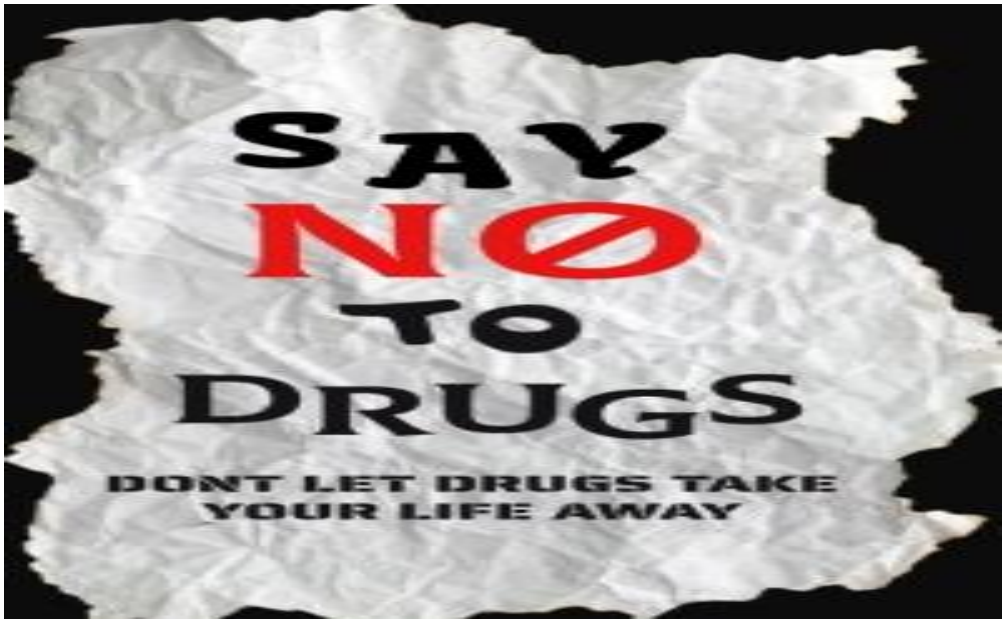
SUMMARY REPORT

EVALUATION OF

NATIONAL ACTION PLAN FOR DRUG DEMAND REDUCTION SCHEME (NAPDDR)



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MINISTRY OF SOCIAL JUSTICE & EMPOWERMENT

SUMMARY REPORT

EVALUATION OF

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1.0 INTRODUCTION

India has made significant strides in addressing substance use disorders through a robust policy and legal framework, including the Narcotic Drugs and Psychotropic Substances Act (NDPS Act), 1985, the National Policy on Narcotic Drugs and Psychotropic Substances (2012), and the National Action Plan for Drug Demand Reduction (NAPDDR) (2018-2025). These initiatives focus on prevention, treatment, rehabilitation, and harm reduction, supported by awareness campaigns, accessible treatment services, and community engagement. The Ministry of Social Justice and Empowerment's efforts, such as the Central Sector Scheme and preventive education programs, target vulnerable populations and aim to facilitate Whole Person Recovery. With the NAPDDR in operation for several years, an evaluation was crucial to assess its effectiveness, identify gaps, and inform evidence-based improvements to ensure its goals of reducing drug abuse prevalence and promoting public health are achieved comprehensively.

2.0 STUDY OBJECTIVES

In this backdrop, Development & Research Services (DRS) Pvt. Ltd., New Delhi was responsible for conducting an evaluation study of the NAPDDR scheme. The broad study objectives were:

(a) Impact of intervention in the Drug Demand reduction
(b) Impact of programs carried out by NISD
(c) Impact of services provided by State Level Coordinating Agencies (SLCAs), Integrated Rehabilitation Centers for Addicts (IRCAs), Community based Peer led intervention (CPLI), Outreach & Drop In Centers (ODICs) and District De-Addiction Centers (DDACs).

The reference period of the study is 2020-21 to 2022-23.

3.0 STUDY METHODOLOGY

The evaluation of the NAPDDR Scheme uses a cross-sectional **'Case Only Study Design'** with a mixed-method approach, combining qualitative reviews of scheme guidelines and stakeholder discussions with quantitative surveys of staff and clients at treatment centers. This method ensures a comprehensive assessment of the scheme's effectiveness from both implementers' and beneficiaries' perspectives.

4.0 SAMPLE COVERAGE

A total of 155 centres/facilities were covered under the survey which included 4 SLCAs, 102 IRCAs, 20 ODICs, 11 CPLIs, 8 ATFs, and 10 DDACs across the states/UTs of Chandigarh, Delhi, Maharashtra,

Meghalaya, Tamil Nadu, Telangana and Uttar Pradesh. State wise list of all the facilities was provided by the Department along with their contact details to facilitate data collection. In order to gauge the impact of the programme on beneficiaries, 10 beneficiaries/clients were randomly selected from each facility while ensuring that they had stayed in the facility for at least 15 days.

5.0 STUDY TOOLS & KEY RESPONDENTS

Study tools used were:

- State level coordinating agencies (SLCA) schedule - Nodal person of the SLCA
- Integrated rehabilitation centre for addicts (IRCA) schedule - Nodal person of the IRCA
- District De-addiction centre (DDAC) schedule - Nodal person of the DDAC
- Community based peer-led intervention (CPLI) schedule - Area coordinator of CPLI
- Outreach drop-in center (ODIC) schedule - Center in-charge cum counsellor of the ODIC
- Addiction treatment facility (ATF) schedule - Nodal person of the ATF
- Beneficiaries/client schedule –Scheme beneficiaries/clients

6.0 STUDY FINDINGS

6.1 State Level Coordinating Agencies (SLCA)

The State Level Coordinating Agencies or SLCA are organizations/Institutions of repute and experience who the Ministry of Social Justice & Empowerment has designated as agencies responsible for devolution of the mandate of NCDAP in their jurisdictional area.

4 SLCA were covered as a part of our study namely SPYM, Kripa Foundation, TT Ranganathan Clinical Research Foundation, and New Hope Association. All SLCAs seem to have done all that they were mandated to do. All SLCAs prepare an Annual Action Plan for their activities which include visits, capacity building, monitoring & evaluation exercise for DDACs / IRCAs implementing ODICs and CPLIs. All the SLCAs have NGOs working under them in the form of IRCAs, DDACs, ODICs and CLPIs. SLCAs have been making scheduled visits to treatment centers on a regular basis. SLCAs mentioned that they conducted assessment of training needs of the service providers, developed training materials and modules, and also trained service providers. All SLCAs have provided technical support to NGOs, CBOs and enterprises in strengthening their programs. In particular they mentioned about technical support in the form of CC Cameras, Web Portal, PFMS, E-Anudaan etc., all of which are part of their mandate. All SLCAs mentioned that they developed IEC materials like Brochures, Pamphlets, Posters, reading materials etc., and that all awareness activities, special

day programs, meetings attended, movement register are documented in the form of monthly reports with photographs of the event on a regular basis. All SLCAs also do advocacy, research and monitoring on regional issues. In our view, the selection of nodal agencies to be SLCAs in each of the study states have been done with a lot of due diligence and all the SLCAs have played a critical role in planning, executing, and monitoring, and mentoring all stakeholders involved at the execution level. This research has found their engagement to be quite satisfactory and is advocating for their continuance with the program.

6.2 Integrated Rehabilitation Centre for Addicts (IRCA)

Integrated Rehabilitation Centre for Addicts (IRCA) is a centre with in-patient facility for addicts. It aims to help drug users in achieving total abstinence from drug by improving their quality of life. For this IRCA is mandated to identify and deal with personality defects of drug users, strengthen their inter-personal relationships, develop healthy work ethics and financial management among them, develop healthy recreational activities and establish a crime free life. For sustainability of the recovery of substance users follow up services are also supposed to be provided by IRCA.

A total of 102 IRCAs were covered in the study. Our assessment reveals that these centres were smoothly functioning with adequate number of staff for the respective tasks. There was adequate provision of infrastructure and material resources. There was, however, lack of educational and vocational activities for the patients. There were inadequate funds by the government and were not allotted to the centre on time. But apart from these, and despite them, the procedure of counselling was effectively done in order to spread awareness and educate not only the drug users but also their family. These centres, however, have not taken steps to prepare the unemployed patients towards gainful employment after their recovery. Lack of vocational training activities from the government was the key factor that the centre was unable to fulfil its objectives fully. There were other suggestions that were exhaustively provided by Key Informants at the centres themselves, which included additional outreach programs in every district, provision of a psychiatrist in every IRCA, or provision for a doctor to be present 24 hours in the IRCA, and additional training for the staffs of IRCA. Finally, a demand that deserves serious consideration is that there needs to be a provision of at least 1 vehicle in each IRCA to conduct daily routine activities. From the evaluator's side, there are three key recommendations, viz. a) more IRCAs should be opened in smaller towns apart from district headquarters; b) Duration of stay in the IRCAs should be increased as 30 days stay is too less for complete detoxification and rehabilitation; and c) Increased number of days can be utilized for providing skill/vocational trainings to minimize the relapse cases. Despite all these suggestions, the overall quality of care and counselling was

high, and beneficiaries having received or receiving care from these centres had nothing but praise about their experience. This leads us to conclude that IRCAs are executing their mandates to the best of their abilities and a little more support from the program would enhance their efficiency to a level where all their mandates can be met.

6.3 District De-Addiction Centre (DDAC)

District De-Addiction Centres (DDACs) stand as crucial facilities established at the district level, offering vital treatment and rehabilitation services for individuals grappling with substance abuse and addiction. These centers often offer a range of services, including counseling, medical interventions, detoxification programs, therapy sessions, and support groups. The initiative focuses on a comprehensive approach to preventing and addressing substance abuse, particularly among vulnerable populations. It includes conducting awareness programs and life skills training to prevent the initiation of substance use and delay its onset. The program also identifies individuals at risk and facilitates their referral to rehabilitation centers for treatment and rehabilitation. A key component is the Whole Person Recovery (WPR) model, which offers treatment, aftercare, and skill development to support long-term recovery. Additionally, the initiative works on drug demand reduction to curb illicit substance use and alleviate the broader societal consequences of substance dependence, benefiting individuals, families, and communities.

A total of 10 DDACs were covered as a part of our study. The ministry supports setting up of district De-addiction centres in those districts across the country where there are no IRCA, DDIC and CPLI centres being run. In our view, this means there will be in-patient facilities, outreach activities, and peer educator support all under one roof. Since DDACs are mostly located in district headquarters (attached to district hospitals), our observation is that this has severely restricted the access of potential patients by restricting outreach to all corners. Instead of having all functions of centres such as ODIC, CPLI and IRCA under the same roof, the number of ODICs and CPLIs should be increased to cater to more population. Decentralized ODICs and CPLIs will be able to capture larger areas and in turn they will redirect the needy clients to IRCAs from diverse geographies. The beneficiary interviews threw up some interesting suggestions to improve their experience while staying at the centre. Most felt that the number of days of stay should be increased. They also pointed out that cleanliness was an issue and there was a need for regular cleaning of toilets, floors, and beds. In the same light, they have suggested that from time to time pest control must be done otherwise belongings of patients get damaged. They also felt that the centre must include basic pathology lab tests, physical tests, and blood tests as a service offered. They also felt that there is a need for more gaming items,

TVs, and musical instruments. The complete lack of any vocational training module offered by these centres was also a felt lacunae. Preventive education, awareness generation, and capacity building programs have had a greater impact on the Drug demand reduction program, encompassing inputs, outputs, yoga, meditation, etc.

6.4 Outreach Drop-In Centre (ODIC)

Outreach and Drop-In Centre (ODIC) is a community-based facility for substance users that caters to individuals, particularly youths who use various substances and those who have the least access to resources. It is client-focused with an ultimate goal to prevent youth in the community to initiate substance use, also to help the current users to become sober by taking treatment. The ODIC is located within close proximity of substance users and located in the hotspot area of the substance users.

A total of 20 ODICs were covered under the study. The evaluation of the ODIC was to be done against the expected outcomes that they are supposed to achieve, viz. reach out to the vulnerable young population in the vicinity of the proposed centre, provide services to substance users and their families at any given point of time, recovering support group establishment, equipping substance users and their families with proper information & education on harmful effects of substance use and its impact so that finally the substance users can conquer their social or communication problems and assume productive lifestyles in the community. Based on our findings from the Key Informants interviews and Centre records, as well as constructive feedback from patients, our conclusion is that ODICs are functioning very well and most are achieving all of the above objectives for which they have been established. The only recommendation, which has come in the form of suggestions from the centres as well, is that the number of outreach workers per centre needs to be increased because current workload is too high to sustain.

6.5 Community Based Peer-Led Interventions (CPLI)

GoI has introduced Community Based Peer Led Intervention which would be appropriate for preventing and reducing the substance use among the young people. Through peer led intervention the aim is to reach children and early adolescents. The target groups are vulnerable children or adolescents in the age group of 10 – 18 years who are non-users.

A total of 11 CPLIs were covered in the study. Findings on the basis of the key informant interviews and review of records at the centre level as well as direct feedback from beneficiaries suggest that all the centres undertake most of but not all the activities that they are mandated to do like outreach activities in the

community, community mapping and assessment, identification and training of adolescents as peer educators, providing psychosocial therapies and providing follow-up care including family counselling. It is also worthwhile noting that beneficiary feedback regarding their experience with peer educators and trainers/counsellors has been positive. This leads us to conclude that CPLIs are functioning well and are an important spoke in the National Action Plan for Drug Demand Reduction or Nasha Mukt Bharat mission. However, there are some suggestions we would like to put up for consideration. The first is to consider an increase in the time of three months per community as the feedback across the board is three months is too short given that most families and users are very reluctant to get their kids involved in such activities. The second suggestion is to consider doing away with the Aadhar card-based registration system. As it is, families and users are very much reluctant to disclose drug use. This is further escalated when they are asked to share the Aadhar numbers by the Centre In-charge for filling forms. Our suggestion is to consider other more nonobtrusive means of registering volunteers.

6.6 Addiction Treatment Facility (ATF)

Ministry of Social Justice and Empowerment provides financial assistance for Addiction Treatment Facilities (ATFs) in Government hospitals through NDDTC, AIIMS or any other agency specified by the Ministry in uncovered (where no IRCA exists) vulnerable districts. These ATFs provide services for identification of individuals with harmful use and dependence of any substance, motivational counselling, detoxification/de-addiction treatment and Whole Person Recovery, after care and reintegration into the social mainstream. As of December 2023, there are 66 functional and approved ATFs in government hospitals supported by the Department of Social Justice & Empowerment.

As per the scope of work, DRS has conducted evaluation of eight ATFs, one each in Maharashtra and Meghalaya and the remaining six in Uttar Pradesh. An ATF works under the day-to-day direct supervision of a nodal officer (usually a senior doctor, mostly psychiatrist) who is in the regular job of the government hospital. Since Substance Use Disorders are chronic, relapsing mental health conditions, emphasis in ATFs is largely on the medical treatment. The ATF scheme envisages OUTPATIENT treatment as the ESSENTIAL component of the treatment services. The in-patient facility (which is required for a minority of patients with substance use disorders) is an 'add-on' feature, available with some ATFs. The outpatient treatment services provided by ATF include a combination of psychosocial and pharmacological treatment approaches based upon the standard treatment guidelines. This includes long-term medicines which are dispensed free of cost. Beneficiary feedback about the services provided by ATFs has been highly positive, though some patients

suggested longer inpatient stays. However, the evaluation recommends limiting inpatient care duration to avoid unnecessary extended stays, as the scheme emphasizes outpatient treatment. Additionally, increasing the number of ATFs is suggested for broader access, as these facilities are part of large hospitals, reducing stigma and making treatment more discreet. Doctors and counselors recommend that preventive education and awareness programs be continuous and involve interventions from abstinent individuals or celebrities for greater impact. They also emphasize the need for additional funds to promote awareness through advertisements and regular training for staff.

6.7 National Institute of Social Defense (NISD)

The National Institute of Social Defense (NISD) plays a crucial role in implementing the NAPDDR scheme by focusing on key responsibilities such as fostering public sensitivity towards marginalized groups, coordinating efforts between government and NGOs, and serving as a Centre of Excellence for research and training in social defense. Its specific tasks include raising awareness about the harmful effects of drugs, reducing stigma, providing community-based services for addiction treatment and rehabilitation, developing the capacity of service providers, and formulating guidelines for drug demand reduction. NISD also undertakes comprehensive efforts to address drug abuse and supports research, innovation, and data collection to enhance prevention and treatment strategies.

NISD provide training to various target group such as School students, Social work students, College and university teaching staff, Self Help Groups (SHGs), Youth clubs, Women's clubs, Community leaders, Parents, CBO's, Civil society members, PRI members (Panchayati Raj Institutions), Factory and industrial workers, Government employees, Para military, including BSF, CRPF, Police and law enforcement agencies, Parents associations, PTA, Teachers and counsellors, SLCA key office bearers, coordinators, experts, NMBA Master Volunteers, Anganwadi workers, ASHA workers, ANM, GNM, IRCA doctors, Nurses and ward boys, Health service providers Outreach workers, and Clinical psychologists.

A large number of training and awareness programmes were conducted by NISD during the study reference year. The programmes has made a significant impact through its drug abuse prevention programs. Key outcomes include increased public awareness about the dangers of drug abuse, reduced stigma towards individuals struggling with substance abuse, and enhanced skills of service providers, improving the quality of care and support. Community involvement has grown, with local communities becoming more proactive in addressing drug abuse, and adolescents volunteering as peer mentors. NISD's efforts in policy formulation

and guideline dissemination have improved the consistency and effectiveness of drug demand reduction programs. Additionally, research and innovation have led to the development of new approaches for drug abuse prevention, contributing to ongoing improvements in the field.

6.8 Conclusion

Finally it can be said that National Action Plan for Drug Demand Reduction (NAPDDR) scheme is a vital initiative aimed at addressing the growing issue of substance abuse in India through a multi-dimensional approach. While it has made significant strides in raising awareness, supporting rehabilitation efforts, and fostering collaboration among various stakeholders, the scheme faces challenges related to limited outreach, stigma, inadequate resources, and slow implementation. To maximize its impact, there is a need for increased funding, better coordination, and greater involvement of community-based and private sector initiatives. Ultimately, the success of NAPDDR depends on strengthening these areas to ensure sustainable and widespread support for those affected by substance abuse. By addressing these areas, NAPDDR can be made more effective in tackling the drug abuse problem in India and providing sustainable support to those in need of rehabilitation.