHC Act to drug dependence treatment are obvious, the implications and potential risks of conflating substance use with mental illness, especially for people who use drugs need to be evaluated.

Prison interventions

The MHC Act devotes attention to mentally ill persons in prisons and custodial settings. Interestingly, the framework for drug-related interventions in prisons has been laid down in the law dealing with mental illness and not in the drug, HIV or prison-related legislations. The reasons behind this reform is not clear. Procedures for care have been elaborated in the Mental Health Care (Rights of Persons with Mental Illness) Rules, 2018 (MHC Rules) notified by the Government of India⁵⁸ which include 'Minimum Standards and Procedures for Mental Health Care Services in Prisons'.⁵⁹ In relation to drug use, the MHC Rules provide for:

- Mandatory urine testing and screening for drug use through a questionnaire at the time of entry into prison
- Random testing for drug use and identification of prisoners with substance use problems
- Identification of injecting drug use among prisoners who use drugs
- Screening of prisoners who use drugs for HIV, STI, hepatitis B and hepatitis C and provision of appropriate treatment, and
- Access to long term pharmacotherapy and opioid substitution treatment with methadone or buprenorphine for opioid dependent prisoners

The National AIDS Control Organisation (NACO) of the MoHFW as well as its affiliate bodies in the states, known as State AIDS Control Organisations (SACs), have initiated HIV-related services in various central and state prisons. NACO is also supporting a project for HIV prevention, care and treatment services in the prisons of the North-Eastern States of India in collaboration with international agencies.⁶⁰ Besides, the State of Punjab has announced plans to introduce OST in custodial settings.⁶¹ Officials guiding these programmes may draw from the provisions of the MHC Rules to expand the nature of services that they are able to offer in prison and other custodial institutions.

Harm Reduction

HIV prevention services

India continues to provide harm reduction services for people who inject drugs, amongst whom there was a national HIV prevalence rate of 6.26% reported in 2017, making it the country with the 10th highest HIV prevalence rate amongst people who inject drugs in Asia.⁶² The estimated adult HIV prevalence in the country was 0.30% among males and 0.22% among females.⁶³ It is widely believed that while India's HIV prevention programme has been successful, efforts to reduce HIV among people who inject drugs have lagged behind.⁶⁴

As of 2016, there were 222 programs for the prevention of HIV among people who inject drugs, known as Targeted Interventions (TIs), which reached about 114,000 clients.⁶⁵ TIs offer services including screening for and treatment of sexually transmitted infections, condoms, clean needles and syringes, abscess prevention and management, HIV counselling and testing and referrals to detoxification and rehabilitation services. The National AIDS Control Programme also supports 213 centres which provide OST to over 20,000 persons who inject drugs. Sublingual buprenorphine is dispensed and administered directly to the client at clinics, which are either run by NGOs or at government hospitals in accordance with guidelines issued by NACO. NACO launched OST using methadone at the Regional Institute of Medical Sciences (RIMS), in Imphal, Manipur, in 2016.⁶⁶

Harm reduction advocates have requested greater flexibility in the NACO's programme including access to 'take home' doses of buprenorphine or alternate day dosing.⁶⁷ While the government acknowledges that this will improve uptake of services, it is yet to modify the official guidelines, which require daily attendance at the OST centre.

Immunity for interventions that may violate the law

In April 2017, Parliament passed the HIV and AIDS (Prevention and Control) Act, 2017 (HIV

Act), after years of campaigning by civil society and people living with HIV. The HIV Act came into force on 10 September 2018, nearly 16 months after its adoption by the Parliament and assent by the President of India. The Act provides a statutory framework for the prevention and control of the spread of HIV and AIDS and for the protection of human rights of persons affected by it. Apart from prohibiting discrimination on the basis of a person's HIV status, the HIV Act provides immunity to interventions that reduce the risk of HIV, which may attract liability under other punitive laws. Section 22 of the HIV Act states that

any strategy or mechanism or technique adopted or implemented for reducing the risk of HIV transmission, or any Act pursuant thereto, as carried out by persons, establishments or organisations in the manner as may be specified in the guidelines issued by the Central Government shall not be restricted or prohibited in any manner, and shall not amount to a criminal offence or attract civil liability.

Section 22 had the potential to cover a range of harm reduction interventions including supervised injecting facilities and heroin-assisted treatment,⁶⁸ but has been limited by the requirement that the "strategy or mechanism or technique" be recognized by central government guidelines. Presently, the interventions for people who inject drugs that are incorporated in NACO's "Operational Guidelines for High risk groups" are needle syringe provision and OST.

Until formally accepted by the government, newer interventions that reduce harms and improve the health of people who inject drugs including supervised injecting facilities and heroin-assisted treatment, will continue to attract criminal liability under the NDPS Act.

Closure of opium registries

The NDPS Act permits, to some extent, the use of traditional opium and poppy straw by persons registered with the State Government.⁶⁹ This colonial-era practice, which allows a person to obtain opium or poppy straw on medical

advice from a licensed vendor, is comparable to contemporary harm reduction methods such as supply of prescription heroin to people dependent on drugs by a medical doctor. Until 2009, at least 14 states were implementing a system of registered supply of poppy straw through Excise Regulations or Rules under the NDPS Act.

The Central Government however, was anxious about the system, considering it to be outside the 'medical use' permitted under the NDPS Act. An Expert Committee comprising medical and law enforcement personnel set up in 2003 concluded that use of poppy straw was not a medical necessity. The Committee's report aided the Department of Revenue, Ministry of Finance in making a policy decision in this regard.

Exercising its legal powers to issue binding directives to states in matters of drug control, the Government of India subsequently advised state governments through directives in 2009, 2012 and 2015 to tighten control over poppy straw suppliers, reduce the number of users and the quantity supplied progressively and eventually discontinue the practice of registering users and supplying poppy straw in their States by 31 March 2015. The deadline was extended by one year at the request of the State Government of Rajasthan, who cited their inability to comply, owing to a large number of poppy straw users in the State, who needed to undergo de-addiction treatment.⁷⁰

The cessation of licit supply of poppy straw, which came into force on 1 April 2016, reportedly caused immense hardship, especially to older users, who had been consuming the substance for decades.⁷¹ State media described distressing consequences of the poppy straw ban including elderly men and women writhing in pain and agony due to the ineffectiveness of 'de-addiction' services offered through government-sponsored camps.⁷² Some hinted at the emergence of a black market for poppy straw and pharmaceutical opioids, which quickly became a substitute for poppy straw. Deaths due to untreated withdrawal have also been reported.⁷³

The poppy straw ban was challenged by users in the state of Gujarat.⁷⁴ The Gujarat High Court

rejected the petition on the grounds that the State Government was empowered to withdraw the supply of poppy straw as the power to regulate a commodity includes the power to restrict and prohibit its trade. The Court declined to interfere with the Expert Committee's view that consumption of poppy straw is not medical use and rejected the petitioner's claim for access on health grounds. Further, the Court declared:

There cannot be a right to consume a particular substance which is like poppy straw, much less the same can by any stretched be viewed or claimed as fundamental right flowing from Article 21 of the Constitution. The concept of 'life' encapsulated under Article 21 signifies healthy, rich and contentful orderly life. Right to health is recognized as part of Article 21. A consumption of intoxicant or narcotic or psychotropic substance is antithetical to the concept of health and therefore stands divorced from the right to life and from any other concomitant rights which may be claimed under the canopy of rights under Article 21.⁷⁵

At a time when countries are expanding regulated access to controlled substances, particularly in relation to cannabis,⁷⁶ India is closing down its centuries old, licit supply model, with deleterious consequences for people who use drugs.

Children and young people

Drugs and the new Juvenile Justice Act

In 2015, the law related to children (persons below the age of 18 years) was re-modelled as the Juvenile Justice (Care and Protection of Children) Act, 2015 (JJ Act, 2015). Influenced by the UN Convention on Child Rights, 1992, the earlier law (the Juvenile Justice (Care and Protection) Act, 2000) laid down a compassionate framework for children who are vulnerable (therefore 'in need of care and protection') and children in conflict with the law. Children belonging to the former category were provided various kinds of community and institutional care under the direction of 'Child Welfare Committees'. Children alleged to have committed an offence were

required to be presented before a 'Juvenile Justice Board' comprising a Judge and social workers, as opposed to a criminal court. A child in conflict with the law could not be tried for an offence, pronounced guilty and sentenced to imprisonment. Instead, the Juvenile Justice Board was mandated to conduct an inquiry and if the child was found to have committed an offence, pass orders in the nature of advice, admonition and counselling, directing the child to perform community service or directing the parents or guardian of the child to pay a fine. The maximum 'penalty' that could be imposed in the case of a child who is found to have committed an offence was detention in a special home for a period of three years. The said procedure was uniform and applied to all cases, irrespective of the age or nature of the crime committed by the child.

The reasons for enacting the JJ Act, 2015, as officially stated, are i) increasing incidents of abuse of children housed in state institutions and, ii) increasing cases of crimes committed by children in the age group of 16 - 18 years. Adopted in the wake of the gang-rape and murder of a young woman in New Delhi in December 2012 by four men, one of whom was a juvenile, the Indian Parliament took the view that the existing law was too lenient and failed to deter young people's involvement in crimes.⁷⁷

Drugs as an issue becomes relevant as under the law, a child is considered to be in need of care and protection where they are a "child who is found vulnerable and is likely to be inducted into drug abuse or trafficking". In addition, children who use drugs or found in possession of drugs are liable to be treated as a 'child in conflict with the law'. According to the JJ Act, 2015, such children will be treated in the juvenile system if they are under 16 years of age, whereas a court has discretion to send a child over 16 years of age to the adult or juvenile justice system if they are also accused of a 'heinous offence' (punishment of 7 years imprisonment and above, whereas a 'serious offence' and 'petty offence' is liable for lesser terms of imprisonment). Drug offences involving a 'commercial quantity' or 'intermediate quantity' of drugs would qualify as a 'heinous offence', whereas consumption and possession of

small amounts would be a 'petty offence'. Thus, children found with a commercial or intermediate quantity of drugs could be treated more harshly under the JJ Act, 2015 including being ordered to attend a "therapeutic centre" or to undergo a "drug de-addiction programme," or to be tried as an accused under the criminal justice system for adults.⁷⁸

The JJ Act, 2015 recognises that a child in conflict with the law may also be in need of care and protection and provides for co-ordination between the Juvenile Justice Board and the Child Welfare Committee in the best interest of the child.⁷⁹ Accordingly, a young person using drugs or found in possession of drugs may be offered care and protection, such as some form of community and institutional care, in addition to being treated as a juvenile offender. It is unclear whether this co-ordination has been given effect to, as institutional facilities for children who use drugs are still divided along the target groups of children in need of care and protection and children in conflict with the law.⁸⁰

Offering any intoxicating liquor, tobacco or narcotic drug or psychotropic substance to a child is an offence, except on the advice of a medical practitioner.⁸¹ Since the law expressly recognises medical advice, provision of OST to opioid dependent children should not face legal hurdles any more.

Using a child as a drug courier is also an offence, punishable with imprisonment up to 7 years.⁸² The aforesaid provisions under the JJ Act, 2015 supplement the NDPS Act, which provides that drug offences that affect children or where children are used for the commission of the offence or where the offence is committed in the vicinity of places accessed by children are liable to higher punishment (more than 10 years imprisonment).⁸³

Policy directions by an alarmed judiciary

In several cases, policy interventions in relation to children and drugs were crafted by courts while hearing public interest litigation (PIL). A petition in the nature of a PIL is filed by a person (which

may be an individual or an organization), who has no personal interest and is not directly affected in the 'lis' (dispute before the Court) but who seeks to bring an issue that the person considers to be of 'larger public interest' before the court, so that the court may direct the concerned authorities to take action. Since a PIL invokes powers conferred on courts under the Indian Constitution, it can only be entertained by superior courts: the High Court of a state or the Supreme Court of India.

A PIL before the High Court of Delhi led to the inclusion of substances like whiteners, erasex, thinning fluids, dendrite glue and rubber solutions, which are known to be used by children to get 'high', as "intoxicating liquor" under section 77 of the JJ Act, 2015. Accordingly, anyone giving such substances to a child will be liable for punishment up to seven years imprisonment and a fine up to Rs one lakh (approximately USD1,400). The validity of this order is questionable as the JJ Act, 2015 does not confer any power on any authority to notify a substance as "intoxicating liquor".

The order of the Delhi High Court, which was emulated by the Uttarakhand High Court in a separate PIL,⁸⁴ included directions requiring the state authorities to form 'narcotics squads' in every district to 'bust' drug peddling, impose surveillance on persons involved in drug offences in the State, set up 'anti-drug clubs' in schools and colleges, ask teachers and other school staff to be alert to drug peddlers and report them to the police, and require all persons accused of drug offences to be tested for drug use and sent for compulsory treatment in jail. Many of these measures are beyond what is provided in the law and reflect judicial overzealousness to eradicate drugs from their states.

In response to a PIL seeking the establishment of a national action plan on the issue of alcohol and substance use among children, the Supreme Court of India directed the MoSJE to complete a national survey on the extent and pattern of drug use in the country, within six months of the date of the order (14 December 2016).⁸⁵ The results of the exercise are still awaited. The Court also mandated the development of age-appropriate curriculum to warn children of the dangers of

drug use and take steps to report drug use in schools.

Since all the PIL cases were seeded in the 'drug-free' philosophy, the courts failed to take notice of more practical measures to reduce drug-related harms among young people. As a result, these interventions do not advance any new thinking or programmes for children and drug use but merely perpetuate more of the same interventions that have not proven effective in either reducing drug use or drug-related harms.

Proportionate penalties and sentencing in the criminal justice system

Quantity-based sentencing

The NDPS Act adopts a strictly punitive approach towards drug-related activities, with punishments ranging from one to twenty years imprisonment for a first-time offender, depending on whether the amount of drugs involved is 'small', 'commercial' or in-between the two. A person convicted for drugs found in 'small quantity' is liable to punishment of up to 1 year imprisonment and/ or fine of Rs 10,000 (approximately US\$140). But a person convicted for commercial quantity is subjected to a minimum term of 10 years in prison, which may extend to 20 years and a fine of Rs 1 lakh (approximately US\$1,400), which may also be extended. Apart from punishment, the amount of drugs also determines the accused person's ability to access bail on arrest and diversion into treatment, which is only available to persons charged with consumption of drugs or a small quantity offence.

A schedule enlisting "small" and "commercial" quantities of all drugs to which the NDPS Act applies was notified by the Central Government in 2001.⁸⁶ Since penal provisions are dependent entirely on the quantity of the drug seized, the manner of calculating the weight assumes enormous importance in drug cases. In 2008, the Supreme Court declared that for drugs found mixed with "neutral substances", only the actual content of the narcotic drug is relevant

for determining whether it constitutes small, commercial or intermediate quantity.⁸⁷ Drug law enforcement agencies saw this verdict as a major setback in prosecuting offenders, which led the Central Government to issue a notification in 2009 stating that in determining drug quantity, the total weight will be considered and not the purity.⁸⁸

The said notification was challenged before various High Courts on the ground that it led to disproportionate sentences and was contrary to the provisions of the NDPS Act, which penalise narcotic and psychotropic drugs and not neutral substances. These petitions were unsuccessful. The leading decision – that of the Delhi High Court,⁸⁹ which was followed by other courts, was appealed against. Finding the issue to be of “seminal public importance”, the Supreme Court in July 2017 directed the case to be heard by a three-judge bench, to be especially constituted for this purpose.⁹⁰ In the meantime, persons found with small amounts of the actual narcotic or psychotropic drug continue to be treated as serious offenders and sentenced harshly because of the manner of calculation prescribed in the notification.

Determination of drug quantity significantly impacts people who use drugs, as provisions for immunity from prosecution and diversion into treatment also depend on the quantity of drug involved. So far, no representation from people who use drugs or community groups has been forthcoming on the issue.

Court allowing discretion, where it does not exist

Another recent verdict that attempted to address the question of proportionality of punitive measures under the NDPS Act was by the High Court of Punjab and Haryana.⁹¹ The question before the court was whether it was fair for drug users, who are in possession of drugs for their own use, to be subjected to severe punishment simply because the quantity that they possessed fell within the commercial threshold. The High Court stated that drug law enforcement officers have no duty to ascertain whether a person

arrested under the NDPS Act was in possession for her/his personal use. It is for the accused person to produce evidence in Court in support of her/his personal use or dependence. At the same time, in what appears to be a judicial tweaking of the quantity-based sentencing structure, the High Court said that in a case where the court is satisfied that the drug, though seized as commercial quantity, was intended for personal use, the judge may impose lesser punishment, i.e. punishment for intermediate quantity (which results in 1 to 10 years imprisonment) and not for commercial quantity (which results in 10 years imprisonment or higher). The court did not lay down any guidelines for exercising such discretion but indicated that it could be done on an individualized basis, considering the nature and quantity of the drug seized as well as the profile and medical history of the offender.

Death penalty for first-time offenders

In July 2018, the Chief Minister of the State of Punjab, which has been dealing with severe opioid dependence, publicly announced his demand for imposing the death penalty on first-time drug offenders to deter involvement in drug supply.⁹² The State of Punjab has been clamping down on the drug trade with mass arrests and enforcement operations. The Government has even set up a ‘drug war room’ at the police headquarters to co-ordinate anti-drug actions.⁹³ Presently, the NDPS Act provides the death penalty or imprisonment up to 30 years for certain repeat offences but not first-time offences.⁹⁴ Several human rights groups opposed the Punjab Government’s suggestion.⁹⁵ In August 2018, the Central Government turned down the State’s proposal by citing international law and the lack of support for the death penalty under international drug conventions as well as opposition by the UNODC.⁹⁶ The Centre’s decision in this regard is significant, as India has otherwise been expanding the number of crimes punishable with death including for sexual crimes against children.⁹⁷

Reforms on the horizon?

From the perspective of people who use drugs, the last few years have seen growing debate in the media on cannabis policy reform, with many law makers openly criticizing its criminalization under the NDPS Act. A Member of Parliament is also seeking to introduce a Private Member's Bill proposing the legal regulation of cannabis, opium and certain other drugs.⁹⁸ It is significant that the Bill is being presented by a lawmaker from Punjab, who has witnessed first-hand, the failure of the 'war on drugs' and its negative consequences on individuals and society.⁹⁹ While the Bill is not expected to pass in Parliament, it has opened up opportunities for advocacy against the criminalization of people who use drugs and the need for alternatives.

The Indian Government has recently stated in Parliament that it is not considering any proposal to amend the NDPS Act to legalise or decriminalise the use of cannabis.¹⁰⁰ However, partly due to growing interest and reforms around the world, conversations on cannabis and drug law reform are unlikely to fade away.

Conclusions

1. Although the overall drug policy environment in India remains the same, there have been some potentially positive changes in legislation not directly associated with drug control, such as the Mental Health and HIV laws. Their implementation needs to be monitored to evaluate their impacts and the extent to which they are effective in meeting their objective of increasing access to necessary healthcare, and ensuring access to HIV prevention, treatment and care for people who use and people who are dependent on drugs.
2. There have been policy changes that pose greater challenges to access to drug dependence treatment, including through the criminalisation of doctors providing OST services, closure of opium registries, harsher punishment for young people under the Juvenile Justice Act, 2015, and imposition of disproportionate penalties under the framework for quantity-based sentencing.

Conversations about the ineffectiveness of criminalisation and punishment in addressing the harms associated with drug use, as well as the need for proven harm reduction interventions and drug treatment programmes that are based on scientific evidence and human rights are few and far between.

3. The policy changes taking shape at state-level show that the Central Government is no longer the exclusive site for advocacy and reform. In addition, courts have shown that they can play an important role in transforming laws and policies. However, prohibitionist and drug-free objectives remain dominant policy goals, and it remains to be questioned the extent to which the judiciary should be directing drug policy or directing measures such as 'drug-free clubs' and 'surveillance of drug suspects', that are outside the law
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About this briefing paper

This paper outlines the key drug policy developments in India since the UNGASS Outcome Document was adopted in 2016, which highlights health and human rights concerns in relation to both drugs and drug policies. These concerns include the themes of availability and access to controlled medicines, evidence-based treatment for drug dependence, measures to minimise “the adverse health and social consequences” of drug use including overdose deaths and transmission of HIV, viral hepatitis and other blood-borne diseases, interventions to address the specific needs of children and youth, and proportionate responses in the criminal justice system.

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About IDPC

The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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