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DRUG ABUSE AMONG STREET CHILDREN IN DELHI

Policy Brief Based on Field Study

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I. DRUG ABUSE AMONG STREET CHILDREN IN DELHI

A. Introduction

The controversial film ‘Udta Punjab’ touched upon a grim reality of the drug menace in India - the widespread use of drugs by children and adolescents. Drug addiction, as the film depicted, is certainly not confined to children of any particular section of society but it is fair to assume that street children, being one of the most vulnerable and marginalised groups, would be at a considerably higher risk.

The condition of street children is compounded by an exploitative socio-economic structure within and outside the family, lack of access to education and healthcare, rapid urbanisation, rural to urban migration, rapid population growth, and extreme poverty. These children work as rag pickers, hawkers, prostitutes, shoe shine boys and helps in shops, restaurants and *dhabas*. Many scavenge for food, beg and take to petty crimes. They are exposed to high health hazards, unhygienic conditions of living and harassment by the police.

Drug abuse among children has serious consequences in terms of health, crime rates and economic and social development of the country. Many countries, including India, have taken steps to address the widespread problem with varying degrees of success.

This policy brief studies the extent and nature of the drug abuse among street children sampling Delhi as a field study. It also analyses government responses and their effectiveness in tackling the menace.

B. Review of Literature and Methodology

In the mid-1970s and early 1980s, general population surveys¹ were conducted to determine the extent and pattern of drug abuse in various sections of society. These studies documented drug abuse among school and college students, street children, psychiatric patients and young adults.

Since the 1990s, a body of research² on drug abuse among street children was developed providing insights about the nature, extent and impact of the problem. These studies

¹ “Review of Literature” in *The Extent, Pattern and Trends of Drug Abuse in India: National Survey*, Ray, R., Ministry of Social Justice and Empowerment, Government of India & United Nations Office on Drugs and Crime, Regional Office for South Asia, 2004.

² “Substance use by child labourers,” Bansal RK et.al., *Indian Journal of Psychiatry*, July 1993; 35(3):159-61; “Drug abuse among street children in Bangalore,” NIMHANS Monograph funded by CRY, Benegal, V. et. al. 1998; “Lost in the Haze: A Study on Substance Abuse Among Children,” Childline India Foundation, Chingsubam, Bangkim et.al., 2008; “Substance abuse among street children: community risk and protective factors,” Saha, Apurba, R. et. al. *Indian Journal of Social*

were based on one or two cities with sample sizes ranging from 9 to 1500. The cities, from which samples were taken, included Delhi, Surat, Kolkata, Bangalore, Chandigarh, Aligarh, Guwahati and Manipur. There were about nine studies³ conducted exclusively for street children in Delhi (including studies sponsored by the government⁴). The studies done by independent researchers mostly looked at the circumstances in which street children became addicts and the impact the addiction had on their overall health, physically and mentally.⁵ The government sponsored studies critiqued the gaps in the government's approach to the problem including the prevalent treatment and rehabilitation strategies and suggested ways to address the problem.⁶

However, till 2004, there was no official data on the magnitude of the drug abuse problem in the country. In 2004, the Ministry of Social Justice and Empowerment and the UN Office on Drugs and Crime (UNODC) jointly sponsored a survey to measure the extent and pattern of the problem in India.⁷ The survey sampled 40,697 males between 12 and 60 years of age spread out in 25 states of India. The survey found that 0.7% of the population above 15 years were using opiates and 3% were using cannabis. Also, most persons who sought treatment at the drug dependence treatment centres initiated drug use during adolescence.⁸ However, the 2004 survey did not throw much light on the prevalence of the problem among street children.

Psychiatry, 2012, 28 (1-2), 53-59; "A Study on prevalence and pattern of substance abuse among street children and adolescents in Andhra Pradesh," Reddy, Adidela Praneeth et. al., Indian Journal of Fundamental and Applied Life Sciences, 2014, Vol 4(3) 1-14; "Substance Abuse amongst the Street-children in Guwahati City, Assam," Islam, F. et. al., Annals of Medical and Health Sciences Research, Sep-Oct 2014, 4 (Suppl 3): S233-S238; "Study of substance abuse among street children near Bangalore Medical College, Bangalore," Kautilya, Vijay D. et. al., Indian Journal of Forensic and Community Medicine, 2015, Vol.2, Issue 4, 220-224.

³ "Risk Factors of Substance Use Among Street Children from Delhi," Pagare, Deepti et.al., Indian Paediatrics, March 17, 2004, Vol. 41, 221-225; "Dream on Wheels: A situation review of children living or working on 8 Railway Stations from Hazrat Nizamuddin to Bhopal," Plan India, New Delhi, 2005; "Drug use among juveniles in conflict with law," Malhotra, Chetna et.al., Indian Journal of Pediatrics, May 2007, 74(4):353-6; "Use or Abuse? A Study on the Substance Abuse Among Street and Working Children in Delhi," Sanjay Gupta, CHETNA, 2008; "Inhalant Use among Street Children in Delhi: A situation Assessment," Ray, R. et. al. National Drug Dependence Treatment Centre, AIIMS, Jointly Sponsored by Government of India and World Health Organization Collaborative Program (Biennium 2008-2009), "Prevalence and pattern of substance abuse among school children in Northern India: A Rapid Assessment Study," Qadri et. al., International Journal of Medical Science and Public Health, 2013, 2(2):273-282; "My body breaks. I take solution." Inhalant use in Delhi as pleasure seeking at a cost,' Gigengack, Roy, International Journal of Drug Policy, July 2014, 25(4):810-818.

⁴ "Substance abuse among School dropout children: A Study in Delhi," Delhi State Legal Services Authority (DSLISA), 2015; "Substance Abuse by Children in Delhi: A Status Paper on Rehabilitation Strategies," DCPCR, Govt. of NCT of Delhi, June 2015.

⁵ See Footnote 2.

⁶ See Footnote 4.

⁷ "The Extent, Pattern and Trends of Drug Abuse in India: National Survey," Ray, R., Ministry of Social Justice and Empowerment, Government of India & United Nations Office on Drugs and Crime, Regional Office for South Asia, 2004.

⁸ "Prevalence of Drug Abuse in India through a National Household Survey," Pal, Hemraj et. al., International Journal of Current Science, 2015, 15:E, 103-113.

In 2013 the government sponsored a national level survey to assess the drug abuse problem among children.⁹ This survey, sponsored by National Commission for the Protection of Child Rights (NCPCR), sampled 4024 children (3855 males and 169 females) who were below 18 years and had used at least one substance other than tobacco in the past year. The children were spread across 135 sites in 27 states and two Union Territories (including Delhi) and focussed exclusively on profile, pattern and types of substance use among children.¹⁰

Two Delhi specific studies were conducted in 2015 by the Delhi State Legal Services Authority (DSLISA) and the Delhi Commission for Protection of Child Rights (DCPCR). The DSLISA study attempted to identify the number of drug abusers among school drop-out children in Delhi. The findings of the study showed that the incidence of drug abuse was higher among children and adolescents than the general population.¹¹

The DCPCR sponsored study focussed on the status of rehabilitation strategies for children who were addicts in Delhi.¹² The Report gave a detailed profile of children abusing drugs based on various existing studies and developed a model of rehabilitation strategy. The model, called the Four 'R' Model of Intervention Strategy, suggested that the strategy should focus on (i) reduction of demand; (b) reduction of supply; (c) reduction of harm; and (iv) reintegration.¹³

Box 1: Four 'R' Model of Intervention Strategy
Four 'R' Model of Intervention Strategy

- **Reduction of Supply:** Limit access to drugs by curbing production, distribution and trafficking of illicit drugs.
- **Reduction of Demand:** Develop strategies aimed at reducing the desire of the child to take drugs.
- **Reduction of Harm:** Initiate a range of public health policies which seek to minimise harmful consequences of substance abuse among children.
- **Reintegration:** Evolve strategies to reintegrate the child in mainstream society. This should include post-treatment follow up focussing on the socio-economic empowerment and psychological support of the child.

In 2012-13, the Don Bosco National Forum for Young at Risk (YaR), a non-government organisation working with street children, conducted a Rapid Assessment of Street Children in 13 YaR Centres in India. The purpose was to make an attempt to fill the gap

⁹ "Assessment of Pattern and Profile of Substance Use among Children in India," National Commission for Protection of Child Rights (NCPCR), Government of India, 2013.

¹⁰ Ibid.

¹¹ "Substance abuse among School dropout children: A Study in Delhi," Delhi State Legal Services Authority (DSLISA), 2015, pg 36.

¹² "Substance Abuse by Children in Delhi: A Status Paper on Rehabilitation Strategies," Delhi Commission for the Protection of Child Rights (DCPCR), Govt. of NCT of Delhi, June 2015.

¹³ Ibid.

in knowledge about street children - magnitude, demographic features and needs - in hope that the information could lead to better provisioning for children in national policies and programmes.¹⁴ According to this study, Delhi had the highest number of street children.¹⁵ Another 2011 study, which was a census of Delhi's street children, found that there were 50,923 street children below 18 years.¹⁶

Since both these studies indicated high concentration of street children in Delhi, this policy brief has used Delhi as a case study to highlight the issue of drug abuse among them.

Although various independent studies have looked into the problem of drug addiction among street children, they have focussed on the medical repercussion of addiction. The NCPCR and DCPCR surveys did not investigate the legal provisions or the infrastructure available to the street children for treatment and rehabilitation.

This policy brief aims to (a) lay out the prevalence, profile and pattern of drug addiction among street children in Delhi; and (b) identify and analyse the limitations of the legal provisions, the infrastructure and the rehabilitation strategies available in Delhi. The methodology used for the policy brief is a combination of desk based secondary research and qualitative, semi-structured interviews with key informants/stakeholders working in the area of rehabilitation.

Annexure 1 lists the people who were interviewed for the report.

C. Extent of Drug Abuse among Street Children in Delhi

The data on street children in the country is sketchy because there are no official estimates. Some studies have attempted to estimate the number but the estimates vary widely between 3 million to 20 million.¹⁷

According to the 2011 Census, Delhi's child and adolescent population (0-19 years) was 62.3 lakh, out of which 33.4 lakh were male.¹⁸ An estimation of Delhi's street children

¹⁴ Rapid Assessment Survey of Street Children in 13 YaR Centres in India, Don Bosco National Forum for the Young at Risk, 2012 (accessed on Aug 10, 2016 <http://www.yarforum.org/?p=143>).

¹⁵ "Street Children," Unstarred Question No. 352, Answered on July 7, 2014, Anurag Singh Thakur.

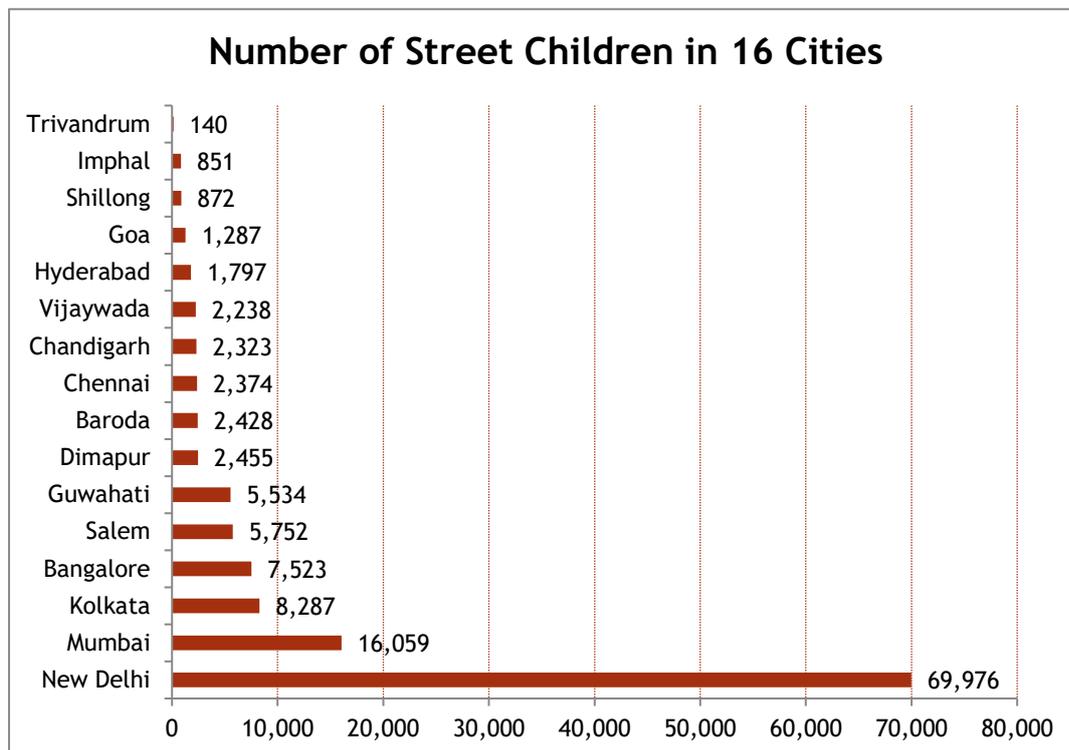
¹⁶ "Surviving the Streets: A census of street children in Delhi," Institute for Human Development and Save the Children, 2011 (accessed on Aug 10, 2016 <http://www.alnap.org/resource/6493>).

¹⁷ "A Composite Report of Situational Analysis of Urban Street Children in India - Based on the Study of Reports of Six Major Cities of India," Institute of Psychological and Educational Research (1991); Kolkata; "A Civil Society Forum for South Asia on Promoting and Protecting the Rights of Street Children, 12-14 December 2001 - Colombo, Sri Lanka, Organized by the Consortium for Street Children, in partnership with Child Hope and Protecting Environment And Children Everywhere (PEACE), CRIN, (2001); "Street Children," Agarwal, R. (1999), Shipra Publications, New Delhi; "Human Rights in India: Status Report 2012," Working Group on Human Rights in India and the UN, New Delhi; Rapid Assessment Survey of Street Children in 13 YaR Centres in India, Don Bosco National Forum for the Young at Risk, 2012 (accessed on Aug 10, 2016 <http://www.yarforum.org/?p=143>).

¹⁸ Statistical Abstract of Delhi, 2014, Government of NCT of Delhi (<http://www.delhi.gov.in/wps/wcm/connect/f508bc8046667b0e9cf6bcf5a4ed47e7/Statistical+A>

population was done by two studies - the Rapid Assessment Survey (RAS) conducted by the Don Bosco National Forum for the Young at Risk (YaR) in 2012-13 and the Census of Delhi's street children by Institute of Human Development and Save the Children in 2011. The RAS estimated the number of street children in 16 Indian cities.¹⁹ Delhi had the highest number of street children (69,976) followed by Mumbai (16,059) and Kolkata (8,297). Since the full report is not publicly available, it is unclear whether it delved into the reason why the number of street children in Delhi was significantly higher than other cities.

Chart 1: Number of Street Children across 16 cities in India



The 2011 study pegged the figure of Delhi's street children population at 50,923.²⁰ This study was sponsored by the Ministry of Women and Child Development.

It is hard to find reliable data on the extent of drug abuse among street children. Among existing literature, a few are government-sponsored. The latest study was conducted in 2015 by the DSLSA to identify the number of drug abusers among school-dropouts in Delhi.²¹ It found that out of the total sample, 36% of children used substances for

bstract+of+Delhi+2014.pdf?MOD=AJPERES&lmod=-1346796026&CACHEID=f508bc8046667b0e9cf6bcf5a4ed47e7).

¹⁹ Street Children, Unstarred Question No. 352, Answered on July 7, 2014, Anurag Singh Thakur.

²⁰ See Footnote 16.

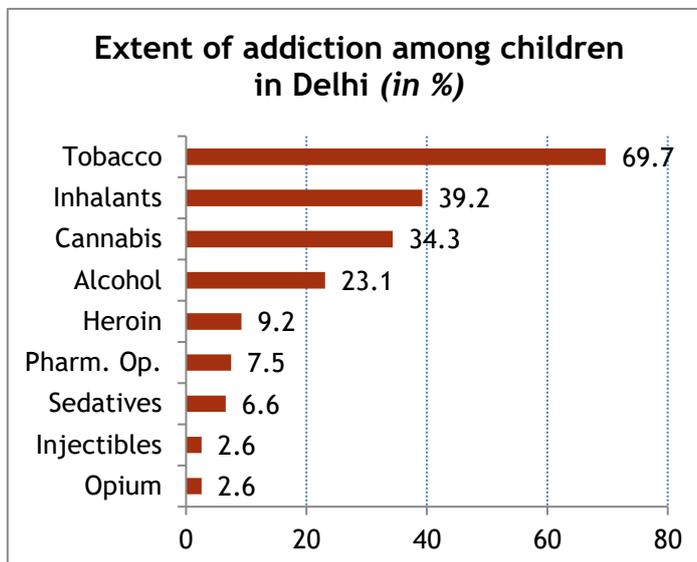
²¹ "Substance abuse among School dropout children: A Study in Delhi. Delhi," Delhi State Legal Services Authority, 2015, in *Substance Abuse by Children in Delhi: A Status Paper on Rehabilitation Strategies*, DCPCR, Govt. of NCT of Delhi, June 2015.

intoxication. Even children under 10 years (17% of the sample) had started taking drugs.²²

Chart 2: Extent of addiction among children in Delhi

The NCPCR sponsored national level study of 2013 had 347 respondents from Delhi.²³

Among the sample, 242 (69.7%) children surveyed used tobacco, 80 (23%) used alcohol, 119 (34%) used cannabis, 136 (39%) used inhalants and 26 (7.5%) used pharmaceutical opioids (pharm. Op.).²⁴ The sample included children who lived with families, went to school and those who lived on the streets.



The census of street children conducted in 2011 also found that nearly 22% of the children were addicted to tobacco and pan masala. The children also reportedly used alcohol, whiteners, and thinners. Nearly 50% were daily consumers, 28% were weekly consumers and 20.6% were monthly consumers.²⁵

A 2009 study conducted by National Drug Dependence Treatment Centre (NDDTC) reported that the activities of street children are significantly related to their drug use behaviour and almost one third of inhalant users reported using inhalants throughout the day.²⁶

In 2008, a study by CHETNA revealed that of the 1.5-2 lakh street children in Delhi, 80% were involved in substance abuse, mostly white fluids, cannabis and tobacco.²⁷

In 2004, a study conducted by Department of Community Medicine, Maulana Azad Medical College, New Delhi (Pagare and others) found that 57.4% of the sampled street

²² Ibid, pg. 36.

²³ See Footnote 9, pg 103.

²⁴ Ibid, pg 104.

²⁵ See Footnote 16, pg. 9.

²⁶ National Drug Dependence Treatment Centre, (2009), "Inhalant use among Street Children in Delhi- A Situation Assessment," Report submitted to WHO (India) and Ministry of Health and Family Welfare, Govt. of India.

²⁷ "Use or Abuse? A Study on the Substance Abuse among Street and Working Children in Delhi," Childhood Enhancement through Training and Action (CHETNA), (2008), New Delhi.

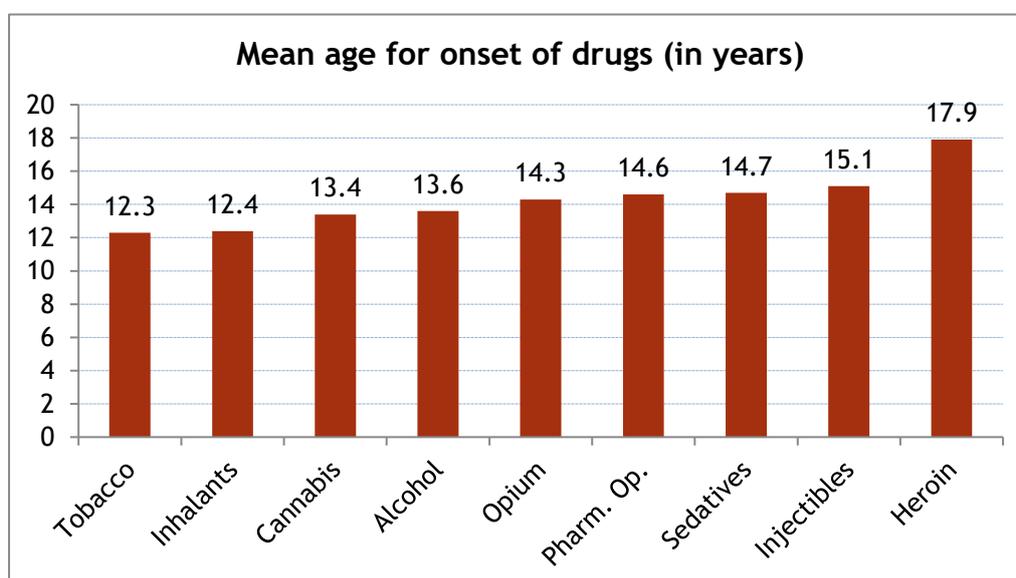
children used drugs (Nicotine 54%, Alcohol 50% and Inhalants 25%).²⁸ Other studies in different cities also found high prevalence of drug use among street children.²⁹

D. Profile of Children Addicted to Drugs

Age profile

According to the NCPDR sponsored national-level study of 2013, the first substance that children were most likely to use was tobacco. The mean age for use of tobacco was 12.3 years in India. This was followed by inhalants, cannabis and alcohol. As the children grew older, they were likely to move on to harder drugs such as opium, heroin and injectibles.

Chart 3: Mean age for onset of drugs



Source: Assessment of Pattern and Profile of Substance Use among Children in India, National Commission for Protection of Child Rights (NCPDR), 2013, pg 32

The 2015 DCPCR study found that the mean age of street children in Delhi taking drugs was about 13 years (range 10-17 years) although there were some reports of children aged below 10 years taking drugs.³⁰ The age of initiation into drugs could be as low as 5 to 7 years (the mean age being 9 years).³¹

In fact, the Pagare (2004) study found that among its sample population of 115 boys in the age group of 6-16 years in an Observation Home in Delhi, the minimum age of substance abuse was 5.5 years.³²

²⁸ Pagare, D.; Meena, G.S.; Singh, M.M., Saha, R. (2004), Risk Factors of Substance Use among Street Children from Delhi. *Indian Paediatrics*, 41.

²⁹ Malhotra C, et al, Drug abuse among Juveniles in Conflict with Law, *Indian Journal of Pediatrics*, Vol: 74, April 2007, pg.353 to 356.

³⁰ See Footnote 12, pg 57.

³¹ Ibid, pg. 58.

³² See Footnote 28, pg 222.

Gender Profile

Existing studies on drug addiction among street children usually focus on boys because the assumption is that the prevalence of drug abuse among girls is much lower than boys. The DCPCR study reported that drug abuse was almost exclusively limited to boys among street children.³³

However, according to Jahnvi, a social worker at Society for Promotion of Youth and Masses (SPYM) in Delhi, the problem exists but is largely hidden.³⁴ This is also somewhat borne out by the findings of the NCPCR study, which had a sample of 169 girls ranging between 6 to 18 years (4.3% of the total sample). The mean age of onset of drugs was below 12 years for girls and the use of pharmaceuticals opioids, sedatives and injectible substances was more common among girls. However, the study cautioned against generalising the data to the entire population since the sample was taken only from five states - Mizoram being the highest - and therefore not representative of all states.³⁵

Education and occupation

According to the DCPCR study, unsurprisingly, 90% of the children had dropped out from school, having been educated only till primary school. Their education was terminated when they left home or were forced to work by a family member.³⁶

The NCPCR study reported that among the sample children only about 15% of the street children had attained educational level beyond the primary school.³⁷

In terms of occupation, most of the children worked as unskilled labourers.³⁸ Interestingly, a study found that children addicted to drugs were more likely to be working than those who were not, in most instances, to support their drug addiction.³⁹ From the sample in the NCPCR study, a larger percentage (80%) of street children earned their living by working part-time or full time but many out-of-school children living at home also worked to earn a living, thereby having unsupervised time. Rag picking and street level vending were common occupations among children.⁴⁰

Table 1: Employment status of drug users (inhalant users) vs non drug non users among street children in Delhi

Employment Status	Drug Users (%)	Non Drug Users (%)
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³³ See Footnote 12, pg 57.

³⁴ Interview with Jahnvi, Social Worker, SPYM, Delhi Gate, January 19, 2016.

³⁵ See Footnote 9, pg 69-70.

³⁶ See Footnote 12, pg. 57.

³⁷ See Footnote 9, pg. 71.

³⁸ See Footnote 12, pg. 58.

³⁹ "Rapid Situation Assessment Study," National Drug Dependence Treatment Centre, AIIMS, Delhi in association with six NGO partners (Butterflies, CHETNA, Don-Bosco Ashalayam, Prayas, Project Concern International (PCI) & Salam Balak Trust), 2009 in "A Trainer's Manual on Drug Use Prevention, Treatment and Care for Street Children," UNODC and National Institute of Social Defence (Accessed on Aug 8, 2016

https://www.unodc.org/documents/southasia/Trainingmanuals/Street_children_Trainers_Manual.pdf).

⁴⁰ See Footnote 9, pg. 71 and Footnote 16, pg 30.

Currently employed full time	61	41.9
Currently employed part time	33	22.6
Currently not employed	4	9.7
Not known	2	25.8

Source: "Rapid Situation Assessment Study," National Drug Dependence Treatment Centre, AllMS, Delhi in association with six NGO partners (Butterflies, CHETNA, Don-Bosco Ashalayam, Prayas, Project Concern International (PCI) & Salam Balak Trust), 2009 in "A Trainer's Manual on Drug Use Prevention, Treatment and Care for Street Children," UNODC and National Institute of Social Defence.

From our interviews with Mr. Sanjay Gupta (Founding Director, CHETNA) and few child drug users, we learnt that most children working as rag pickers and at railway stations use inhalants to cope with the repugnant nature of their work.⁴¹

LEGAL PROVISIONS

A. Juvenile Justice (Care and Protection of Children) Act, 2015

The Juvenile Justice (Care and Protection of Children) Act, 2015 (which replaced the JJ Act, 2000) addresses, *inter alia*, the needs of children addicted to drugs. The Act, reiterating the provisions of the JJ Act 2000, categorises children as those who are in conflict with the law and those who are in need of care and protection. The definition of "children in need of care and protection" includes those who are "likely to be inducted into drug abuse or trafficking" along with those found without any home, begging, living on the streets, living with unfit parents etc.

Section 31 of the JJ Act, 2015 mandates that a child who is found in need of care and protection shall be brought before the Child Welfare Committee (CWC) within 24 hours. The state government is required to constitute a CWC in each district to deal with children in need of care and protection. Section 36, which delineates the procedure for conducting an inquiry by the CWC, provides that after a child is brought before the CWC, a Social Investigation Report is required to be prepared within 15 days. Functions of the CWCs include conducting inquiries, selecting registered institutions for placement of a child, addressing the needs of child in need of care and protection; and ensuring appropriate rehabilitation or restoration of the child depending on its needs. Further, section 18 of the JJ Act, 2015 empowers the Juvenile Justice Board (JJB) to order a child suffering from addiction to undergo a de-addiction programme and section 93 allows for CWCs and JJBs to direct children to rehabilitation centres for addicts when they are found to be battling drug addiction.

⁴¹ Interview with Mr. Sanjay Gupta, Founding Director, CHETNA on 11 February, 2016.

B. National Policies

National Policy on Narcotic Drugs and Psychotropic Substances

In 2012, the Ministry of Finance (Department of Revenue) issued a National Policy on Narcotic Drugs and Psychotropic Substances stating that the policy would serve as a guide to various Ministries to combat the drug menace in a holistic manner.⁴² The policy focussed on both supply and demand reduction strategies. The provisions specifically related to children included strategies to curb drug peddling and reduction of sale of drugs to schoolchildren.⁴³

Box 2: Demand Reduction Strategies

Strategies to tackle sale of drugs to school children

- Local police shall pay special attention to areas surrounding schools and colleges in their efforts to tackle drug peddlers.
- Schools and colleges will be encouraged to look out for peddlers in their vicinity and report them to police.
- Schools and colleges will be encouraged to conduct surveys (possibly anonymous) to assess the levels of drug addiction among their students, and if addicted students can be identified, to talk to their parents or wards to find medical help to cure their addiction.
- The Central and State Education Authorities will be encouraged to include a mandatory and comprehensive chapter on drug abuse and illicit trafficking and its socio-economic cost to self, society and the country in the syllabus for 10+1 and 10+2 students.
- Schools and colleges will be encouraged to constitute Anti-Drug Club to promote a drug free life among its members and also in the institution.

Strategies to tackle drug peddling

- Increase public awareness about the potential harm street peddlers can do to their societies and their children and the need to report peddlers to police and to follow up.
- Increasingly involve NGOs, resident welfare societies, etc. in reporting peddlers and following up with police.
- Sensitise police to the fact that dealing with street peddlers is an important part of their job.
- Train and build capacities of local police to deal with peddlers including those

⁴² "National Policy on Narcotic Drugs and Psychotropic Substances," Feb 9, 2012, Press Information Bureau (accessed on Aug 10, 2016 <http://pib.nic.in/newsite/efeatures.aspx?relid=80202>).

⁴³ "The National Policy on Narcotic Drugs and Psychotropic Substances". Available at: <http://cbn.nic.in/html/NationalPolicyEnglish.pdf> (accessed on Aug 10, 2016)

who are addicts themselves.

- In large cities, develop special, mobile, anti-peddling squads of police with jurisdiction all over the city and linked to a helpline.

Source: The National Policy on Narcotic Drugs and Psychotropic Substances (accessed on Aug 10, 2016 <http://cbn.nic.in/html/NationalPolicyEnglish.pdf>).

There were also guidelines for treatment, rehabilitation and social reintegration of all drug addicts. The Policy characterised drug abuse as a psycho-social medical problem, which needed both medical intervention and community based interventions. Hence, its strategy for demand reduction consisted of (a) awareness building about ill-effects of drug abuse; (b) treating drug addicts through programmes of motivational counselling, treatment, follow-up and social-reintegration, (c) imparting training to rehabilitation service providers.⁴⁴

The Policy also included strategies for harm reduction through needle syringe exchange programmes and oral substitution in case of injectable drug use. It identified the Ministry of Social Justice and Empowerment and the Ministry of Health and Family Welfare as the nodal ministries to support demand reduction strategies and deal with healthcare issues respectively.⁴⁵

According to experts, however, staff providing harm reduction services continue to face the risk of prosecution for ‘aiding and abetting’ of drug use.⁴⁶ Further, the Policy has been criticised by experts for being flawed and regressive in its narrow definition of harm reduction, its treatment of drug addicts in prison and lack of specific input about achieving harmonisation among various agencies.⁴⁷

Draft National Policy for Drug Demand Reduction

In 2014, the Ministry of Social Empowerment and Justice released a Draft National Policy for Drug Demand Reduction. The Draft Policy sought to create awareness about ill effects of drugs, provide community based interventions, strengthen human resource development, facilitate research and avoid stigmatisation of drug addicts.⁴⁸ It consulted

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Tripti Tandon, (2015), “Drug Policy in India”, International Drug Policy Consortium, London, United Kingdom. Available at: http://idhdp.com/media/400258/idpc-briefing-paper_drug-policy-in-india.pdf (accessed on 12 August 2015).

⁴⁷ Ambekar, A. et. Al (2013), ‘India’s National Narcotic Drugs and Psychotropic Substances Policy, 2012: A 20th century document in the 21st century’, International Journal of Drug Policy, 24(4): 374-75 (accessed on Aug 10, 2016 [http://www.ijdp.org/article/S0955-3959\(13\)00002-9/fulltext](http://www.ijdp.org/article/S0955-3959(13)00002-9/fulltext)).

⁴⁸ Draft National Policy for Drug Demand Reduction (accessed on Aug 10, 2016 <http://www.malda.gov.in/Acts,Orders%20&%20Circulars%20related%20to%20ICPS%20,%20Child%20Protection%20&%20Social%20Welfare%5CNational%20Drug%20Demand%20Reduction%20Policy.pdf>).

state governments, Union Territories, concerned ministries and other stakeholders so that there was awareness of the issue at all levels.⁴⁹

According to news reports, the 2014 Draft is in the process of being redrafted after orders from the Prime Minister's Office to reduce the length of the draft.⁵⁰

ISSUES AND CHALLENGES

Given the high prevalence of drug use especially among street children, it would seem that the government's policies have been largely ineffective in tackling the problem. The reasons for the failure are many, the most basic being a lack of understanding among policy makers about the nature of the problem as well as the ways to address it.

A perusal of the parliamentary debates⁵¹ on the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act) and its subsequent amendments show that on the one hand, MPs were concerned about the prevalence of drug abuse among children but on the other hand, made little effort to ensure that concrete steps were taken to address the problem in a holistic manner. It is pertinent to note that some MPs did raise concerns about the lack of specific provisions for the treatment of child addicts and the lack of clarity about the roles and responsibilities of ministries on provisions related to rehabilitation and treatment of addicts.⁵² However, these concerns did not translate into real policy change.

A. Data Availability

There is no real mechanism to collect data on a regular basis, the absence of which makes adequate policy formulation and implementation regarding children addicted to drugs difficult. Data on available rehabilitation facilities, professionals such as doctors, psychologists and other specialists in Integrated Rehabilitation Centres for Addicts (IRCA) is poorly gathered. IRCAs are de-addiction centres run by NGOs and voluntary organisations and given financial assistance under the Scheme of Assistance for

⁴⁹ "Union govt prepares draft on National Policy on Drug Demand Reduction," Nandita Vijay, Pharmabiz.com, Dec 29, 2014 (accessed on Aug 10, 2016 <http://www.pharmabiz.com/NewsDetails.aspx?aid=85883&sid=1>).

⁵⁰ "Ministry Redrafts National Policy for Drug Demand Reduction," India Today, Feb 10, 2016 (accessed on Aug 10, 2016 <http://indiatoday.intoday.in/story/ministry-redrafts-national-policy-for-drug-demand-reduction/1/592601.html>).

⁵¹ See: Rajya Sabha Debate on Narcotic Drugs and Psychotropic Substances Bill, 1985 (Dated: 29 August, 1985); Lok Sabha debate on Narcotic Drugs and Psychotropic Substances Bill, 1985 (Dated: 26-28 August, 1985).

⁵² See: Lok Sabha Debate on Narcotic Drugs and Psychotropic Substances Bill, 1985 (Dated: 28 August, 1985).

Prevention of Alcoholism and Substance (Drug) Abuse of the Ministry of Social Justice.⁵³ In addition, according to some studies, the data record of CWC is poorly maintained and not easily accessible.⁵⁴

B. Overlapping Roles and Responsibilities

The Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act) empowers agencies to investigate and prosecute offences related to drug production, transportation, possession, abuse etc.⁵⁵ It is also responsible for establishing de-addiction centres for treatment and rehabilitation of addicts. Multiple ministries are responsible for a variety of functions related to drug demand and supply reduction.⁵⁶ Drug demand reduction is handled by the Ministry of Social Justice and Empowerment (MoSJ)⁵⁷ while the treatment and rehabilitation of drug addicts falls under the domain of the Ministry of Health and Family Welfare (MoHFW).⁵⁸

Focusing solely on the treatment and rehabilitation aspect of the problem, it is clear that there is an overlap of responsibilities between ministries. The Social Defence Division of the Ministry of Social Justice states that it “coordinates and monitors all aspects of drug abuse prevention, which includes assessment of the extent of the problem, preventive action, treatment and rehabilitation of addicts, dissemination of information and public awareness.” It also runs a Scheme for Prevention of Alcoholism and Substance (Drug) Abuse since 1985, which partially funds eligible agencies for setting up IRCAs, drug awareness and counselling centres, de-addiction camps, awareness and prevention programmes.⁵⁹

The Ministry of Health and Family Welfare is also mandated to run treatment and rehabilitation programmes for drug addicts. Under the Drug De-Addiction Programme, the ministry provides funds to the central government’s de-addiction centres, which include the National Drug Dependence Treatment Centre (NDDTC), AIIMS; De-addiction centres in Chandigarh (PGIMER), Pondicherry (JIPMER) and Bangalore (NIMHANS). It is also supposed to coordinate with the Ministry of Social Justice, the Narcotics Control

⁵³ Drug De-addiction Centres, Ministry of Social Justice, Press Information Bureau, Aug 4, 2015 (accessed on Aug 10, 2016 <http://pib.nic.in/newsite/PrintRelease.aspx?relid=124284>).

⁵⁴ “Child Welfare Committees in India: A comprehensive analysis aimed at strengthening the Juvenile Justice System for children in need of care and protection,” March 2013, HAQ Centre for Child Rights study for NCPCR (http://ncpcr.gov.in/view_file.php?fid=461).

⁵⁵ Sections 15-30, Narcotic Drugs and Psychotropic Substances Act, 1985.

⁵⁶ Section 71, Narcotic Drugs and Psychotropic Substances Act, 1985.

⁵⁷ Annual Report 2015-16, Ministry of Social Justice and Empowerment, Govt of India, pg 30 (accessed on Aug 10, 2016

http://socialjustice.nic.in/writereaddata/UploadFile/SOCIAL%20JUSTICE%20ENGLISH%2015_16.pdf).

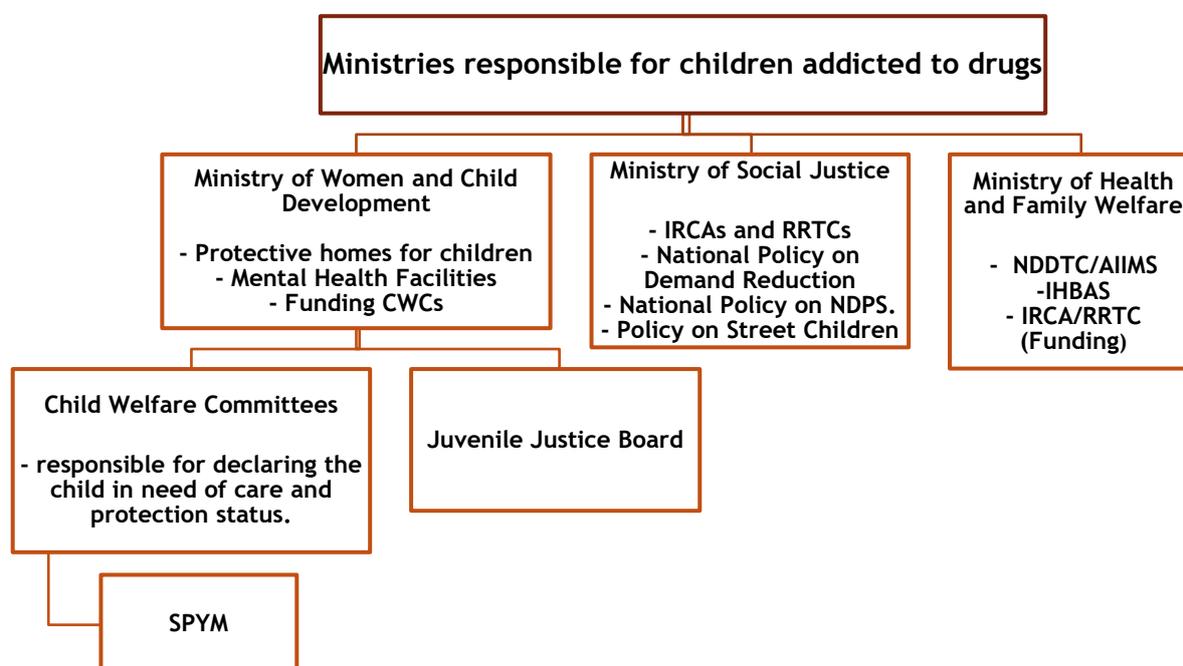
⁵⁸ Drug De-addiction Programme, Ministry of Health and Family Welfare, Govt of India (accessed on Aug 10, 2016 <http://mohfw.nic.in/index1.php?lang=1&level=0&linkid=227&lid=1350>)

⁵⁹ See Footnote 56, pg. 30.

Bureau and the International Narcotics Control Board on matters related to de-addiction.⁶⁰

Thus, both Ministries are mandated to fund de-addiction and rehabilitation programmes. Although the Social Justice Ministry is the nodal ministry for drug demand reduction, the Health Ministry is responsible for funding central government's de-addiction centres and coordinating with other agencies on matters related to de-addiction.

In case of children addicted to drugs, Ministry of Women and Child Development (MWCD) has a prominent role as these children are referred to CWCs, which fall within the domain of the ministry.⁶¹



The budgets of the concerned ministries are allocated according to their respective schemes. Since none of the ministries have specific schemes targeted at vulnerable groups such as street children addicted to drugs, the problem is mostly overlooked by the ministries.⁶²

⁶⁰ Ibid.

⁶¹ Ministry of Women and Child Development, Government of India (accessed on Aug 16, 2016 <http://www.wcd.nic.in/act/2315>).

⁶² Sakshi (2016), "How 'The Future of the Nation' Fell By the Wayside in Union Budget 2016". Accessed on Aug 10, 2016 http://www.huffingtonpost.in/sakshi/how-the-future-of-the-nat_b_9989654.html

Further, the ministries work in silos, neither sharing resources nor financing joint operations that can address child welfare comprehensively.⁶³ For instance, the Ministry of Women and Child Development runs the Integrated Child Protection Scheme, which acknowledges that child protection is a complex subject and needs a comprehensive and multi-pronged approach. However, little effort is invested in coordinating with other ministries. Also, owing to a narrow definition of health care, limited to HIV/AIDS and physical disabilities, health care issues such as substance abuse get completely side-lined. Such lack of coordination among relevant ministries leads to an incomplete idea of child protection.

C. Working of the CWCs

There are many challenges in the functioning of CWCs, which are the most critical district-level bodies for ensuring that children in need of care and protection are provided the necessary care, protection and rehabilitation.

According to a NCPCR sponsored study on CWCs,⁶⁴ there are many issues that adversely impact their working in the best interest of the child. For instance, the report noted that Delhi and some other states did not establish CWCs in every district as required by the law, there were also jurisdictional confusion, serious deviations in the selection process of members, lack of infrastructure, time consuming legal processes, shortage of competent staff and unavailability of well-functioning child care institutions.⁶⁵

Specifically, in case of children addicted to drugs, the CWC does not have the mandate to take action against rehabilitation centres if they fail to perform their responsibilities. They are allowed to take action only if a complaint is made.

According to Ms. Aparna Dwivedi, a CWC member, in Delhi children are generally referred to CWC by social workers, police or parents. Although there are six IRCAs in Delhi (out of 338 in India),⁶⁶ the CWC at Mayur Vihar refers children addicted to drugs only to SPYM, a registered IRCA for boys, where the treatment primarily consists of denying access to drugs. Even though she was aware of the Centre, Ms. Dwivedi said that they had never referred children to NDDTC in AIIMS because there was no express order that allowed them to do so. Another reason cited by Ms. Dwivedi for not referring the children to NDDTC was that the Centre required guardians to accompany children, which often times was not possible because the children did not have fit guardians. The

⁶³ Ibid.

⁶⁴ "Child Welfare Committees in India: A comprehensive analysis aimed at strengthening the Juvenile Justice System for children in need of care and protection," March 2013, HAQ Centre for Child Rights study for NCPCR (accessed on Aug 10, 2016 http://ncpcr.gov.in/view_file.php?fid=461).

⁶⁵ Ibid.

⁶⁶ Unstarred Lok Sabha Question No. 5556 for 28.4.2015 and Lok Sabha Starred question no. 494 dated 12.08.2014.

CWC did not have the wherewithal to provide them with these care takers that NDDTC needed.⁶⁷

On the issue of training of CWC staff, Ms. Dwivedi commented that the members of the CWC, as well as the social workers attached to it lacked specialised training in dealing with children suffering from drug addiction. In addition, they did not distinguish between children suffering from one vulnerability from those suffering from multiple vulnerabilities (for example, a street child as opposed to a drug addicted orphaned street child), leading to absence of adequate responses towards these children.⁶⁸

D. De- Addiction, Rehabilitation and Re-Integration of Children

NDDTC became functional in 2003 and established the first and only adolescent clinic in India. It boasts of experienced doctors who have had a rich background of working on issues of drug abuse. However, they do not have adequate support staff. As a consequence, they require parents or guardians of the children to stay with them during the period of treatment. This demand is difficult to fulfil for families of poor and daily wage labourers. Thus, many children choose out-patient treatments, even though they often need in-patient care.⁶⁹

What makes matters worse is that NDDTC has unspent funds from its allocated budget, although it is not able to utilise the same for recruiting more support staff.

Table 2: Funding pattern of NDDTC, AIIMS

Financial Year	Sanctioned amount (<i>Rs in lakh</i>)	Amount utilised (<i>Rs in lakh</i>)	Unspent amount (<i>Rs in lakh</i>)
2012-13	1191.85	1155.85	36
2013-14	1444.00	1387.00	57
2014-15	1663.24	1560.00	103

Source: Information under the RTI Act (no. MOHFW/R/2016/50251/2)

Further, Scant attention has been paid to re-integrating children addicted to drugs into society. According to Jahnvi, SPYM follows up for six months with the children but it is not clear how successful they are in ensuring that the children stay away from drugs. The shortage of social workers in the CWCs also means that they are unable to follow-up regularly with at-risk children.⁷⁰

Jahnvi further added that in case children did not want to go back to their families, or their families could not be traced, there were very few options, except sending them to

⁶⁷ Interview with Aparna Dwivedi, Member, CWC, Mayur Vihar, Phase 1, Feb 22, 2016.

⁶⁸ See Footnote 63.

⁶⁹ Interview with Dr. Anju Dhawan, NDDTC, AIIMS, February 23, 2016.

⁷⁰ Interview with Jahnvi, Social Worker, SPYM, Delhi Gate, January 19, 2016.

children's homes, which were neither well-managed nor adequately equipped to ensure that the children were not exposed to drugs or sexual abuse. According to Jahnvi, the staff at these children's homes was reluctant to send children who were or had once been addicted to drugs to school. This is because they lacked the manpower to supervise these children on their way to and back from school and they feared that the children's cravings for drugs would force them to run away or find other means to procure drugs.⁷¹

It is clear that even though the Right to Education Act, 2009⁷² mandates that all children up to 14 years have a right to education, there is no systematic coordination between the different ministries to ensure that these children are able to go to school after they complete de-addiction treatment.⁷³

E. Inadequate Funding

The budgetary allocation for child welfare (health, education and protection) has been deemed to be grossly inadequate by child rights groups such as HAQ Centre for Child Rights. According to their report, there has been significant decrease of 14.4% in the share of allocation of funds for the protection of children in the 2016-17 Union Budget.⁷⁴ The Report has raised concern about the falling share of budgetary allocation for children by highlighting that in the 2016-17 Union Budget, child health allocation as a proportion of Union Budget has declined from 0.13% in 2015-16 to 0.12% in 2016-17. Similar decline was reported for education and child protection.⁷⁵

Tellingly, in spite of lip service about the welfare of children by policy-makers, there is no specific scheme that allocates funds for child drug addicts or the welfare of street children.

IV. TOWARDS DEVELOPING AN EFFECTIVE STRATEGY

Drug use among children, especially those living on the streets and out of school children is a matter of urgent concern - both from a public health perspective and rights perspective. It interferes with physical growth and leads to chronic physical and mental ailments. It also severely impacts the possibility of them getting an education, their occupational goals and acquisition of basic life skills. Therefore, it is imperative for government policy to ensure early identification and prevention of drug use as well

⁷¹ Ibid.

⁷² The Right of Children to Free and Compulsory Education Act, 2009 (accessed on Aug 10, 2016 <http://mhrd.gov.in/rte>).

⁷³ Interview with Jahnvi, Social Worker, SPYM, Delhi Gate, January 19, 2016.

⁷⁴ HAQ Centre for Child Rights (2016), "Budget for Children 2016-2017: Not Even Halfway through its Demographic Dividend". Available at: <http://haqrc.org/wp-content/uploads/2016/03/budget-for-children-2016-17-not-even-halfway-through-its-demographic-dividend1.pdf> (accessed on 12 August, 2016).

⁷⁵ Ibid, pg 4-5.

as provide adequate access to education, nutrition, shelter and protection from exploitation, abuse and neglect.

As this policy brief demonstrates, although the intention of the juvenile justice legislation is to act in the best interest of the child and ensure that the child gets the required care and protection, huge implementation gaps have rendered the law largely ineffective.

There needs to be a change in how street children and children addicted to drugs are understood, not only by the government but also by society at large. These children are all around us, selling us trinkets, offering to shine our shoes; but they are largely invisible. They need to be seen as equal citizens of the country with rightful entitlement to education, healthcare and other opportunities for growth. The state needs to be held accountable for its responsibilities towards the welfare of these children.

Since drug addiction among children is primarily attributable to socio-economic deprivation, the problem cannot be addressed in a piecemeal manner. Based on our research we make the following recommendations:

- i. First, there is a need to get all stakeholders on board and agree on a well-formulated treatment and rehabilitation strategy to address the issues, taking into account poverty, social vulnerability and marginalisation.
- ii. Second, there should be clear-cut demarcation of responsibilities among relevant ministries accompanied by effective oversight of their functions. Overlapping responsibilities among different ministries leads confusion and lack of actual on-ground action in terms of building sufficient rehabilitation infrastructure.
- iii. Third, a well-functioning juvenile justice system requires proper infrastructure, adequate staff and training facilities. There needs to be greater attention to ensuring that observation and children's homes are well managed and children are provided with adequate support including food, education and vocational training to ensure their successful reformation and rehabilitation.
- iv. Fourth, there needs to be adequate funding by the government to ensure that facilities can be run smoothly and the children can be provided with adequate care and treatment. This is an essential aspect of the problem on which the success of the government's strategy will depend.
- v. Finally, drug addiction needs to be viewed as a healthcare management issue and its remedies need to be integrated with existing healthcare system in the country. Tackling drug addiction requires a well-resourced, community based treatment programme with fully trained and supported staff.

Drug addiction among children is a symptom of a larger problem of the deprivations faced by the urban poor. Ensuring that children do not fall prey to drugs requires a much deeper understanding of the problems of survival faced by them and the will to tackle the problem on a war footing. The strategy for tackling drug addiction among children needs to be comprehensive and holistic, taking into account not only the specific healthcare needs of a drug addicted child but also of his larger surroundings.

Annexure 1: Interviews Conducted During the Field Study

1. Dr. Rajesh Kumar, Executive Director, Society for Promotion of Youth and Masses on 9 November 2015.
2. Jahnvi, Social Worker, Society for Promotion of Youth and Masses, Delhi Gate Unit, New Delhi on 19 January 2016.
3. Interview with Children in the residential facility of SPYM's rehabilitation centre on 19 January 2016.
4. Sanjay Gupta, Founding Director, Childhood Enhancement Through Training and Action (CHETNA) on 11 February 2016.
5. Social Workers at CHETNA and the children admitted at the institution's day care centre, Nizamuddin on 12 February 2016.
6. Aparna Dwivedi, Member, Child Welfare Committee, (Mayur Vihar Phase I) on 22 February 2016.
7. Dr. Anju Dhawan, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences on 23 February 2016.



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