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# Drug policy in India

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## Introduction

India's response to drugs flows along an extraordinary spectrum – of tradition and modernity; of widespread availability and stringent enforcement; of tolerance and prohibition; of production for medical use to lack of medical access to opiates. India's long history of cannabis and opium use is referenced extensively in policy analysis.[1] Being a country with significant volumes of licit and illicit drug cultivation, a transit route as well as a consumer market, India's drug policy dilemmas span 'demand' and 'supply' control. Its large chemical and pharmaceutical industry draws the country into deliberations on the illicit manufacture of drugs and precursor control as well as the non-medical use of prescription drugs. Some parts of the country report alarmingly high rates of drug dependence, HIV and viral hepatitis amongst people who inject drugs, making health and harm reduction important policy considerations. While India's harsh drug control laws (in particular the criminalization of drug use and the imposition of the death penalty for certain drug offences) conform strictly with prohibition, its regulated opium cultivation industry provides insights for countries that are experimenting with alternatives to prohibition.

## Context

Cannabis has been consumed for spiritual, medicinal and recreational purposes in India since the classical era, with earliest documented references to cannabis use dating back to 2000 B.C. Post-colonization, the British attempted to regulate it through excise laws that licensed cultivation and imposed taxes on the sale of hemp.[2] The cultivation and use of opium is believed to date as far back as the 10th century. During the colonial period, the British organized opium into a large-scale commercial enterprise, consolidating and bringing cultivation of poppy and manufacture of opium (but not consumption) under greater control through the Opium Acts of 1857 and 1878.[3]

By the 1920s, the growing nationalist movement became critical of the colonial government's commercially driven drug policy. Indian leaders distanced themselves from traditional use and the eradication of drugs became an avowed policy goal.[4] Many provincial governments passed laws to restrict the consumption of opium.[5] Cannabis was classified as an intoxicating drug and continued to be regulated through provincial excise Acts.[6]

In 1930, the Dangerous Drugs Act was enacted and sought to extend and strengthen control over drugs derived from coca, hemp (cannabis) and poppy plants by regulating the cultivation, possession, manufacture, sale, domestic trade and external transactions through licenses and penalizing unlicensed activities.[7] There were no offences attached to cannabis or to drug consumption. The framework of the Dangerous Drugs Act continues to prevail in the current

legislation, especially the statutory definitions for coca, opium, hemp and their derivatives, the category of "manufactured drugs" and the division of rule-making powers between the central and state governments.

The Drugs and Cosmetics Act, 1940[8] was adopted for the regulation of medicinal drugs including cannabis and opium. The Dangerous Drugs Act, however, continued to apply.

At the time of independence, gained in 1947, narcotics were a heavily regulated commodity as 'dangerous' substances, medicinal products, as well as goods subject to excise tax.

This position continued post-independence. With the adoption of the Indian Constitution in 1950, all laws became subordinate to constitutional provisions, in particular, fundamental rights.[9] There were some challenges to drug laws on the grounds that they were discriminatory and contravened farmers' freedom of trade and occupation. The cases, however, were unsuccessful.[10] Courts relied, among other things, on India's international drug control commitments to justify the restrictions on cultivation, use and trade.

The prohibitionist sentiment became further entrenched by way of Article 47 of the Constitution which states: "The State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health". Although these Directive Principles of State Policy are non-enforceable,[11] this provision is frequently invoked to justify punitive drug policies.

The Constitution also earmarked subjects on which Parliament or state Legislatures could make law either exclusively or concurrently. "Drugs and poisons" was placed in the concurrent list,[12] allowing both center and states to legislate. "Public health" and "prisons and other institutions of like nature and persons detained therein" are only on the state list.[13] The division of legislative powers is significant because it determines state governments' ability to 'break' from national drug policies and employ alternatives[14] in areas where they are empowered to frame policy.

# Current legal framework

## Narcotic Drugs and Psychotropic Substances Act, 1985

India is a party to the three United Nations drug conventions – the 1961 Single Convention on Narcotic Drugs (1961 Convention), the 1971 Convention on Psychotropic Substances (1971 Convention) and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention). Domestic legislation to give effect to these treaties was introduced only in the 1980s when the 'grace period' for abolishing non-medical use of cannabis and opium under the 1961 Convention expired.[15] Exercising its powers to make law for the country for implementing "any treaty, agreement or convention or decision made at international conference",[16] the Indian Parliament passed the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act) hastily, without much debate. The NDPS Act came into force on 14 November 1985, replacing the Opium Acts and the Dangerous Drugs Act. The 1940 Drugs and Cosmetics Act, 1940, however, continues to apply.[17]

The official record states that the NDPS Act was enacted in order to provide adequate penalties for drug trafficking, strengthen enforcement powers, implement international conventions to which India was a party, and enforce controls over psychotropic substances. The Act was amended in 1989, 2001 and more recently in 2014.

The NDPS Act prohibits cultivation, production, possession, sale, purchase, trade, import, export, use and consumption of narcotic drugs and psychotropic substances except for medical and scientific purposes in accordance with the law.[18] Preparation to commit certain offences is punishable as is attempt. Accessory crimes of aiding and abetting and criminal conspiracy attract the same punishment as the principal offence.[19]

The Act covers three broad classes of substances: 1) narcotic drugs, that is, those covered under the 1961 Convention; 2) psychotropic substances or those covered under the 1971 Convention as well as other psychoactive substances such as ketamine which are not yet classified under

international conventions; and 3) "controlled substances"[20] that are used to manufacture narcotic drugs or psychotropic substances, for example precursor chemicals such as acetic anhydride, ephedrine and pseudoephedrine.

Narcotic drugs include:

- **Cannabis:** plant; resin or *charas* and its concentrated variant called *hashish*; dried flowering or fruiting tops of the plant, that is, g*anja* and any mixture of *charas* or *ganja.* Importantly, *bhang* or the cannabis leaf is excluded (in accordance with the 1961 Convention) and regulated through state excise laws
- **Coca: plant:** leaf; derivatives include cocaine and any preparation containing 0.1% of cocaine
- **Opium:** poppy plant; poppy straw; concentrated poppy straw; juice of opium poppy; mixture of opium poppy juice; preparations with 0.2% morphine; derivatives include heroin, morphine, codeine, thebaine, etc.

Narcotic drugs also fall under the overlapping category of "manufactured drugs".[21] Psychotropic drugs are not defined but include all drugs notified by the government as such. Amphetamines, methamphetamines, LSD, MDMA and buprenorphine amongst others are on this list, which the government may expand or constrict on the basis of evidence of actual or potential 'abuse' or changes in scheduling under international conventions.[22]

The NDPS Act lays down the procedure for search, seizure and arrest of persons in public and private places.[23] Safeguards such as prior recording of information, notifying a superior, limiting powers of arrest to designated officers, informing the person being searched of her/his rights have been scrupulously enforced by the courts, in light of the stringent punishments prescribed under the Act.[24] At the same time, norms for investigation and evidence are permissive and have been interpreted in a manner that prejudices the accused.[25]

While the NDPS Act is predominantly punitive, it also contains provisions to regulate drugs. The Act empowers the central and state governments to frame rules[26] and authorize drug-related activities within the rubric of "medical and scientific purpose", a term which is neither defined nor described in the Act. While some activities are reserved exclusively for the government,[27] others can be carried out by private entities under license.[28] The regulatory system also includes supply of opium to registered users, who are dependent on opium, for consumption on medical advice – a measure comparable to contemporary harm reduction strategies.[29] Though provided in the law, the practice has fallen into disuse[30] and as of last year, there were less than 1,000 opium users registered in the entire country.[31]

In 1988, the NDPS Act was supplemented by the **Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act** to provide for preventive detention of people suspected or accused of involvement in drug trafficking.[32]

## NDPS Amendments, 1989

In 1989, the NDPS Act underwent the first set of amendments, after a Cabinet Sub-Committee for combating drug trafficking and abuse recommended that the law be made more stringent. The 'tough on drugs' rhetoric led to the introduction of very harsh provisions such as mandatory minimum sentences of 10 years' imprisonment, restrictions on bail, bar on suspension and commutation of sentences, forfeiture of property, trial by special courts and mandatory death sentence for certain repeat offenders. The changes, which came in less than four years after the law was initially passed, seem to have been influenced by international, regional and domestic developments – namely, the signing of the 1988 Convention; deliberations at the South Asian Association for Regional Cooperation (SAARC) on the growing menace of drug trafficking, increasing political dissent and 'terrorist' activity in northern states and the perception that terrorism is fuelled by drug trafficking.

Following these amendments, people caught with small amounts of drugs faced long prison sentences and hefty fines; unless they could prove that the drug was intended for personal use (in that case, the offender would be subjected to six months or one year in prison depending

on the drug).[33] With bleak chances of release on bail, many people arrested for possessing minor amounts of drugs intended for personal use languished in jail for over 10 years for a few milligrams of contraband.[34]

### NDPS Amendments, 2001

Criticism of this harsh and disproportionate sentencing structure created a momentum for reform. In 1998, the NDPS (Amendment) Bill, was introduced in Parliament and subsequently examined by the Parliamentary Standing Committee on Finance. The amendments were finally adopted in 2001, to grade punishment[35] on the basis of the quantity of drugs involved – that is, "small",[36] "commercial"[37] or "intermediate". Thresholds were specified by the central government through a notification dated 19 October 2001.[38]

### NDPS Amendments, 2014

In early 2014, the NDPS Act was amended for the third time and the new provisions came into force on 1 May 2014. The main features include:

- Creation of a new category of "essential narcotic drugs",[39] which the central government can specify and regulate uniformly throughout the country[40]
- Widening the objective of the law from containing illicit use to also promoting the medical and scientific use of narcotic drugs and psychotropic substances[41] in keeping with the principle of 'balance' between control and availability of narcotic drugs that underpins the international drug control treaties
- Including the terms "management" of drug dependence and "recognition and approval" of treatment centers, thus allowing for the establishment of legally binding treatment standards and evidence-based medical interventions[42]
- Making the death penalty discretionary for a subsequent offence involving a certain quantity of drugs under section 31A. The court will have the alternative to impose imprisonment for 30 years under section 31
- Enhanced punishment for small quantity offences from a maximum of six months to one year imprisonment[43]
- Allowing private sector involvement in the processing of opium and concentrated poppy straw[44]
- Raising the rank of officers authorized to conduct search and arrest license holders for alleged NDPS violations[45]
- More elaborate provisions for forfeiture of property of persons arraigned on charges of drug trafficking.[46]

## Significant aspects of the NDPS Act

### Quantity-based sentencing

The quantity and punishment range for some drugs is shown on page 5.

As can be seen, the scale of sentencing and fine varies significantly depending on the substance and quantity found. Consequently, determining the amount of drugs involved in an offence is vital and much litigation revolves around this question, especially around the terms "mixture"; "preparation" and "with or without neutral material" that are contained in the law. Since the NDPS Act does not provide guidance for ascertaining quantity, some courts began to rely on the statutory definition of drugs, especially those that refer to a numerical percentage (e.g. opium and opium derivatives) to calculate the quantity involved. This resulted in inconsistent interpretations and conflicting decisions not just between different classes of drugs but even for the same drug.

The 'purity vs total weight' controversy waged on even after the Supreme Court held that for drugs mixed with 'neutral substances', only the actual content of the narcotic drug is relevant for determining whether it constitutes a small or commercial quantity.[47] A year later, the government declared that in calculating the quantity, the total weight of the seized product must be considered and not the pure drug content.[48] This change is significantly damaging for people who use drugs and other low-level offenders who risk being sentenced for intermediate or commercial quantity offences, since street drugs are heavily 'cut' and rarely ever seized in pure forms.

| Drug | Quantity and Punishment | | | | |
|---|---|---|---|---|---|
| | Small Quantity | Punishment | Commercial Quantity | Punishment | Quantity greater than small but lesser than commercial (Intermediate) |
| Heroin | 5g | Maximum of 1 year rigorous imprisonment or a fine up to Rs 10,000 or both | 250g | Rigorous imprisonment from 10 years (min) to 20 years (max) and a fine from Rs 1 lakh to 2 lakhs | |
| Opium | 25g | | 2.5kg | | Rigorous imprisonment that may extend to 10 years & fine that may extend to Rs 1 lakh |
| Morphine | 5g | | 250g | | |
| Ganja (cannabis) | 1000g | | 20kg | | |
| Charas (cannabis resin) | 100g | | 1kg | | |
| Coca leaf | 100g | | 2kg | | |
| Cocaine | 2g | | 100g | | |
| Methadone | 2g | | 50g | | |
| Amphetamine | 2g | | 50g | | |
| THC | 2g | | 50g | | |
| LSD | 0.002g | | 0.1g | | |

Though lauded as rational and proportionate, quantity-based sentencing makes other vital considerations like the motive and role of the offender irrelevant. Simple possession attracts the same amount of punishment as distribution for profit. Another reason for courts to pass uniform sentences for both types of activities is the inclusion of mandatory minimum sentences, where discretion is allowed only for enhancing and not reducing the sentence.[49]

## Death penalty

The harshness of the NDPS Act is demonstrated by the inclusion of the death penalty for certain repeat crimes (production, manufacture, possession, transportation, import and export) involving a large quantity of drugs.[50] Introduced as a mandatory punishment in 1989, the range of offences punishable with death was narrowed in 2001. In February 2008, two drug offenders were sentenced to death by NDPS special courts in Mumbai and Ahmedabad respectively. Ironically, both sentences were for cannabis (*charas*). A constitutional challenge followed, which led the Bombay High Court to declare the mandatory provision unconstitutional and read the same as discretionary, that is, in a manner where the sentencing court will hear the offender on punishment and have the power to impose a prison sentence instead of death.[51] Subsequently, by separate judgments, both convicts were sentenced to 30 years of imprisonment.[52, 53] A third convict sentenced to death by the trial court also succeeded in appeal.[54] The status of a fourth person, who was also given capital punishment under the NDPS Act in Punjab,[55] is not known.

Internationally, drug offences are not considered to be the 'most serious crimes' for which capital punishment may be invoked. The Indian

government, however, maintains that a narcotic offence is more heinous than murder because the latter affects only an individual while the former leaves its deleterious impact on society. The government also contends that other Asian countries impose the death penalty for offences involving lower drug quantities and that the International Narcotics Control Board (INCB) had never objected to the same. It remains to be seen how the government will respond to the INCB's statement of March 2014 in which it encourages states to consider abolishing the death penalty for drug-related offences.[56]

## Criminalization of people who use drugs

Consumption of drugs is illegal and results in a jail term of up to six months or one year and/or a fine, depending on the substance consumed.[57] The consumption of heroin and cocaine will lead to a lengthier sentence of imprisonment while cannabis will lead to a less severe sentence. The category of "possession of small quantity intended for personal consumption" was done away with in 2001 and presently, possession of small amounts attracts uniform punishment, irrespective of intent.

A person arrested under the Act for minor offences like **consumption** and those involving **small quantity** of narcotic drugs and psychotropic substances is **entitled to bail.**

*Abdul Aziz v. State of U.P.* 2002 CriLJ 2913; *Shaji v. State of Kerala* 2004 (3) KLT 270; *Stefan Mueller v. State of Maharashtra* 2010 Vol. 112(7)] Bom.L.R.] 2990

Though meant for serious offenders, restrictions on grant of bail were also being applied to cases involving consumption or possession of small amounts of drugs. Courts have clarified that people charged with offences involving small quantities of drugs have a right to get bail. Yet, neither police nor people who use drugs seem to be aware of the law, indiscriminate raids and arrests, especially of street users are not uncommon.[58]

Official crime statistics do not reveal what proportion of drug law arrests and convictions are conducted against users or low-level offenders (involving small quantity offences) as opposed to 'traffickers' (involving larger quantities of drugs).[59] Since the law itself does not distinguish between possession for personal use and possession with intent to sell for profit, it is difficult to comment authoritatively on whether enforcement is targeted at 'users' or 'traffickers'. The only indicator for such an analysis is the quantity of drugs involved in each case, which is also not discernable either from drug crime data. Besides, as discussed elsewhere, quantity itself is an imperfect criterion for determining the type of activity associated with the drug; in many cases where large quantities are seized, people who are arrested were merely carrying or transporting the substance, and not controlling or managing the trade.

## Treatment for drug dependence

The NDPS Act supports treatment for people who use drugs both as an 'alternative' to, and independent of criminal measures. Several provisions stipulated under the Act depenalise consumption and offences involving small quantities of drugs, and encourage treatment seeking.

### • National Fund

A National Fund for the Control of Drug Abuse was established in May 1989. Rules for its administration were notified almost twenty years later, in 2006. The fund can receive contributions from the central government, individual donors and proceeds from the sale of property forfeited from drug trafficking. Applications are screened by a governing body, which comprises a senior officer and other members appointed by the government.[60] NGOs and government departments are eligible to make requests for grants for drug control activities including treatment. Preventive education and awareness on the 'ills' of drug dependence have been prioritized for funding.[61]

### • Treatment centers

'De-addiction' centers are the mainstay of drug treatment delivery. According to the NDPS Act, these centers may be set up by the central or state governments or voluntary organizations. Presently, services for drug dependence are available through:

1. ***Government hospitals*** that provide inpatient and outpatient care, mostly detoxification. As per official statistics, drug treatment is

| Key features of the NDPS Act on treatment | Section |
|---|---|
| An "addict" is a person who is dependent on any narcotic drug or psychotropic substance | 2 (a) |
| Treatment is one of the measures that the central government must take and allocate funds for, from the National Fund | 4 (2) (d) and 7 A |
| Drug dependent people, who are charged with consumption or an offence involving a small quantity of drugs can choose to undergo treatment and be exempt from prosecution | 64 A |
| Instead of sentencing, courts can *divert* drug dependent people convicted for consumption or an offence involving a small quantity of drugs, to a recognized medical facility for detoxification, instead of sentencing | 39 |
| The government (central and/or state) can set up and regulate centers for the identification, treatment and care of drug dependent people | 71 , 76 (2) (f) and 78 (2)(b) |

available in 122 government hospitals across the country. The central government has recently announced plans to open 'drug treatment clinics' at some such hospitals and offer opioid substitution therapy.

2. ***NGOs***, which receive grants from the Ministry of Social Justice and Empowerment (MOSJE) and their state counterparts (Departments of Social Welfare) to run integrated rehabilitation centers in order to make "addicts drug free, crime free and gainfully employed". 346 such NGO centers were being funded in 2013-14.[62]
3. ***Psychiatric hospitals or nursing homes***, operating privately, under license by the Mental Health Act, 1987.[63] These institutions offer a range of psychiatric services besides drug dependence treatment.
4. ***Private 'de-addiction' centers*** that operate without registration or license.

Despite the statutory responsibility on the government to make rules for the establishment and regulation of treatment centers, neither the central nor state governments have framed such rules. As a result, a large number of unauthorized 'de-addiction' centers have proliferated to cash in on the desperation of people who use drugs and their families. Instead of medical care, 'punishments' are meted out to patients, inflicting severe torture and, in some cases, causing death. These incidents have come to light from all across India, indicating that existing norms around minimum quality standards of care[64] are not being followed.

A legal intervention in 2009[65] led to the promulgation of NDPS Rules for treatment facilities in Haryana[66] and Punjab,[67] which *inter alia* require all drug treatment and rehabilitation facilities to obtain license and be subject to inspection. The Rules unequivocally support voluntary admission into treatment and provide for closure and, in some cases, criminal action against centers that operate without a license or where human rights are violated. Despite the institution of statutory rules, people who use drugs continue to be detained involuntarily and experience violence, brutality and a host of other human rights violations in such centers.[68]

- **Diversion from prison to treatment**

Instead of sentencing a drug dependent person convicted for a low-level drug offence to imprisonment, the court can, after assessing her/his background and health status and obtaining consent, remand her/him to a treatment facility maintained or recognized by the government. Treatment access is contingent upon submission of medical reports and taking an oath not to commit drug-related offences again. Upon

completion of treatment, the court may defer the sentence and release the offender on a bond. To date, few people, if any, have benefited from this provision. One of the main reasons for this is that many people remain in detention while undergoing trial, which usually takes a long time to conclude. As such, when the conviction is pronounced, the sentence is set off against the period the person has already spent in prison,. Consequently, there is consequently no occasion to divert him/her to treatment as an alternative to the prison sentence which has effectively already been served.

- **Enrolment in treatment and protection from prosecution**

Drug dependent people who express willingness to get treated can claim immunity from prosecution, provided the offence they are charged with is that of consumption or involves a minor quantity of drugs.[69] Criminal proceedings may be reinstated if the treatment program is not completed.

Being beneficent in nature, the provision ought to be construed liberally and not strictly.[70] Courts have, however, tended to restrict its scope by holding that immunity is available only for drug dependent individuals[71] and not occasional users, and that drug dependence must be "proved by production of sufficient evidence by the person concerned".[72] In another case, contrary to the language of the section, immunity was denied to a woman who had consumed drugs and was charged with selling a small amount.[73] Such decisions inadvertently undermine the legislative intent of the section, which is to discourage criminalization of people dependent on drugs and encourage treatment seeking.

Granting immunity has also been impaired by the controversy over the determination of drug quantities, since immunity is available only for offences involving small amounts, which is often a subject of dispute in a case. It is also unclear whether substitution therapy qualifies as having undergone and 'completed' treatment.

In the implementation of the NDPS Act, treatment provisions have neither been prioritized nor applied in earnest by courts.

## Harm reduction

Presently, there are an estimated 200,000 people who inject drugs in the country and HIV prevalence among them is estimated at 7.14%. Prevalence in some states is reported to be much higher, in Punjab, 21.1% of people who inject drugs are believed to be infected with HIV, while in Manipur prevalence reaches about 12.9%. Nationally, HIV trends among people who inject drugs are reported to be stable.[74] Rates of hepatitis B and C infection are believed to be high but no official surveillance has been carried out, whether at national or state level, to estimate the burden of blood-borne infections among people who inject drugs.

Harm reduction practices were pioneered in the early 1990s after injecting drug use and attendant blood-borne infections were noticed in many parts of the country, in particular, in Manipur, Mizoram and Nagaland in the North East and the cities of Delhi, Mumbai, Chennai and Kolkata.[75] The earliest interventions took off through peer contact and outreach, supplemented by drop-in centers, doctors, counselors, the provision of condoms and sterile needle and syringes, prevention and management of abscesses, opioid substitution therapy (OST), referral to HIV testing, TB and anti-retroviral treatment (ART) as well as detoxification and rehabilitation services. Overdose prevention and management were done locally and not through formal support. Harm reduction programs had modest origins – in the North East, they started out of homes and communities,[76] while in cities services were delivered on railway platforms, in parks, under flyovers and other ghettos occupied by street users.

Harm reduction services expanded under the third phase of the National AIDS Control Program (2007-2012) (NACP III) when they were formally incorporated as 'Targeted Interventions' or programs intended to stabilize and reduce the spread of HIV among people who inject drugs, who were identified as one of the 'high risk groups' or 'most at risk populations'.[77]

The high point of NACP III was the introduction of OST, which involved daily administration of

buprenorphine tablets taken sub-lingually. Initially rolled out through accredited NGOs, the program was also initiated in select government hospitals in order to integrate OST services in state healthcare delivery and enable clients to access other HIV-related services, including HIV testing and ART.[78] Presently, there are 107 centers providing OST to 11,500 clients in different parts of the country.[79]

In 2008, OST was introduced in Tihar jail in Delhi as a collaborative program and study between the prison administration, the National Drug Dependence Treatment Center (NDDTC) of the All India Institute of Medical Sciences (AIIMS) and the United Nations Office on Drugs and Crime (UNODC).[80] The results were found to be satisfactory with the need to ensure services upon release from prison.[81] The promising outcomes of the study led to a call to "upscale OST in prisons, both as a drug treatment and harm reduction strategy" across the country.

In early 2012, UNODC in partnership with the NDDTC started a pilot program for methadone maintenance treatment (MMT) for opioid dependence. The program, which ran for 18 months in five sites, has demonstrated the effectiveness and feasibility of providing MMT.[82] Encouraged by the results, the Ministry of Health has shown willingness to offer MMT as part of its Drug De-addiction Program as well as under the National AIDS Control Program.

### Box 1: NDPS Amendment 2014: thumbs up for harm reduction but not people who use drugs?

In September 2011, the NDPS (Amendment) Bill was introduced in the lower house of Parliament. The Bill, *inter alia*, sought to make statutory changes for sentencing to be based on the net weight of the seized substance as opposed to actual narcotic content, to reduce punishment for consumption of drugs, to support harm reduction interventions and to strengthen property forfeiture provisions.

The Bill was referred to the Parliamentary Standing Committee on Finance, which received submissions from national and international civil society organizations, especially on criminalization and sentencing. The Standing Committee submitted a 'mixed report' in March 2012. It rejected the proposal for sentencing based on net weight and asked that the death penalty be made discretionary. It also supported amendments for harm reduction and the regulation of drug dependence treatment. The Committee, however, did a U-turn on low-level offences; it not only rejected the proposed reduction in the severity of sanctions for consumption but also asked that the penalty for small quantity offences be increased. The Committee made no observations on access to opiates for medical use but asked the government to be attentive to the concerns of the pharmaceutical industry which carries out legitimate activities in relation to narcotic and psychotropic drugs.

Civil society, especially palliative care groups, reorganized to demand that the problem of non-availability of morphine for cancer and pain relief be addressed through the amendments. Subsequently, the government agreed to consider more amendments to the law to ensure easier access to opioids for medical use.

The Parliament passed the NDPS (Amendment) Bill in February 2014 and the law came into force on 1 May 2014. The management of drug dependence and the regulation of treatment facilities were incorporated in section 71, thus legitimizing OST and other harm reduction services and enabling oversight of treatment centres. At the same time, the amendments increased penalties for low-level offences and continued to criminalize the consumption of drugs.

Source: http://www.lawyerscollective.org/updates/parliament-passes-ndps-amendment-bill-2014-gains-losses.html#more-2762

## Policy endorsement for harm reduction?

Manipur was the first state in the country to formally endorse harm reduction after witnessing staggeringly high rates of HIV among people who inject drugs. The government of Manipur adopted a State AIDS Policy in 1996 which talked of providing clean needles, bleach, sterilization equipment and condoms.[83] In 2002, the **National AIDS Prevention and Control Policy** (NAPCP) of the Ministry of Health and Family Welfare supported 'harm minimization' as a strategy to prevent HIV among people who inject drugs while simultaneously aiming towards the reduction and eventually the cessation of drug use itself.[84] While the NAPCP spoke of provision of bleach and sterile needles, it remained silent on substitution therapy, which, as discussed above, came to be accepted much later in the official program. Importantly, the NAPCP considered criminal laws that are inconsistent with the rights of vulnerable groups as an impediment to HIV prevention and committed the government to review the same.[85]

However, no such assessment of the law on drug use took place. Harm reduction services continue to operate in a restrictive legal environment with program staff facing the risk of prosecution for 'aiding and abetting' drug use.[86] For people who inject drugs, the fear of being identified and harassed by the police constitutes a significant barrier for accessing prevention and treatment facilities.[87] Other negative consequences of punitive laws have also been documented.[88]

Ironically, the government's understanding of harm reduction narrowed even further in 2012, when the **National Policy on Narcotic Drugs and Psychotropic Substances** was introduced. The policy casts harm reduction in very negative and incorrect terms. Besides derogatory and pejorative references – such as "shooting galleries", "weaning from drugs" and "supporting or incentivizing the drug-using habit", the document views harm reduction as something that entails the "distribution of drugs for oral consumption or drug paraphernalia (such as syringes) freely on the streets" or becoming a "cover to push illicit drug use". Ignoring the positive experience of harm reduction policies and programs globally as well as in India, the policy states that: "harm reduction will be allowed only as a step towards de-addiction and not otherwise". The repressive approach towards low-level offenders, drug use in prisons and a host of other issues that have been successfully managed in other parts of the world with harm reduction principles, is also disappointing. Experts have rightly criticized the national policy as being flawed and regressive.[89]

The **Draft National Demand Reduction Policy** of 2014, prepared by the Ministry of Social Justice and Empowerment does not embrace harm reduction either. As with the 2012 national policy on narcotic drugs and psychotropic substances, the draft policy on demand reduction also adopts a zero-tolerance approach to drug use, reiterating the conventional strategies of creating awareness and education to *prevent* the use of drugs and providing counseling and rehabilitation to *stop* drug use, rather than seeking to stop the harms relating to consumption.[90]

Harm reduction is far from being a pillar or principle of drug policy in India. Rather, it is constricted to a service or a program, implemented in the limited context of HIV prevention among people who inject drugs.

## Absence of data

One of the glaring gaps in Indian drug policy is data. The nature and extent of drug use, dependence and its attendant health implications, which ought to be the most important considerations for drug policy, remain unknown. The first and only survey estimating the extent of drug use was conducted in 2001-2002, that is, more than a decade ago. According to that survey, there were an estimated 8.7 million cannabis users, of which 2.3 million were dependent (26%). The number of opiate users was estimated to be 2 million, of which 0.5 million (22%) were thought to be dependent.[91] A Drug Abuse Monitoring System (DAMS) exists for collecting data from patients seeking treatment for drug dependence at NGO and government centers but does not function well. The central government has announced its intention to conduct another nation-wide survey[92] but no updates were available at the time this paper was drafted. Lack of data on drug law enforcement is amplified by the opacity of the Narcotics Control Bureau (NCB), the key policy enforcement agency, set up under the NDPS Act.[93]

### Box 2: Punjab wages a 'war on drugs'

Drug use and dependence is high in the northern Indian state of Punjab. No official survey has been conducted but the media reports that nearly 75% of the youth in the state are affected by drug use. The issue took on political dimensions during national elections in early 2014 and the state government began a clampdown on people who use drugs, with mass arrests, seizures and interdictions under the NDPS Act. Over 14, 564 persons were arrested under the NDPS Act in a span of 8 months and more than one third of prisoners in the state are reportedly facing drug-related charges. 'Special drives' were launched against people who use drugs, who were either arrested or forced to take admission in 'de-addiction' centres. While the authorities have announced plans to expand treatment and rehabilitation facilities, policy alternatives which approach drug use as a health rather than a criminal issue (such as increasing the availability of harm reduction measures and the decriminalization of drug use)were not considered. On the contrary, harm reduction practitioners, particularly doctors who prescribe and dispense OST in private clinics have been threatened with legal sanctions. This demonstrates the incongruous nature of drug policy – while the law embraces harm reduction, drug enforcement agencies continue to abandon it.

**References:** Mansi Cholsi, 'Heroin Trafficking from Pakistan Into India Is Crippling an Entire Generation', 4 Dec 2014, https://news.vice.com/article/heroin-trafficking-from-pakistan-into-india-is-crippling-an-entire-generation

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### Harsh and disproportionate penalties

Like many other countries in Asia, India too, has adopted exceedingly harsh measures for drug control. Many facets of the NDPS Act such as the criminalization of drug use, punishment for possession of drugs for personal use and the death penalty are more strict or severe than those provided by the UN drug control conventions.[94] Despite attempts by civil society to demonstrate the ineffectiveness of such measures and highlight their non-obligatory status under the international drug conventions,[95] law makers have not committed to reviewing or repealing these provisions.[96]

## Access to essential medicines

The NDPS Act allows the medical use of narcotic drugs and psychotropic substances. Yet, morphine and other opiates were unavailable to patients due to strict provisions and penalties. Until recently, rules for possession and use of morphine and other medical opiates were framed by state governments, which meant that medical providers had to obtain multiple licenses from multiple agencies. Availability did not improve even after the central government proposed a simplified procedure for procuring morphine in 1998. Palliative care groups questioned how India produced and supplied morphine to the developed world while patients back home had no access.[97] The problem was finally addressed through legislative amendments in 2014, which eliminated onerous state licenses for essential narcotic medicines and allow for uniform regulations.

## Uneven co-ordination amongst government agencies

Drug policy administration is divided not only between central and state governments but also between ministries and departments at the same level. The distribution of subjects between the center and state has already been discussed in the paper. The division between ministries and departments is described in the First Schedule under the Government of India (Allocation of Business) Rules, 1961, which demarcates the scope of work of each agency (see table on next page).

The implementation of drug policy has sometimes seen a confusing overlap and, at times, an abdication of responsibility. For instance, the Department of Revenue under the Ministry of Finance is entrusted

| Task | Department | Ministry |
|---|---|---|
| Policy development including framing/amending the NDPS Act, Rules and notifications thereunder | Revenue | • Finance |
| Policy coordination | Narcotics Control Bureau ("NCB") | • Home |
| International drug control (representation, liaison, reporting etc.) | • Revenue<br>• NCB | • Finance<br>• Home |
| Opium production and manufacture | • Central Bureau of Narcotics<br>• Government Opium and Alkaloid Factories<br>• (both are under the Department of Revenue) | • Finance |
| Enforcement of the NDPS Act | • Directorate of Revenue Intelligence<br>• Central Bureau of Narcotics<br>• NCB<br>• Customs<br>• Excise (central &state)<br>• BSF, para military forces or other designated officers<br>• Police including Anti Narcotic Cells | • Finance<br>• Finance<br>• Home<br>• Finance<br>• Revenue<br>• Home & Defense<br>• State governments |
| Drug use and dependence:<br>Prevention<br>Treatment<br>Rehabilitation | • National Institute of Social Defense<br>• Drug De-addiction Program<br>• Health or Social Welfare | • Social Justice & Empowerment<br>• Health & Family Welfare<br>• State governments |
| Injecting drug use and HIV | • National AIDS Control Organization | • Health &Family Welfare |
| Drugs for medical use/ Pharmaceutical drugs (including distribution, marketing &retail trade) | • Drugs Controller General of India<br>• State Drug Controllers | • Health & Family Welfare<br>• State governments |

with the administration of the NDPS Act, 1985 as well as with matters relating to the international conventions on narcotic drugs, psychotropic substances and precursor chemicals, except those managed by the Ministry of Home Affairs.[98] The Department of Internal Security within the Ministry of Home Affairs is tasked with handling all matters relating to NCB and with the coordination of drug control measures. It also deals with matters relating to the international conventions in respect of illicit traffic in narcotic drugs, psychotropic substances and precursor chemicals except those allocated to the Ministry of Finance, Department of Revenue. An inconsistent stand between the two Ministries was seen on the question of the death penalty under the NDPS Act. While the then Finance Minister

announced support for making capital punishment discretionary,[99] the NCB filed a petition in the Supreme Court to preserve the mandatory death penalty under the NDPS Act.[100]

Another example of poor coordination and accountability was apparent in the case concerning human rights abuses against people who use drugs in treatment centers, where neither the Ministry of Health nor the Ministry of Social Justice and Empowerment took responsibility for private, unfunded centers as they ostensibly do not have rule making powers under the NDPS Act. In addition, the Ministry of Finance said that while it is in charge of making NDPS rules, it was not responsible for treatment and therefore could not make rules on the subject.[101]

## Lack of consultation in policymaking

The lack of policy co-ordination is compounded by the non-application of consultative mechanisms provided in the NDPS Act and the NDPS Consultative Committee Rules, 1988[102] (the Committee Rules).

The NDPS Act allows the central government to establish a 20-member NDPS Consultative Committee (the Committee) as a policy-advisory body with a broad mandate.[103] The Committee Rules allow the Committee to review the NDPS Act and Rules, advise the government on policy matters, and consider any other issue requested by the government.[104] The Committee may prepare a special report on any topic of importance for the government's consideration.[105] The Committee may delegate specific policy matters to sub-committees, including sub-committees that review policy enforcement and treatment, rehabilitation, social reintegration and other connected matters.[106]

The Committee can draw upon experts and civil society representatives to review and recommendchanges in nearly all areas of drug policy. Sadly, these provisions have not yet been invoked.

In 2008, the government announced the setting up of a National Consultative Committee on De-Addiction and Rehabilitation (NCCDR) under the Chairmanship of the Minister for Social Justice and Empowerment to advise the central and state governments on drug demand reduction, especially education/awareness building, de-addiction and rehabilitation.[107] The composition of the NCCDR does not appear to be in accordance with the law. Not much is known about its role and functioning.

## Points for consideration

In response to the policy challenges outlined above, the following reform possibilities are proposed to the government of India for consideration:

- Review the harsh and disproportionate sentencing structure under the NDPS Act, and remove the criminalization of drug use and imposition of the death penalty for drugs offences
- Ensure that the legal provisions on drug treatment are adequately applied in a way that enables people who use drugs to access evidence-based treatment services without the threat of punitive sanctions such as criminal prosecution and imprisonment
- Adopt and enforce minimum quality standards to ensure that the treatment programs are scientifically proven and respect the human rights of people dependent on drugs
- Expand access to narcotic and psychotropic medicines necessary for treating a range of medical conditions, with practical safeguards against illicit diversion
- Improve co-ordination between government departments with a clear remit for each state agency on developing and implementing policies and practices relating to drugs
- Consult with civil society groups, including representatives of people who use drugs, medical professionals, academics and patient groups specializing in drugs issues in drug policy formulation
- Establish regular data collection on drug use, dependence and related health implications such as HIV and viral hepatitis prevalence amongst people who inject drugs.

- Apply harm reduction principles to drug policy formulation with the objective of reducing the harms associated with drugs, instead of being guided by the unachievable goal of creating a 'drug-free' society.

## Endnotes

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5. See, for example: the Assam Opium Smoking Act, 1927, the Bengal Opium Smoking Act, 1932, and the Bombay Opium Smoking Act, 1936 criminalized a range of activities around opium smoking, including smoking individually or with two or more people, possession of paraphernalia and allowing premises to be used for opium smoking
6. See: Bengal Excise Act 1909; Punjab Excise Act 1914; Madhya Pradesh Excise Act, 1915. Wholesale and retail trade in cannabis was permitted under these laws, subject to quantity limits. The drug, however, could not be sold to women and persons under the age of 25
7. The Dangerous Drugs Act, 1930 (Act 2 of 1930). See sections 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14
8. The Drugs and Cosmetics Act, 1940 (Act 23 of 1940)
9. Article 13(1), The Constitution of India
10. See: *Balley Singh v State of Uttar Pradeshand O*rs AIR1967Al341, where the Allahabad High Court cites a decision of the Supreme Court of India dated 17/2/1956, where a challenge to the Opium Acts and the Dangerous Drugs Act on the grounds of Article 14 (right to equality before law) and Article 19(1)(g) (right to freedom of trade and occupation) was rejected
11. Article 37, The Constitution of India
12. See: Entry 19, List III, Seventh Schedule, The Constitution of India
13. See: Entries 51, 6 and 4, List II, The Constitution of India
14. See: Articles 73 and 162 of the Constitution of India according to which the power of central government extends to all matters over which the Parliament has power to make law and the power of state governments extends to all matters over which state legislature has power to make law, respectively
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17. See: Section 80, NDPS Act
18. See: section 8, NDPS Act
19. See: Sections 28, 29and 30, NDPS Act
20. See: Section 2 (viid), NDPS Act
21. See: section 2 (xi), NDPS Act
22. See: Sections 2(xxiii) and 3, NDPS Act as well as the Schedule to the NDPS Act
23. See: Sections 41, 42, 43 and 50, NDPS Act
24. See: *State of Punjab v. Baldev Singh* (1999) 6 SCC 172
25. See: *Raj Kumar Karwal v Union of India* (1990) 2 SCC 409 and *Kanhaiyalal v Union of India* (2008) 4 SCC 668. In both the cases, the Indian Supreme Court, in a departure from the settled position on the law on evidence, made confessions to drug law enforcement officers admissible as evidence
26. Subjects on which the central government can make rules are delineated in sections 9 and 76 while the state governments' powers are laid down in section 10 and 78 of the NDPS Act
27. Poppy is cultivated by farmers but at the instance and on behalf of the central government. Processing of raw opium and manufacture of opium and alkaloids like morphine, thebaine is done at the government Opium and Alkaloid Factories situated in Neemuch and Ghazipur. Export of opium is also exclusively by the central government. See sections 5, 31, 32, 36 NDPS Rules, 1985
28. Manufacture, import and export of pharmaceutical drugs containing narcotic or psychotropic substances is open to private entities in accordance with the NDPS Act, Rules and terms and conditions of license, if any
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32. The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 (Act 46 of 1988)

33. At the time, the offences of possession for personal use and consumption were clubbed together under section 27, which read: '27. *Punishment for illegal possession in small quantity for personal consumption of any narcotic drug or psychotropic substance or consumption of such drug or substance.- Whoever, in contravention of any provision of this Act, or any rule or order made or permit issued thereunder, possesses in a small quantity, any narcotic drug or psychotropic substance, which is proved to have been intended for his personal consumption and not for sale or distribution, or consumes any narcotic drug or psychotropic substance shall notwithstanding anything contained in this chapter, be punishable,*

    *a) where the narcotic drug or psychotropic substance possessed or consumed is cocaine, morphine, diacetylmorphine or any other narcotic drug or any psychotropic substance as may be specified in this behalf by the Central Government, by notification in the Official Gazette, with imprisonment for a term which may extend to one year or with fine or with both;*

    *and (b) where the narcotic drug or psychotropic substance possessed or consumed is oth er than those specified in or under clause (a), with imprisonment for a term which may extend to six months or with fine or with both. Explanation. - (1) For the purposes of this section "small quantity" means such quantity as may be specified by the Central Government by notification in the Official Gazette. (2) Where a person is shown to have been in possession of a small quantity of a narcotic drug or psychotropic substance, the burden of providing that it was intended for the personal consumption of such person and not for sale or distribution, shall lie on such person'.*

34. See: *Raju v. State of Kerala* AIR 1999 SC 2139: the appellant had served 10 years of rigorous imprisonment and was imposed a fine of Rs 1 lakh for possession of 100 mg of heroin worth Rs 25. Absence of withdrawal was seen as evidence that the appellant was not drug dependent and therefore, the heroin was not meant for personal use. The Supreme Court finally held that such a small quantity could not have been meant for sale or distribution and reduced the sentence to that for possession for personal consumption

35. See: Statement of Objects and Reasons of the NDPS (Amendment) Act, 2001, which expresses the intent to punish people trafficking significant quantities of drugs with deterrent sentences and imposing lighter punishment on people dependent on drugs and those who commit less serious offences

36. See: Section 2(xxiiia), NDPS Act

37. See: Section 2(viia), NDPS Act

38. See: Notification S.O 1055(E), dated 19th October 2001 published in the Gazette of India, Extra.,Pt II, Sec 3(ii), dated 19 October 2001

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44. See: Section2(iva), NDPS Act

45. See: Section 42(1), NDPS Act

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60. See: section 7A(3) and (4), NDPS Act

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66. Haryana De-addiction Centres Rules, 2010

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## Notes

## Notes

## About this briefing paper

India's response to drugs flows along an extraordinary spectrum – of tradition and modernity; of widespread availability and stringent enforcement; of tolerance and prohibition; of production for medical use to lack of medical access to opiates. Some parts of the country report alarmingly high rates of drug dependence, HIV and viral hepatitis amongst people who inject drugs, making health and harm reduction important policy considerations. While India's harsh drug control laws conform strictly with prohibition, its regulated opium cultivation industry provides insights for countries that are experimenting with alternatives to prohibition.

## 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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