**BASIC GUIDELINES FOR THE DRUG DEPENDDENCE TREATMENT CENTRES TO FOLLOW WITH REGARD TO PHYSICAL FACILITIES; TREATMENT; HUMAN RIGHTS STANDARDS AND MONITORING**

**RE: *submission by Sharan Society for Urban Poverty pursuant to order of the Hon'ble High Court of Punjab and Haryana at Chandigarh dated 30.05.09 in Cri. Misc. No. M-26374 OF 2008***

1. The High Court of Punjab and Haryana at Chandigarh have directed the State of Punjab and Haryana by order dated 30.05.09 to formulate rules/ regulations/ scheme/ policy under NDPS Act, 1985. The Court also directed the State of Punjab and Haryana to consult NGOs and renowned organizations in the area of drug dependence treatment in the process of framing the said rules.
2. Pursuant to the above said order the intervener, SHARAN organized a meeting with drug users, several of which were from the State of Punjab and Haryana. The minutes of the meeting are attached herewith and marked as Annexure P-11. Based on the experiences shared by the people who use drugs and the suggestions made by them to improve the system of drug dependence treatment, the Intervener, SHARAN is making this written submission urging the State of Punjab and Haryana to consider the submissions and incorporate them in the rules/ regulations/ scheme/ policy that they will frame.
3. The suggestions contained in the present written submissions have been outlined by the community of people using drugs themselves and are based on their experiences in the drug dependence treatment centres. The people who use drugs will be directly impacted by any rules/policies or strategies that the

government may formulate and it is only right that their voice and experiences should be heard and taken into account before formulating any such rules/policies and strategies. The principle of participation is one of the recognized universal human rights norms.

4. The written submissions have been divided into 4 key points, namely,
    a) physical facilities and environment in drug dependence treatment centres;
    b) scientific and evidence based treatment and concomitant medical/clinical facilities and arrangements in centres;
    c) Human Rights standards to be complied with in the centres;
    d) Monitoring and inspection of the centres.

**A. Every drug dependence treatment centre should provide proper physical facilities and environment**

5. It is the right of the people using drugs that every drug dependence treatment centre ought to have standard physical facilities and environment. For successful treatment outcomes, it is crucial that the physical environment of a center is pleasant, comfortable and conducive to the well-being of people who use drugs. Several instances have been brought to light about poor physical facilities In the drug dependence treatment centres, regarding overcrowding, inedible and inadequate food, unclean drinking water, general unhygienic and unsanitary conditions etc. After identifying the existing problems the following suggestions are made:

6. Wholesome Food – every drug dependence treatment centre should provide adequate and edible food at least three times a day, including breakfast, lunch

and dinner. Drug users admitted in the centres should be provided with a balanced and nutritious diet. The centres should also provide special diet modified as per the dietary requirements of patients with other co-morbidities like, TB, Hepatitis, diabetes, etc

7. Clean potable water – every centre should provide clean drinking water
8. Adequate running water for bathing and cleaning purposes. – every centre should provide sufficient water for bathing and cleaning purposes
8. Adequate and clean toilets – every centre should have adequate toilets depending on the number of in-house patients. The MoSJE Minimum Standards states that there should be 1 bathroom for 10 patients and 1 toilet for every 5 patients. These standards are however not followed. It should be ensured that every centre follows these minimum standards.
9. Overall sanitary conditions – several complaints have been made that the centres have unhygienic and unsanitary living conditions. It is the right of the person using drugs that the centres should be maintained in a clean and hygienic manner. The centres should have provisions for providing clean and sanitary toilets, bed linen, pillows, utensils, clothes etc.
10. Ventilation – many people using drugs have said that the centres are very stuffy and have very poor ventilation. It is important that the centres should be airy, well-lit and well-ventilated. The MoSJE Minimum Standards provides that the centres should be well-lit and ventilated but these are largely ignored by the centres.
11. Proper accommodation – there are numerous complaints about overcrowding in drug dependence treatment centres. Sometimes, the centres are said to have stuffed 40 people in one room. The centres ought to follow the guidelines

regarding sufficient spacing between the beds as laid down in the MoSJE Minimum Standards, which states that there should be a gap of at least 1 foot between two beds.

12. Staffing – It has been brought to light that many centres do not have adequate number of staff and many centres do not have any doctors whether part time or full time. The MoSJE Minimum standards lay down the staffing requirement of centers with different bed strengths. However, the standards state that for centres having 15 beds and centres having 50 beds only one part time doctor ought to be available. It is submitted that for 15 bed centres there shall be at least one full time or part time doctor. However for centres which have 50 beds, there should at least be 2 doctors, with at least one full time doctor, the other either part time or full time. The staffing requirement of the MoSJE standards should be strictly implemented. All the centres should be mandated to have the requisite number of staff, including doctor, nurse, psychologist/psychiatrist, ward boys etc
13. Training of doctors and other staff - People who use drugs have related through their experiences that the doctors and other staff are not capable of handling medical conditions arising from drug dependence and emergency situations. This necessitates that doctors and other staff are properly and continuously trained on handling drug use treatment and drug use related co-morbidities and also quickly and effectively intervene in medical emergencies.
14. Recreational facilities – every centre should provide recreational facilities in terms of outdoor and indoor games, magazines, books, TV, radio etc.

15. Tools for personal hygiene – every centre ought to provide basic tools by which patients can maintain their personal hygiene, such as, soaps, shampoos, hair-oil, nail cutter, shaving kit, or arrangement of a barber etc.
16. Life skills education, information about other infections and diseases – every centre should provide life skills education to patients which would include information about other infections and diseases that they could be vulnerable to and measures to effectively protect themselves from such infections and diseases.
17. Referral, continuum of care, complete rehabilitation, guidance on employment opportunities, vocational training. – To achieve the claimed objective of "Whole-person recovery" of the person using drugs, the government must ensure that every centre provides the whole continuum of care to achieve complete rehabilitation of the client. The rate of relapse after being released from centres is quite high. After treatment the real challenge is to prevent relapse. Apart from the medical/pharmacological reasons for relapse, the problems related to employment and social reintegration contribute heavily to relapse and unsuccessful treatment outcome. To achieve "whole person recovery" and to keep the patients consistently away from drugs, it is crucial that they are given some vocational training, which will keep them gainfully employed after they are released from the centre. The government can also maintain a networking or referral system through which patients who have a degree or are considerably educated can be given a job after their discharge to help them on their path to social reintegration.
18. Marginalised /street based drug users –

a) Considering that street based drug users do not have families or relatives to care for them, the centre should provide them things like, clothes, shoes, slippers, innerwear etc. at the time when they are admitted in drug dependence treatment centres and thereafter as and when required.

b) In order to achieve means of sustainable livelihood a full package of social assistance and support needs to be made available to people who use drugs, particularly those who live on the streets, as they are unemployed, homeless and abandoned by their families. A continuum of care in terms of accommodations, free food vouchers and job opportunities should be made available to such persons using drugs in collaboration with social services parallel to treatment services. Only such a package of social assistance will minimize the chances of relapse for people who use drugs.

19. Day care centre facilities – as has been stated above, after the patient is discharged from the centre, the main challenge is to prevent relapse. Every centre should have a day care drop-in centre to keep the discharged patient in the loop. The patient, even after discharge, can spend some time in the day care drop-in-centre and this time and space could be utilized to provide further motivational counseling to, *inter alia*, prevent relapse.

20. Counseling

    a) Confidentiality – any information divulged to the counselor by the patient should be kept confidential. Information obtained by the counselor pertaining to the client's drug use, environmental factors, family information, and general medical conditions etc. should be kept confidential by the counselor.

b) Sensitivity – in order to effectively counsel drug users, it is crucial that the counselor should be sensitive and non-judgemental. The counselor should be empathetic and understanding when counseling drug users only then will the client develop trust and confidence in the counselor.

c) Family counseling – every centre should provide counseling sessions for the family of the drug users as well. Family is an important component in achieving the treatment outcome. It is important to counsel the family about the needs of the drug user. This will help in building an understanding support system for the drug user when he is discharged from the centre, thereby, reduce the chances of relapse and further the chances of the social reintegration of the drug user and hence assist in "whole person recovery".

d) Support group counseling – every centre should provide support group counseling for the drug users. Such sessions provide a support base and motivation for drug users and help them in their treatment.

e) Mixture of peer counselors and professional counselors – considering that both the peer counselors and professional counselors have important roles to play, every centre should provide a mixture of peer and professional counselors.

21. Counseling on legal rights – drug use is stigmatized in our society and results in disentitlements and discrimination. There are many drug users who are abandoned by their families and deprived of their legal rights to for instance,

inheritance. Such drug users have nowhere to go and no money or resources to start their lives afresh once they are discharged from the centres. This makes them vulnerable to relapse. For successful rehabilitation, it is crucial that drug users be provided legal aid counseling to make them aware of their rights and enable them to access and obtain their rights. Providing legal aid counseling therefore becomes a crucial tool to ensure "whole person recovery" and every centre must provide for it.

**B. Safe Treatment for drug dependence is a right of every drug user and every centre should provide for evidence based treatment for drug dependence treatment and other concomitant medical and clinical facilities**

22. In order to appreciate the nature of drug dependence and provide medical and clinical interventions for it, it is important to understand that drug dependence is a multi-factorial health disorder that often follows the course of a relapse and remitting chronic disease. Opioid addiction is a chronic disorder and a single episode of treatment seldom leads to prolonged abstinence from drugs. Majority of drug users relapse within the first year of treatment, most within the first three months. Most persons who manage to achieve long-term abstinence have had numerous treatment attempts in the past.
23. Sufficient duration of treatment- the duration of treatment interventions is determined by individual needs and there can be no pre-set limits to duration of treatment. The present strategy of the government which states that the patients should be weaned off drugs in just 1-2 months in flawed and not based on experience. In treating chronic drug dependence and prevent relapse, long-lasting treatment programmes have been found the most effective

strategies. It is therefore, necessary that government formulate a strategy to formulate long term client retention in treatment.

24. Multidisciplinary approach is required - Further, the biopsychosocial model has recognized drug dependence as a multifaceted problem requiring the expertise of many disciplines. Drug dependence is a treatable and preventable disorder and effective preventive and treatment interventions are available for it. The best results are achieved when a comprehensive multidisciplinary approach which includes both pharmacological and psychosocial interventions are available to respond to different needs. The integration of pharmacological and psychological treatment methods forms a holistic treatment strategy, treating the person as a whole and not just the addiction and significantly improves the treatment outcome.

25. Range of pharmacological and psychological interventions - One formula doesn't fit all cases of drug dependence. It is the right of every person using drugs to have a bouquet of treatment options from which the most conducive and effective option/ or combination of options could be chosen for each individual case. No single treatment is appropriate for all persons and differentiated and targeted treatment interventions respond best to the specific needs of each critical condition. The present strategy of the government which stresses on total abstinence and detoxification as a straight jacket formula is unscientific and contrary to the accumulated body of evidence in the field of drug dependence treatment. Therefore, the present strategy is flawed and needs to be altered urgently as it is the biggest impediment in the government's own stated objective of "whole person recovery".

26. Abscess management – formation of abscess is a major health problem for injecting drug users. Abscess formation occurs when drug users repeatedly inject drugs and puncture their skin at or around the same point. Repeated injecting and puncturing of the same area leads to formation of abscess, which if left untreated becomes infected and leads to amputation. Therefore, it is crucial that the all the doctors and other staff in every centre are trained in abscess management to prevent loss of limb.
27. Oral Substitution Therapy (OST) should be made available for both short term withdrawal/detoxification and long term maintenance.
28. OST for short term withdrawal/detoxification – people who use drugs have several symptoms when they are experiencing withdrawal, namely, nausea, diarrhea, body ache, breathlessness, insomnia, abdominal pain etc. Currently drug users are given separate medicines for each of the withdrawal symptoms. This way the client ends up having 4-5 medicines just for his withdrawal symptoms, which are often not effective enough to provide relief to the patients. On the other hand, there is OST with buprenorphine, which can be given for all the symptoms together and it is also far more effective in providing relief to the client than the separate medicines for each symptom. Every centre should provide OST with buprenorphine for short term withdrawal/detoxification, which is in the 'best interest of the client' for only one medicine has to be taken for all symptoms and it is also more effective in providing relief.
29. OST for long term maintenance –
    a) Detoxification is at best the first step to achieve a drug-free state. The most difficult phase is to prevent relapse. Detoxification is a preparatory step for

starting long lasting drug free oriented programmes like, OST with buprenorphine or methadone. Opioid dependence being a chronic disorder requires long-term therapy of months if not years. Clearly just detoxification, the current strategy employed by the government, is not the answer.

b) OST is effective and efficacious in preventing relapse and stabilising drug dependent persons. The basic principle of OST besides preventing relapse, is to reduce drug use, improve patient's well being, reduce the transmission of blood-borne infectious diseases, reduce deaths due to overdose, reduce crime committed by people dependent on drugs, facilitate an improvement in a patient's social and occupational functioning, improve economic status of the patients and their families and ultimately to achieve abstinence from drug use. Clearly OST does not have just better and more effective rate of success for keeping the patients away from drugs forever but also has a whole range of benefits which the government aims for but has failed to achieve due to its over emphasis on just detoxification and total exclusion of OST. The government's objective of "whole person recovery' just remains a laudatory idea on paper without including OST as a treatment option.

c) OST with Buprenorphine has been used widely in several countries with very successful treatment outcomes. The feasibility and effectiveness of buprenorphine in Indian setting has also been documented. The National Drug Dependence Treatment Centre at All India Institute of Medical Sciences (AIIMS) provides buprenorphine according to a medically developed protocol.

d) Methadone is another agonist which is used in OST worldwide with very good treatment results. Like buprenorphine, it is safe, cost effective and can be administered under medical supervision. Both buprenorphine and methadone are on the WHO's list of essential drugs and ought to be provided by the government in its drug dependence treatment programmes.

30. Admission screening/ assessment and diagnosis –

a) At the time of admission, assessment and diagnosis should be made for other co-morbidities like, HIV, TB, Hepatitis, diabetes, hypertension etc. and followed up by doctors. Every centre should maintain complete and updated medical records of each client in the centre. Accurate diagnosis of drug dependence and other co-morbidity conditions should be established before initiating treatment.

b) The screening tests should be done only after informed consent of the patient derived through counseling.

c) Every centre should keep in stock all the medicines required for such co-morbidities.

d) A proper referral system should exist with other health care institutes for referral of patients with other co-morbidities for treatment and the centre should also have adequate staff to facilitate this referral.

31. Further, a comprehensive assessment should be made of health status, mental health status, individual temperament and personality traits, vocational and employment status, family and social integration and legal status. The assessment should also include, environmental and developmental factors,

including childhood and family history and relationships, social and cultural circumstances and previous treatment attempts. Such an assessment will act as the first step in developing a partnership with the patient and engage the patients into treatment.

32. Treatment plan should be developed with the patient – every centre should devise a treatment plan along with the patient. A treatment plan designed with the patient sets treatment goals based on the patient's identified needs and sets interventions to meet those goals. The treatment plan should then be monitored and revised according to the patient's changing situation.
33. Medicines for general health problems should also be stocked in every centre, including a first-aid kit.
34. Infection control measures – every centre should have adequate infection control measures so that communicable infections don't spread from one patient to another. An instance was highlighted by a person dependent on drugs, when a patient was found suffering from cholera. The centre staff stuffed the remaining 40 patients into one room in order to prevent them from getting infected. Not only did the 40 patients suffer from such overcrowding but some of them were infected with cholera. Hence it is crucial that every centre is equipped with adequate infection control measures and also that all the staff are routinely trained on how to use them.
35. Emergency medical interventions – every centre should be equipped to intervene in medical emergencies. In the above said instance, the patient who was first infected with cholera died because he was not given emergency treatment which his situation demanded. Instead he was just isolated in one

room. The staff in every centre should be trained to deal with such situations and be equipped to respond effectively in medical emergencies.

36. Regular family visits – the patients should be allowed family visits once every fortnight. These family visits should be in private. This boosts the moral of the patients and provides them with psychological support. This also offers an opportunity to counsel the family members and keep them involved in the treatment plan.
37. Sensitive attitude of staff at centres – every centre should have regular sensitization trainings for its entire staff. All the treatment goals will be lost if the staff are not empathetic and non-judgemental towards the patients. The staff can have motivating and equally demoralizing effect on the patients depending on their attitude. If they do not form a rapport with the patients or ill-treat the patients, there are chances that the patients will drop out of the centre and never come back. It is crucial for the staff to be sensitive to the needs and sensibilities of the patients because they are the ones coming in direct contact with the patients.
38. Treatment should be made available in prisons and police lock-ups –. The government should make arrangements for providing treatment for drug dependence in lock-ups and prisons
    a) People dependent on drugs who are kept in prisons and lock-ups experience acute withdrawal symptoms which left untreated can lead to immense pain and even death.
    b) Prisoners and detainees do not lose their right to life and health just because they are behind bars. The right of prisoners and detainees

to life and health and dignity has been upheld in a number of judgments.

c) Further, research has shown that treatment for drug dependence in prisons can reduce post release use of drugs and re-offending.

d) Cognizant of the fact that there are considerable number of persons dependent on drugs in prisons, the Tihar prison administration has initiated roll out of OST for drug dependents with a history of injecting drug use. The National Drug Dependence Treatment Centre of the All India Institute of Medical Sciences provides the technical support for the same. This practice needs to be emulated in prisons and jails across India.

e) Besides, injecting drug use is quite common in prisons. Injecting practices inside the prison involves more harmful patters (sharing of needles) leading to increased risk of contamination with diseases like, HIV and Hepatitis. This necessitates providing OST in prison settings which minimizes the practice of injecting the drugs and thereby minimizing the chances of transmitting diseases like HIV and Hepatitis.

**C. Drug dependence treatment services should always comply with human rights obligations and recognize the inherent dignity of all individuals.**

39. Compliance with human rights standards in drug dependence treatment includes responding to the right of all individuals to the highest attainable standard of physical and mental well being and ensuring non-discrimination.

40. In the meeting with people dependent on drugs organized by intervener SHARAN, several disconcerting instances of practices which violate human rights standards was brought to light. People using drugs reported that they faced humiliation and indignities at the hands of the staff on a regular basis. One of the participants recounted the horror of a treatment centre in the following words,

> *"I have been using drugs since 1978. In 1985, my family took me to a reputed psychiatrist. I stood in queue and met the doctor. I said that I do drugs. The doctor asked if I had ever tried to give up. I hadn't in the last 15 days. He wrote "mad" on my card and sent me to the mental hospital in Shahdara. I received severe beatings there. It was a TC [therapeutic community] and they had a house tight rule. We were 40 people, and the dal was cooked with exactly 40 lentils. The rest was all water. We had to search for that one lentil of our share…it was humiliating."*
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> [See attached minutes of the meeting with people dependent on drugs organized by SHARAN]

Another participant narrated his experience in a well known drug dependence treatment centre in Delhi –

> *"Forty of us were locked up in a dingy basement. One boy fell sick with cholera because of the dirty water we were made to drink. The owner allowed us to eat only 3 thin rotis a day, if some one asked for more, he was tied up and thrashed. Our heads were shaved off. We were treated like animals…worse than animals. We managed to escape from the centre .only after the sick boy died and the police visited."*

[See attached minutes of the meeting with people dependent on drugs organized by SHARAN]

41. Some centres follow humiliating and degrading practices in the name of treatment and sometimes in the name of punishment and disciplinary actions, which in almost all cases amounts to sheer torture. Patients are sometimes sought to be punished for things like, “why is your sleeve rolled up?”, and “why is your shirt button open?”

    a) Chaining hands and feet of patients in heavy iron chains was reported as a resorted means to “cure” addicts of drug dependence.

    b) Solitary confinement of patients when they experience withdrawal without treating the withdrawal symptom. patiens are locked alone without any treatment and their screams for help are all together ignored.

    c) In order to apparently keep the patients engaged they are made to dig holes in the ground, then fill it and then dig it again and fill it again and so on…

    d) ‘Kambal (blanket) parade’ – patients are wrapped in a blanket and then beaten with sticks and rods. The patients are wrapped in blankets before they are beaten because the blanket cover ensures that the beating leave no mark on the body.

    e) patients are made to strip and sit on a brick for hours sometimes more than 24 hours without food or water and they are not even allowed to get up to go to the toilet. If any patient falls off the brick, he is beaten with rods and made to sit on the brick again.

f) ‘Spare parts’ – this punishment entails stripping the patient and then tying a mop around his waist and make him sweep the floor with the mop while sitting on his hips.

g) ‘Blasting’ – patients are first subjected to physical torture all day and in the evening they are locked in a room and subjected to an hour of ‘blasting’, meaning the staff of the centre surround him and hurl abuses and indignities at him for over an hour.

h) The patients are made to measure the length and breadth of a room with matchsticks.

i) The patients are given two bowls, one empty and one filled with water. They are given a spoon and asked to transfer spoons full of water from the full bowl to the empty one and then repeat the process when the other bowl becomes full. They are made to do this for hours on end.

j) One form of punishment entails making the patiens count the number of holes/gaps in the window netting.

k) Another mode of punishment is making the patients clean all the toilets with their bare hands and make them eat without letting them wash their hands.

l) Starving the patient is another popular form of punishment.

m) Sometimes patients are given a bowl containing a mixture of sugar and tea leave and they are asked to separate them with their mouths, while their hands are tied at their back.

n) Whereas beating the patients, making them stand with cylinders on their heads for hours, etc. are very common forms of punishment.

42. Clearly the above said practices whether in the name of treatment or as disciplinary measures are barbaric and violate the human and fundamental rights of the patients. Atrocities and torture in the name of treatment or punishments should be stopped. Human rights of people dependent on drugs should never be restricted on the grounds of treatment and rehabilitation. Inhuman or degrading practices and punishments should never be a part of treatment. If there is a need of disciplinary measures then counseling and support group sessions can be resorted to.
43. Forced labour of any kind should not be allowed in the centres.
43. Treatment should be voluntary - every centre should ensure that they take patients who are voluntarily willing to undergo treatment and not forced by families. Coerced and forced treatment is not only violative of human rights of people dependent on drugs but it will also never meet its identified treatment goals. If treatment is forced there are chances that the patient will relapse into drug use as soon as he is released from the centre. At the time of admission screening, every centre must ensure that the persons dependent on drugs themselves volunteer for treatment without any coercion by family.
44. Treatment only with informed consent of the patient – every centre should ensure that treatment is started only after informed consent of the client. It is the right of every drug user to be counseled about the nature and content of the treatment as well as the risks and benefits to be expected of treatment and then give consent for undergoing treatment. Moreover, the written consent should be taken in writing and a copy of the signed consent form should be given to the patient.

45. Patients should not be detained against their will – it is the right of every person dependent on drugs to withdraw from the treatment for any personal reason without any physical or psychological harassment. No centre should be allowed to detain patients against their will.

46. Visits from and communication with family – every patient should have the right to have visits from family at least once every fortnight. Every centre should have adequate arrangement for and allow the patients to communicate with their family via telephone or letters etc.

**D. Monitoring and inspection to ensure stringent compliance with rules/regulations**

47. The importance of an efficient and rigorous system of monitoring and inspection cannot be emphasised enough. No matter how well formulated the rules are they will fall short of their objectives in the absence of an effective monitoring system. This is sufficiently borne out by the present situation. Although deficient on many counts, the MoSJE Scheme and Manual do lay down certain guidelines particularly concerning the human rights standards to be complied with. However as the examples stated herein above regarding the torture meted out to patients in the name of treatment and disciplinary actions drive the point home that the centres are flouting the MoSJE guidelines with impunity. One of the ways to ensure that the centres follow the rules and regulations is by having a rigorous and effective monitoring and inspection mechanism in place.

48. The following measures can be adopted to provide for a strong system for monitoring and inspection to ensure strict compliance with the rules framed and to check and deal with any digression.

a) Compulsory registration of all private drug dependence treatment centres – so far there is no requirement of registering centres before opening them. This makes it impossible to even know the exact no. of centres operating let alone monitor them. The government should make it mandatory to register all centres, whether government or private, before opening them.

b) Appointment of Ombudsman - Enquire/investigate into allegations of action, inaction, corruption and mal administration in centres.

c) Oversight Committee in each state – the government should form a committee in each state comprising NGO representatives, representatives of people who use drugs, medical experts, lawyers and government officials.

d) The oversight committee could also act as a grievance redressal committee, for the purposes of which they could meet once every month.

e) Complaints mechanism – a proper system should be formulated by which the patients could make complaints against the centres and those complaints should reach the grievance redressal committee.

f) Regional coordinators - The government should appoint regional coordinators whose job would be to inspect the centres once every quarter and submit inspection reports to the oversight committee as well as the state and central governments. The regional coordinator

should meet the patients in the centres in private and the inputs of the patients should be incorporated in the report. However the inputs given by the patients should remain confidential.