RESEARCH ARTICLE

Addiction treatment in India: Legal, ethical and professional concerns reported in the media

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Abstract

As per the Magnitude of Substance Use in India 2019 survey report, over 57 million of the Indian population is in need of professional help for alcohol use disorders and around 7.7 million for opioid use disorders. The increasing demand for addiction treatment services in India calls for professionalising every aspect of the field. Frequent human rights violations and various unethical practices in Indian addiction treatment facilities have been reported in the mass media. This study is a content analysis of newspaper reports from January 1, 2016 to December 31, 2019 looking into legal, ethical and professional concerns regarding the treatment of substance use disorders in India. The content analysis revealed various human rights violations, the use of improper treatment modalities, the lack of basic facilities at treatment settings, and the presence of unqualified professionals in practice.

Keywords: *substance use disorders, addiction, treatment ethics, India, content analysis*

Introduction

In India, substance use disorders (SUDs) are the most prevalent mental health morbidity according to the National Mental Health Survey of India, 2015-16 (1), as well as one of the most worrisome public health issues. As per the 2019 survey report on substance use in India, over 57 million of the Indian population are in need of professional help for alcohol use disorders and around 7.7 million for opioid use disorders (2). Among the ministries responsible for addressing drug- and alcohol-related issues in the country, the Ministry of Social Justice and Empowerment (MSJE) and the Ministry of Health and Family Welfare (MoHFW) implement demand reduction strategies which also include strategies for treatment and rehabilitation of addicts (3). The current system of addiction treatment in India involves brief outpatient-based interventions, medical detoxification, residential rehabilitation, substitution therapies, and community-based interventions. According to the lists published by the MSJE and MoHFW, there were 398 Integrated Rehabilitation Centres for Addicts (IRCAs) in India as of 2017, and 212 Opioid Substitution Clinics as of 2019 (4,5). In addition to these, de-addiction services are provided at various medical colleges and district hospitals in different states (3). There are also several private de-addiction and rehabilitation centres around the country, and these outnumber the government facilities. However, the 2019 survey reports a substantial treatment gap in the country; it states that treatment (including "spiritual " and "religious" help) is accessible to only about 2.6 % and 12% of all alcohol- and drug-dependent individuals, respectively (2).

In India, on the one hand, a sizeable proportion of the affected population is deprived of professional help, and on the other, there are serious concerns about the functioning of the available facilities offering de-addiction and rehabilitation services. In May 2018, in connection with a lawsuit, the Delhi State Legal Services Authority submitted a comprehensive inspection report to the Delhi High Court on 124 de-addiction centres in the National Capital Territory (NCT) of Delhi. The inspection team interacted with 2,135 inmates from various centres and found that 750 of them were involuntarily detained in these facilities. The report also detailed several other deficiencies such as lack of basic facilities, non-maintenance of patient records, lack of trained professionals, and many other human rights violations (6). The newspaper *Daily News and Analysis (DNA)* reported in 2018 that there were 250-300 de-addiction centres running illegally in Delhi alone (7). This is not just an issue of Delhi; a similar situation prevails in various other parts of the country. Surprisingly, many private addiction treatment facilities seem to be operating beyond the radar of the laws and regulations of the country (8). Though the news media have been reporting horror stories in addiction treatment facilities frequently, the mode of operation, treatment modalities, and ethicality of private de-addiction and rehabilitation centres in India are insufficiently documented in the research literature. Despite

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To cite: *Joseph S, Hemalatha K. Addiction treatment in India: Legal, ethical and professional concerns reported in the media. Indian J Med Ethics*. 2021 Oct-Dec; 6(4) NS: 306-13. DOI: 10.20529/IJME.2021.030.

Published online on April 29, 2021.

Manuscript Editor: Sandhya Srinivasan.

Peer Reviewers: Two anonymous peer reviewers

their seriousness, ethical and professional issues in addiction treatment in the Indian scenario are still under-researched. This paper is an effort to identify legal, ethical, and other professional concerns surrounding addiction treatment in India, using newspaper reports. Ethics provides the code of conduct that guides professional practice, while the law includes all the statutory rules and regulations prevailing in the country. The article also tries to look into some of the other profession-related concerns that prevail in connection with addiction professionals.

Materials and methods

The three English language newspapers in India with the highest circulation – *The Times of India, The Hindu*, and *Hindustan Times* (9) – were chosen for this study. *The Times of India* has editions in most of the states, *The Hindu* in the southern region and *Hindustan Times* in the northern region. Content analysis was done of articles and reports that appeared in the online versions between January 1, 2016 and December 31, 2019. Searches were conducted on the homepages of each newspaper website. The keywords used were "de-addiction centre", and "drug and alcohol rehabilitation". The inclusion criteria were news reports on the functioning of addiction treatment facilities, on inspections or raids of these facilities, of human rights violations in such facilities, and interventions of the courts or other government agencies in their functioning. After scanning through the title and preview of a total of 1,400 news reports in the three newspapers that appeared in the search results, 243 reports were collected that fit these criteria. After omitting duplication and excluding unrelated content, 157 articles were included in the final analysis. Regarding some incidents, several news reports or follow up reports were found. In such cases, all were taken for the analysis. *NVivo 12 for Mac* was used for content analysis. All the news reports and articles were read to facilitate an overall immersion with the topic and to frame guiding rules for analysis. Both qualitative and quantitative content analysis was conducted.

In the first stage, qualitative analysis, a line-by-line coding was done for all the newspaper content, based on three guiding questions:

- What are the ethical violations reported in treating individuals with substance use disorders (SUDs)?
- What are the professional concerns reported?
- What are the legal issues reported?

The coding was done by the first author and reviewed by the second author. Disagreements were discussed and resolved. The newspaper articles reported raids or inspection reports of 51 addiction treatment facilities. In the second stage, quantitative content analysis was conducted of those articles that contained inspection reports of those 51 treatment facilities.

Results

The 157 articles studied contained reports from 13 states. Most reports were from the state of Punjab (n= 70), followed by Delhi (n = 21) and Tamil Nadu (n = 18). The highest number of reports on unethical incidents were from Punjab and Delhi; the maximum number of reports on the involvement of the courts also came from these states. The complete list of news reports is available in Appendix 1 in the online version.

The qualitative content analysis yielded newspaper references to legal, ethical and other profession-related issues in the treatment of SUDs and other addictions in India. Our findings suggest that these three sets of issues are often mutually-inclusive, strongly interconnected and coexist in the country. The issues mentioned do not represent the whole range of legal, ethical and professional issues in the treatment of SUDs in India, but only those that are reported in the newspaper reports covered in the study. Nevertheless, they represent the nature of concerns that ought to be the focus of attention and further research.

The most commonly reported violations that need immediate attention were human rights violations at the treatment facilities, and professional deception in the private treatment industry. The most referenced category was physical and mental torture followed by the presence of unlicensed or illegal treatment facilities, involuntary admissions or detaining without consent, presence of unqualified professionals, lack of basic facilities, denying communication, forced labour, mismanagement of medication, abduction disguised as assisted admission, and not maintaining proper patient records

Involuntary admissions appeared to be carried out without prior assessments by psychiatrists or other qualified mental health professionals. Cases of forcible shifting of individuals with SUDs from their homes to facilities on the request of family members, mostly late at night or in the early morning, were reported. In two such incidents reported in the newspapers, the staff were seriously injured as the patients overpowered staff during the attempt to shift them.

Abuse, as reported in the newspapers, would often amount to torture. Patients were tied up, chained, beaten up with sticks, kept in locked rooms, and punished in various other forms when they resisted continuing of the treatment. In one report, the local residents barricaded the staff of the de-addiction centre in after they repeatedly heard the inmates crying out for help to save them from beatings by the staff. There were a few reports of such torture being used as punishment, as well as on the pretext of "treatment" and as a means to manage crisis situations. Sometimes, such torture led to the deaths of patients. The articles also reported ample instances of facilities with substandard living conditions, forced labour and denial of communication with family members. Such concerns were reported in both licensed and unlicensed facilities. There have been many references in the newspaper content to unlicensed de-addiction centres and rehabilitation

facilities operating in the country. In most reports on unlicensed facilities, officials found out about the existence of such illegal facilities only after receiving complaints from patients or families.

Lack of qualified addiction professionals and the presence of unqualified personnel in treatment facilities were also reported. Another concern found in our analysis was the misuse or mismanagement of medication. Buprenorphine was the most cited medication that is being misused in different ways. There were news articles stating that buprenorphine was being sold frequently without prescription in de-addiction centres, and even, possibly, smuggled out to drug peddlers. Instances were reported of addicts rushing to government de-addiction centres for "immediate relief" with buprenorphine when they did not get heroin or other similar drugs of choice. This drug is sometimes diverted from manufacturers, pharmacies or even from treatment facilities and becomes available as a drug of abuse. Most instances of these issues were reported in the state of Punjab. Another concerning issue was reported from the state of Kerala in which herbal "remedies" laced with Disulfiram were being widely marketed as a magical cure for alcoholism.

Table 1: Issues reported in connection with raids/inspections in 51 de-addiction or drug and alcohol rehabilitation centres in India from 2016-2019

Issues reported	No. and % of the centres (N=51)	
Expired or no current license	26	51%
Physical abuse	26	51%
Lacking the basic facilities mandated by Law	22	43%
Other torture, including psychological	21	41%
Persons with no training or education manage the facility	19	37%
Detaining without consent/Involuntary admission	16	31%
Practice of locking up patients	13	25%
Mismanagement of medication	10	20%
Overcrowding	7	14%
Using violence in the guise of treatment	6	12%
Using violence to manage crises	6	12%
Denying communication	6	12%
Forced labour	6	12%
Abduction disguised as assisted admission	5	10%
Lack of proper patient records	4	8%

The articles studied reported that 13 patients were beaten to death by the staff of the de-addiction centres between January 2016 and December 2019. There were reports of unnatural or accidental deaths or deaths under suspicious or unexplained circumstances in treatment facilities. One thousand eighty individuals were rescued from either illegal de-addiction and rehabilitation centres or from involuntary detention in licensed facilities. Five incidents were reported in which patients died while attempting to escape from treatment centres during this period.

Details of inspections or raids of 51 different addiction treatment facilities were reported in the news content taken for the analysis. Table 1 is a quantitative analysis of the issues stated in those raid and inspection reports, as covered in *The Times of India, The Hindu* and *The Hindustan Times* from January 1, 2016 to December 31, 2019. Of the 51 reported facilities, more than half were not licensed by the concerned authorities at the time of the raid/inspection. As with the qualitative findings, the most frequently reported issue was physical abuse, such as bludgeoning and tying up of patients. There were specific mentions in the reports that some of these facilities use violence in the guise of treatment and as a way to manage crises. Other concerns reported are treatment facilities lacking the required trained professionals and basic amenities mandated by the law.

Discussion

This study attempted to explore the extent of legal, ethical and other professional issues in addiction treatment and rehabilitation in India. There is currently insufficient literature on human rights violations and unethical practices in addiction treatment settings in India. Our study has revealed several concerns that require urgent attention. These findings cannot be generalised to all de-addiction centres in the country, but they do indicate the nature of such violations and malpractices that exist in the addiction treatment industry.

Coerced or involuntary treatment

Coercion as a medically approved means to initiate treatment of substance use disorders has existed for over a century, and the issue of coercion has been discussed and debated in different parts of the world (10). According to the National Institute on Drug Abuse (NIDA), addiction treatment need not necessarily be voluntary to have an effective outcome (11). The element of an individual's willingness to get treated as a precondition to yield an effective treatment is still a subject of debate. Several studies oppose coerced or involuntary treatment, while some support it (12, 13). Coerced or involuntary incarceration in mental healthcare is considered a human rights violation by the United Nations. The International Standards for the Treatment of Drug Use Disorders published by the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC) stipulates; "The patients should grant informed consent

before treatment begins and have a guaranteed option to withdraw from treatment at any time"(14).

In India, the Mental HealthCare Act, 2017 (MHCA, 2017) mandates obtaining informed consent from patients before initiating treatment. The Act does not use the term "involuntary"; it uses the phrase "supported admission". Section 89 of the MHCA, 2017, addresses the issue of supported admission to a mental health establishment and explains the procedure for supported admissions. The law states that the individual needs to be independently examined either on the day of admission or during the preceding seven days, by two mental health professionals or medical practitioners and mandates that one of them must be a psychiatrist (15). These provisions maintain a balance between human rights and public health norms, based on the ethical principle "Do no harm" (16). However, our findings indicate that even treatment facilities that do not have any qualified mental health professionals admit individuals involuntarily. From 2016-19, over one thousand individuals who were admitted involuntarily, without following the norms, were rescued from various addiction treatment facilities of the country by the authorities.

In many reported instances, the rights of individuals admitted involuntarily are violated further in treatment facilities. In fact, involuntary medical treatments were regarded as the cause of repeated human rights violations worldwide (17). Our findings suggest the same, individuals who are admitted and treated involuntarily face more physical and mental torture. The findings also imply that many treatment facilities deny individuals the right to withdraw the consent given at the time of admission or get themselves discharged from the facility if they wish to do so. As per Section 86(7) of the MHCA, 2017, "Subject to the provisions contained in section 88 an independent patient may get himself discharged from the mental health establishment without the consent of the medical officer or mental health professional in charge of such establishment" (15). As per section 88, the medical officer or the mental health professional in charge may withhold the discharge requested for 24 hours for assessment if they think, based on the evidence from the individual's recent behaviour, that the individual is at risk of causing harm to him/herself or others or require "substantial or very high support" in taking the decision. Based on the assessment, the individual should be discharged within 24 hours or follow the rules laid down in section 89 for supported admission. Contrary to these rules, our findings indicate that, in some treatment facilities, those requesting discharge or resisting continuation of the treatment were often locked up, physically and verbally abused, and denied any kind of communication with the outside world.

Many addiction treatment facilities providing inpatient services in India do not permit patients to keep their mobile phones or provide internet access, and allow only limited communication with their family or friends. In many instances, communication is overseen by the staff. Some argue against allowing mobile phones in treatment centres, saying, for example, that mobile phones can be used to obtain substances, and they can distract clients from their treatment programme (18). At the same time, our findings indicate that not allowing clients to communicate with their families or friends privately prevents them from reaching out in case of ill-treatment at the facility, and increases incidents of human rights violations in de-addiction and rehabilitation centres. In this regard, the draft 'Delhi Substance Use Disorder Treatment, Counselling and Rehabilitation Centres Rules, 2018' mandates that every centre applying for registration or license should give an undertaking that "The centre shall allow private interaction with family and provide communication to the patients under supervision of the authorized person of the centre" (19).

The worst form of coercion in private addiction treatment facilities in India is the abduction of individuals from their homes to treatment centres. Such abductions are disguised as assisted admissions or "interventions". Contrary to all international standards and national laws, a team of staff from the rehab facility goes to an individual's house on the request of his or her family member/s and shifts the person to the facility, mostly forcefully. Such unprofessional practices also raise several safety concerns both for patients and staff. Treatment centres choosing night time or early morning to pick up individuals with SUDs indicates that such actions are surreptitious rather than professional interventions. Some of the news reports covered in our study indicate that such forcible admissions take place without having a proper assessment and recommendation by qualified professionals.

Physical and psychological abuse in the name of treatment

Individuals with SUDs are being subjected to inhumane treatment in many treatment facilities. Inmates of a de-addiction centre from Haryana reported that they were "forced to stand holding a pillar in the room and were beaten with sticks by the staff, and never allowed to step out of the dormitory" (20). In another treatment facility, the inspection officials reported that "alcohol and drug addicts were hung upside down and brutally beaten. Some of them were tied to chair and thrashed" (21). It is evident from the newspaper content analysis that torture and other human rights violations are not uncommon in addiction treatment facilities of the country. Aggression and violence are being used in many treatment facilities as a way to address crisis situations as their staff are not trained in non-aggressive de-escalation techniques. Newspapers have reported several incidents of staff bludgeoning patients and death due to such torture. Using aggression and violence on the pretext of treatment was explicitly mentioned in some of the newspaper reports. One of the inspection reports stated that "…Pretending as specialists (sic) they would even beat up the inmates" (22). Such torture sometimes even leads to the death of the individual undergoing treatment. The news articles used in

the study reported 13 of such deaths. The actual number of patients who died would probably be higher as all such incidents would not be covered in the newspapers. Physical and verbal abuse in the name of treatment, as also abduction of patients by treatment facilities on the request of relatives, have been noted in other countries as well (23).

Though not generalisable, our findings imply that it is a practice in several private treatment facilities to use forced labour under the pretext of treatment (recovery/treatment through labour). The treatment providers would argue that this would strengthen the clients to take responsibility in life, but in reality, they save human resource costs by hiring fewer staff. Kitchen chores and cleaning jobs were the main responsibilities that are often assigned to the patients. As reported by some inmates from treatment centres, "They would make us sweep foors, do dishes and other such chores at the centre" (24), "they (patients) were made to clean utensils, mop the floor and forced to stand carrying a cooking gas cylinder on their backs as punishment for misbehaviour or for not following the orders of the staff" (25). Another news article reported that "The centre owner and its staff forced inmates to cut vegetables and help in cooking. When five had objected to it, stating that their parents were paying for their stay, they were beaten up. Inmates said the 14-year-old had fallen unconscious after the beating" (26). Another incident reported that the rehab inmates were made to feed cattle owned by the facility (27). Most of the time, such activities do not help individuals to get trained and find an occupation post-treatment. The MHCA, 2017 mandates mental health establishments to stop forced labour and provide remuneration if anyone is involved in any work at the facility (15). UNODC and WHO state that "neither detention nor forced labour have been recognized by science as treatment for drug use disorders" (28). Our findings also indicate that families were misinformed, at times by treatment providers that forced labour and aggressive handling of clients are part of the addiction treatment. A newspaper report in connection with a 33-year-old man allegedly beaten to death by the staff of a de-addiction centre in Bangalore states that when he complained about the torture and forced labour at the centre, his family believed "all these methods to be some part of treatment to help him kick the bottle" (29).

The United Nations Committee against Torture has emphasised that *"no exceptional circumstances whatsoever* may be invoked by a State Party to justify acts of torture in any territory under its jurisdiction" (30). The committee also holds states responsible when they fail to investigate, prosecute, and prevent, for consenting to or acquiescing in the acts of torture or degrading treatment of non-state officials or private actors.

Lack of trained professionals

The addiction treatment profession is multidisciplinary and includes all those who directly engage in the treatment of substance use disorders and other addictions. There are mainly three categories of addiction professionals; medical (psychiatrists, physicians and nurses), non-medical clinicians (addiction counsellors, psychologists, social workers, family therapists, etc) and support workers (recovery coaches/ mentors, peer counsellors and other support staff). Each of these professionals is entrusted with specific roles in the management of SUDs and other addictions. However, many of the articles in our study reported that several facilities lack trained professionals, and clinical duties are performed by those who had not received any clinical training or education. In the context of India, compared to other professionals, the counselling staff share a significant workload in addiction treatment facilities, and they spend the most time with patients. At the same time, this role is probably the most misunderstood in addiction treatment settings as the prerequisites for becoming a counsellor are sometimes vague. Our findings imply that the more severe violations such as physical abuse are linked to the counselling or non-medical staff.

The Minimum Standards of Care for Centres Providing Substance Use Disorder Treatment and Rehabilitation, 2018, for National Capital Territory of Delhi, defines a counsellor as "a person trained to give guidance on personal or psychological problems, with minimum qualification being graduate in Clinical Psychology/Psychology or Social Work and with 6 month experience in De-addiction services" (31). Individuals in recovery who received the required training and minimum education are known as peer counsellors, recovery coaches, recovery support specialists, or recovery mentors. They, "rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from experiential knowledge and experiential expertise" (32). The role of such trained recovery coaches is incredibly valuable in treatment settings. However, our findings suggest that several private addiction treatment centres in India are managed mostly by individuals in recovery who do not have any training (or education) in addiction treatment or any other related field. This is an indication that in India, being in recovery or having a history of addiction alone is considered or believed to be an adequate qualification to be an addiction professional. As stated by the manager of a de-addiction centre in Gurgaon, Haryana, who is in recovery, "only somebody who has been there would understand what one goes through and what kind of care is needed" (33). One year later, the same facility was charged with gross violations, including degrading and inhuman ways of treating its patients, forced labour, and lack of qualified professionals. An inmate who stayed at the facility for 15 months stated: "Not a single doctor or counsellor has visited the centre for de-addiction during these months. If an inmate falls ill, medicine is given by the staff" (20). Academic training and education are fundamental in assuring high-quality care for individuals with addiction issues (34). Lack of required training and education, in many instances, is directly linked with various other unethical practices. To ensure effective clinical governance, the United Nations Office on

Drugs and Crime as well as the World Health Organization stipulate that "there are sufficient staff working at addiction treatment centres and that they are adequately qualified, and receive ongoing evidence-based training, certification, support and supervision" (28).

As stated in the introduction, the 2019 survey report displays a concerning prevalence of SUDs in India. The magnitude of SUDs is higher than all the other severe mental illnesses combined (35). This high prevalence necessitates the creation of the addiction specialty in the medical and psychology-related professions in India, as in several other countries. In 2007, a proposal was forwarded to the Indian Psychiatric Society for including addiction medicine as a specialty in psychiatry (35). At present, there are a few institutes in India offering a Doctorate of Medicine (DM) degree in addiction psychiatry and Postdoctoral Fellowship in addiction medicine. On the other side, there is rarely any Indian university offering a degree program in addiction studies or addiction counselling[1]. The National Institute of Social Defence and NIMHANS offer some short-term addiction certificate courses and training.

Our findings indicate the presence of unqualified professionals in the industry as well as a general dearth of trained addiction professionals. Unlike in several other countries, no agencies have been set up in India for educating, credentialing, and regulating specialised addiction professionals. The Colombo Plan Asian Centre for Certification and Education of Addiction Professionals (ACCE) was established in 2009 in response to the crisis of insufficient evidence-based addiction treatment services and to address the scarcity of trained addiction professionals in the Asia-Pacific region (36). It had evolved, by 2019, into the Global Centre for Credentialing and Certification (GCCC; www.globalccc.org). GCCC has a few educational providers in India and certifies addiction professionals in the region. Though some efforts have been made to professionalise addiction treatment services in India, more effort has to be made by the government and educational institutions to produce specialised and trained addiction professionals.

Lacking basic facilities

There are many laws and rules in connection with the minimum standards of care of people with substance use disorders. MHCA, 2017 (Sec 20) mandates that individuals have the rights to privacy, to stay in a safe and hygienic environment, and to have facilities for recreation while under treatment in a mental health establishment (15). Various state rules also insist on such minimum facilities for addiction treatment facilities. For example, Minimum Standards of Care for Centres Providing Substance Use Disorder Treatment and Rehabilitation, 2018 for NCT of Delhi, states that "Patients should have access to wholesome food and daily dietary requirements" (31). Our study reveals that many private addiction treatment facilities disregard such rules. Inmates from a de-addiction centre in Ludhiana, Punjab, reported during an inspection that they were given only boiled rice to eat and hot water to drink, and there was no bed provided; inmates slept on mattresses on the floor (37). Another centre did not provide proper accommodation to individuals undergoing treatment; there was not enough space between beds, no potable water facility was provided, and toilet and bathroom facilities were insufficient (38). Also, our study found several reports of de-addiction centres being over-crowded.

Limitations

Our study reports the nature of legal, ethical, professional concerns that exist in addiction treatment services in India. The findings are based on the reports in selected newspapers over a four-year period. One of the characteristics of newspaper reports is that they tend to draw "attention to some aspects of reality while obscuring other elements" (39). As a result, the prevalence and the extent of the issues could be underestimated at times, and exaggerated at other times. There is a possibility that many related incidents might not have been reported in the newspapers. Also, newsworthiness sometimes depends on the sensational nature of the incidents and the popularity and influence of the people and institutions involved. As the study is limited to the newspaper items we have reviewed, it does not give representative data. As we have relied on only three English language newspapers, our study has risked missing out reports from other newspapers, especially regional language newspapers and other media sources such as television. The scope of generalising the findings to the whole of India is also limited as newspaper items from only 13 states were included in the analysis, and about 40% of them were from the state of Punjab. Though our findings cannot be generalised, they certainly indicate that some degree of apathy exists towards the fundamental human rights of individuals seeking treatment for SUDs and other addictions in India and expose several other issues of concern. While duly considering the above limitations of the study, the understanding of the ground realities derived through our findings would guide future researches in this important area.

Conclusions

Worldwide, the approach to addressing addiction is shifting from social exclusion to social reintegration and aiming at restoring the dignity and respect of the affected individuals. This can be achieved by employing evidence-based treatment modalities in practice. The pace of this paradigm shift differs between countries. Our findings suggest that the addiction treatment system in India is still riddled with the old punitive "Teach addicts a lesson" approach. Hence, individuals with SUDs and other addictions still face degrading treatment in some treatment facilities in the country. Even though India does not endorse compulsory drug detention centres, our study indicates that several treatment facilities in the country closely resemble such

detention centres. To ensure proper care, the treatment philosophy of the institutions needs to be constructed on a strong ethical foundation. It is not possible to function within an ethical framework if the laws of the country are not followed in terms of registration and licensing of treatment facilities, staffing as per the minimum standards of care, and ensuring that human rights violations are not happening within these facilities. Instead of being a place for healing, our study indicates that many of the treatment facilities, especially those privately owned, have become places of torture. Inattention from the concerned government bodies, lack of regulation in the addiction profession, and to an extent, lack of awareness of the service users contribute to this crisis. The Indian deaddiction treatment system should be strengthened not just by bringing in evidence-based treatment, but more importantly, through rights-based and compassion-driven interventions.

Treatment centres, research organisations, and the concerned government departments should spare no effort in implementing section 20 of the Mental HealthCare Act, 2017, under which every individual with mental illness including substance use disorders should be "protected from cruel, inhuman or degrading treatment" in the name of therapy. Ethics training for clinical and supporting staff should be made mandatory. Treatment providers should make provision for regular and quality clinical supervision for their staff. Considering the dearth of educational facilities for addiction studies, it is recommended that every treatment provider must make due provision for training of their staff. Indian universities should initiate steps to start degrees on deaddiction studies/science/counselling. Though it might appear to be a remote prospect, as is done in several developed and developing countries, India should start taking steps towards regulating the addiction profession by credentialing, certifying, and licensing professionals.

Conflicts of interest

The authors declare no conflicts of interest. The first author presented an earlier version of this paper at the International Conference on Psycho-Social Rehabilitation 2019 in BMCRI-Bangalore Medical College.

Note:

[1]. The only university degree on addiction found on a Google search was a Post Graduate Diploma in Counselling for Substance and Prevention and Treatment (distance mode) offered by Punjab University.

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