**Addiction Treatment in India; Professional, Ethical and Legal Challenges**

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**Abstract**: As per the *Magnitude of Substance Use in India* 2019 survey report, over 57 million of the Indian population are in need of professional help for Alcohol Use Disorder and around 7.7 million for Opioid Use Disorders. With the increasing demand for addiction treatment services, India urgently calls for professionalizing every aspect of the field. Frequent human rights violations and various unethical practices in Indian addiction treatment facilities have been reported through mass media. This is an unobtrusive study aiming at investigating legal, ethical and professional concerns associated with the treatment of substance use disorders in India, using newspaper reports and articles from 2016-2019. Both qualitative and quantitative content analysis was conducted. The content analysis of press media has displayed various human rights violations, the use of improper treatment modalities, lack of basic facilities at the treatment settings, and the presence of unqualified professionals in practice.

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

**Introduction**

In India, substance abuse is the most prevailing mental health morbidity as well as the most concerning public health issue. As per the 2019 survey report on prevalence and extent of 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, which is about 5.9% of the total population (1). There are several ministries responsible for addressing drug and alcohol-related issues in the country. Ministry of Social Justice and Empowerment (MSJE) and Ministry of Health and Family Welfare (MoHFW) implement demand reduction strategies which also include matters concerning treatment and rehabilitation of addicts (2). The current system of addiction treatment in India involves out-patient based brief interventions, medical detoxification, residential rehabilitation, substitution therapies, and community-oriented interventions. Based on the lists published by the MSJE and MoHFW, there are 398 IRCAs (Integrated Rehabilitation Centres for Addicts) in India as of 2017 and 212 Opioid Substitution Clinics as of 2019 (3,4). Also, de-addiction services are provided at various medical colleges and district hospitals in different states (2). In addition to these, there are several private de-addiction and rehabilitation centres all around the country, which outnumbers the government facilities. However, the 2019 survey reports a substantial treatment gap in the country. It states that treatment (including ‘spiritual ‘and ‘religious’ help) was accessible to only about 2.6 % and 12% of all alcohol and drug dependent individuals, respectively (1).

In India, on one side, a sizable portion of the affected population is deprived of professional help, and on the other side, exist serious concerns on the functioning of the available facilities offering de-addiction and rehabilitation services. In 2018 May, in connection with a lawsuit, Delhi State Legal Services Authority (DSLSA) submitted a comprehensive inspection report to the Delhi High Court, as directed by the court, on 124 de-addiction centres in the National Capital Territory of Delhi. The inspection team interacted with 2135 inmates from various centres and found 750 of them were involuntarily detained in such facilities. The report also details several other glitches, such as lack of basic facilities, not maintaining patient records, lack of trained professionals, and many other human rights violations (5). Daily News and Analysis (DNA) reported in 2018 that there are 250-300 de-addiction centres are running illegally in Delhi alone (6). This is not just an issue of Delhi; similar situations prevail all over the country. Surprisingly, many private addiction treatment facilities are operating beyond the radars of the laws and regulations of the country, and are still unregulated in many parts of India (7). The public press has been reporting several incidents of human rights violations and unethical practices in addiction treatment facilities of the nation. Though news media has 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 rarely documented in the research literature. Despite its seriousness, ethical and professional issues in addiction treatment in Indian scenario still appears to be a novel area of research. This paper is an effort to enquire legal, ethical, and professional concerns surrounding the addicting treatment to suggest probable solutions.

**Materials and Methods**

This is an unobtrusive research, conducted using secondary data published through daily newspapers. Content analysis of articles and reports that appeared between Jan 2016 to Dec 2019 in selected national English newspapers of India was done. Three highest circulated English newspapers (8); The Times of India, The Hindu, and Hindustan Times were chosen for sourcing the articles, and the online version was used. Search words used were de-addiction centre, and drug and alcohol rehabilitation. After scanning through the title and preview, 243 articles and reports were collected. Inclusion criteria were articles and news reporting the functioning of addiction treatment facilities, inspection or raid, human rights violation in such facilities, and interventions of the court or other government agencies on the matter. After omitting duplication and excluding unrelated, 157 articles were included in the final analysis. *NVivo 12 for Mac* was used for analyzing the collected newspaper content. 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, a line-by-line thematic coding was done for all the newspaper content based on three guiding questions: (1) What are the ethical violations prevailing in treating individuals with Substance Use disorders (SUDs)?; (2) What are the profession related concerns reported?; (3) Are there any other legal issues reported? The unit of analysis was phrases, and there was no latent coding, only manifest coding was done. The coding was done by the first author and was reviewed by the second author. Disagreements were discussed and resolved. In the newspaper content, there were individual raid or inspection reports of 51 different addiction treatment facilities. In the second stage, quantitative content analysis was conducted using articles that contained inspection reports of those 51 treatment facilities.

**Results**

The newspaper content used in the analysis were from 13 states, most of which were from the state of Panjab (n.70), followed by Delhi (n.21) and Tamil Nadu (n.18). Punjab and Delhi have reported the highest number of unethical incidents, and at the same time, these states have also reported maximum involvement of the court and efforts from the government to regulate the addiction treatment in the region. Table 1 lists down a state-wise summary of issues reported in the newspaper items used in the analysis.

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| Table 1. State-wise summary of issues reported\* | | |
| States | No. of news reports | Issues reported |
| Punjab | 70 | Detaining without consent/Involuntary admission, Not ensuring the safety of staff and patients, Lack of basic facilities, Mismanagement of medication, Non-licensed facilities, Overcrowded facilities, Not maintaining proper patient records, No regular inspection and monitoring by the authorities, Patients rescued from facilities by authorities, Physical and mental torture, Using violence in the pretext of treatment and to manage crisis, Forced labour, patients allegedly beaten to death by staff, Facilities lacking qualified staff, Abduction disguised as assisted admission, Denying communication and meeting with family, Patient’s death during attempted escape |
| Delhi | 21 | Denying communication with family. Patient’s death during attempted escape, Patients allegedly beaten to death by staff, Physical and mental torture, Lack of basic facilities, Abduction disguised as assisted admission, Not ensuring the safety of staff and patients, Mismanagement of medication, Non-licensed facilities, Sexual abuse, Detaining without consent/Involuntary admission, Forced labour. |
| Tamil Nadu | 18 | Not ensuring the safety of patients and staff, Lack of basic facilities, Detaining without consent/Involuntary admission, Physical and mental torture, Using violence in the pretext of treatment and to manage crisis, Patients allegedly beaten to death by staff, Non-licensed facilities, Overcrowded facilities, Facilities lacking qualified staff, Denying communication or meeting with family, Patients rescued from facilities by authorities, No regular inspection and monitoring by the authorities, Patient’s death during attempted escape |
| Haryana | 13 | Non-licensed facilities, Patients rescued from facilities by authorities, Physical and mental torture, Lack of basic facilities, Detaining without consent/Involuntary admission, Facilities lacking qualified staff, Overcrowded facilities, Denying communication with family, Forced labour, Using violence in the pretext of treatment and to manage crisis, Mismanagement of medication, No regular inspection and monitoring by the authorities. |
| Maharashtra | 11 | Non-licensed facilities, Patients rescued from facilities by authorities, Physical and mental torture, Patient allegedly beaten to death by staff, Forced labour, Detaining without consent/Involuntary admission, Lack of basic facilities, Facilities lacking qualified staff, Not maintaining proper patient records, Denying communication with family, Not ensuring the safety of patients. |
| Karnataka | 5 | Physical and mental torture, Patients allegedly beaten to death by staff, Forced labour, Not maintaining proper patient records, Detaining without consent/Involuntary admission, Patients rescued from facilities by authorities, Facilities lacking qualified staff, Non-licensed facilities, Lack of basic facilities. |
| Uttar Pradesh | 5 | Detaining without consent/Involuntary admission, Patient’s death during attempted escape, Abduction disguised as assisted admission, Not ensuring the safety of staff. |
| Rajasthan | 4 | Patient allegedly beaten to death by staff, Physical and mental torture, Using violence to manage crisis, Lack of basic facilities, Facilities lacking qualified staff. |
| Chandigarh | 3 | No regular inspection and monitoring by the authorities, Mismanagement of medication. |
| Andhra Pradesh | 2 | Non-licensed facilities, Physical and mental torture, Denying communication with family, Facilities lacking qualified staff, No regular inspection and monitoring by the authorities, detaining without consent/Involuntary admission. |
| Kerala | 2 | Mismanagement of medication, Quacks for chronic alcoholism. |
| Madhya Pradesh | 2 | Patient allegedly beaten to death by staff, Physical and mental torture, Detaining without consent/Involuntary admission, Patients rescued from facilities by authorities, Non-licensed facilities. |
| West Bengal | 1 | Physical and mental torture, Patient allegedly beaten to death by staff. |

\* Compiled using only newspaper reports from the Hindu, Times of India and Hindustan Times.

The qualitative content analysis yielded references to legal, ethical and profession related issues in the treatment of SUDs and other addictions in India. Our findings suggest that these three sets of issues- legal, ethical and professional- are strongly interconnected and coexisting in the country. The most prevailing challenge that needs immediate attention was the human rights violations at the treatment facilities and the professional deception in the private treatment industry. Individuals with SUDs are being treated inhumanely in many treatment facilities. The most coded node 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 linked with most other human rights violations. Unlike in several other countries, incidents of involuntary admissions are not court-ordered in India, and in many instances, it is being carried without prior assessments by psychiatrists or other qualified mental health professionals. References were found about a practice of forcefully shifting individuals with SUDs from their homes, mostly at late night or in the early morning, to the treatment facility at the family members’ request. In addition to its ethicality and legality, such unprofessional practices also raise several safety concerns both to patients and staffs. In two such incidents reported in newspapers, the staff were brutally injured as the patients overpowered staff in their attempt to shift them.

The newspaper references to abuse were often to the level of torture. Patients were often tied up, chained, beaten up with sticks, kept in locked rooms and punished in various other forms when they resisted continuing on the treatment. In an incident reported, the local residents blockaded the staff of the de-addiction centre after repeatedly hearing the inmates crying out for help to save them from being beaten up by the staff. There were few citations to such torture being used as punishment as well as in the pretext of ‘treatment’ and as a mode to manage crisis situations. Sometimes such torture led to the death of patients. In addition to physical and mental abuse, newspaper content gave ample references to facilities with substandard living conditions, forced labour and denying communication with family members. It is evident from the newspaper content analysis that torture and other human rights violations are not uncommon in the addiction treatment facilities of the country irrespective of whether the facilities or licensed or not. There have been many references from the newspaper content for unlicensed de-addiction centres and rehabs operating in the country. Ironically, in most instances, officials find out the existence of such illegal facilities existing only after receiving serious complaints from patients or families.

Lacking qualified addiction professionals and the presence of pseudo professionals in the treatment facilities were also reported in newspapers. Another main concern that is being found in the analysis was misuse or mismanagement of medication. Buprenorphine was the most cited medically-used drug that is being misused in different ways. References were found for it to be sold excessively without prescription in de-addiction centres and smuggled to peddlers. Instances were reported in which addicts rushing to government de-addiction centres for an ‘immediate relief’ with buprenorphine when they do not get heroin or their other similar drugs of choice. This drug takes its diversion either from manufactures, pharmacies or from treatment facilities and becomes available as a drug of abuse. Most of these issues were reported in the state of Punjab. Another similar concerning issue reported was in the state of Kerala in which herbal quacks laced with Disulfiram being widely marketed as a magical cure for alcoholism.

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| **Table 2. Relevant secondary data compiled 2016-2019\*** | |
| Number of unsatisfactory inspections of addiction treatment centres reported | 51 |
| Number of patients rescued from facilities functioning against norms | 1080 |
| No. of patients allegedly beaten to death by staff | 13 |
| Patients died during attempted escapes from centres | 5 |

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| **Table 3. Professional, Ethical and Legal Issues reported in connection with raids/inspections in 51 de-addiction or drug and alcohol rehab centres in India 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 manages the facility | 19 | 37% |
| Detaining without consent/Involuntary admission | 16 | 31% |
| Lock up facilities | 13 | 25% |
| Mismanagement of medication | 10 | 20% |
| Overcrowded | 7 | 14% |
| Using violence in the pretext of treatment | 6 | 12% |
| Using violence to manage crisis | 6 | 12% |
| Denying communication | 6 | 12% |
| Forced labour | 6 | 12% |
| Abduction disguised as assisted admission | 5 | 10% |
| Lack of proper patient records | 4 | 8% |

*\* Compiled using only newspaper reports from the Hindu, Times of India and Hindustan Times.*

As shown in Table 2, there have been 13 patients allegedly beaten to death by the staff of the de-addiction centres between Jan 2016 and Dec 2019. The actual number of such deaths would be higher as all such incidents would not be covered in newspapers. Also, there were reports of unnatural or accidental death or death under suspicious or unexplained circumstances in the treatment facilities. During the last four years, 1080 individuals were rescued from de-addiction and rehabilitation centres who are either admitted in illegal rehabs or involuntarily detained in licensed facilities.

Table 3 is a quantitative analysis of the issues reported in raids and inspections of addiction treatment facilities in India, as reported in the Times of India, the Hindu and Hindustan Times from 2016 Jan to 2019 Dec. Out of the 51 reported inspections, more than half of the facilities were not licensed at the time of raid/inspection with the concerned authorities. Similar to the qualitative findings, the most frequently reported issue was physical abuse like bludgeoning and tying the patients. There were specific mentions in the reports that some of these facilities use such violence in the pretext of treatment and as a way to manage the crisis. Other concerns reported are treatment facilities lacking the required trained professionals and basic amenities mandated by the Law.

**Discussions**

Our study has displayed several concerns that require urgent attention, which are being discussed in this section. There is currently a little literature on human rights violations and unethical practices in addiction treatment settings in India. The findings of this study display the vastness of legal, ethical and professional issues in the field.

***Coerced or involuntary treatment***

Coercion as a means to initiate substance use disorders treatment has existed for over a century, and the topic of coercion is well-discussed and debated in different parts of the world (9). According to NIDA, addiction treatment needs not necessarily to be voluntary to have an effective outcome (10). 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 (11, 12). However, it is being considered a human rights violation by the United Nations. The UNODC-WHO International Standards for the Treatment of Drug Use Disorders stipulates, “Informed consent should be obtained from a patient before initiating treatment and guarantee the option to withdraw from treatment at any time” (13). In India, the Mental Health Care Act 2017 (MHCA) mandates that informed consent needs to be obtained from the patients before initiating treatment. The Act does not use the term 'involuntary'; instead, 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 the Law mandates that one of them must be a psychiatrist (14). These provisions maintain a balance between human rights versus public health principles and based on the principle of ‘do no harm’ (15). However, our findings indicate that even treatment facilities that do not have any qualified mental health professionals admit individuals involuntarily. Between 2016-19, over one thousand individuals who are admitted involuntarily without following the norms were rescued from various addiction treatment facilities of the country by authorities.

Many a time, addiction treatment requires some degree of coercion and assistance to initiate the treatment. Not all coercive measures need to be perceived as autonomy infringement; rather, some degree of coercion can be interpreted as a means to ensure good care (16). This stipulation goes wrong when the treatment programs are not rights-based, and ethical principles of beneficence and non-malfeasance are violated. In many instances, the rights of individuals admitted involuntarily are violated further in the treatment facilities. In fact, involuntary medical treatments were regarded as the cause of repeated human rights violations in the world (17). Our findings suggest the same, individuals who are admitted involuntarily face more physical and mental torture. Those resisting to continue on the treatment were often locked up, physically and verbally abused, and denied any kind of communication to the outside world. Most of the 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 supervised by the staff. There are several valid reasons for not allowing mobile phones in treatment centres. For example, mobile phones can be used to obtain substances, and it can distract clients from their treatment program involvement (18). At the same time, our findings indicate that not allowing clients to communicate with their families or friends privately prevents them from informing in case any ill-treatment occurs at the facility and increase the incidents of human rights violations in de-addiction and rehabilitation centres in the country. In this regard, the draft ‘Delhi Substance Use Disorder Treatment, Counselling and Rehabilitation Centres Rules, 2018’ mandates every centre applying for registration or license to 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 of India is the abduction of individuals from their homes to treatment centres. Such abductions are innocently disguised as assisted admissions or ‘interventions’. In contrary to all international standards and laws of the country, a team of staff from the rehab facility goes to an individual's house upon the request of his or her family member and shifts the person to the facility, mostly forcefully. Treatment centres choosing night time or early morning to pick up individuals with SUDs also indicate such act as rather villainous than a professional intervention. Our study suggests that, in most instances, such forceful admissions take place without having a proper assessment and recommendation by qualified professionals.

***Physical and psychological abuse in the name of treatment***

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). Aggression and violence are being used in many treatment facilities as a way to address crisis situations as their staffs 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 in the pretext of treatment was explicitly mentioned in some of the newspaper reports. One of the inspection reports stated that “…Pretending as specialists, they would even beat up the inmates” (22). The use of physical and verbal abuse in the name of treatment, to an extent, resembles the practices at ‘Anexos’, the coercive addiction treatment facilities of Mexico (23). Individuals are abducted from their houses to Anexos, at the request of a family member, by using force.

It is a practice in several private treatment facilities to use forced labour in the pretext of treatment (recovery/treatment through labour). The treatment providers would argue that this would strengthen the clients to take responsibilities in life, but in reality, they save human resource costs by hiring less staff. 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 give remuneration if anyone is involved in any work at the facility (14). UNODC and WHO states that “neither detention nor forced labour have been recognized by science as treatment for drug use disorders” (24). Our findings also indicate that there are families who are 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 years old 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 that “all these methods to be some part of treatment to help him kick the bottle” (25).

The United Nations Committee Against Torture has emphasized that “*no exceptional circumstances whatsoever* may be invoked by a State Party to justify acts of torture in any territory under its jurisdiction” (26). The committee also holds the 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***

Addiction profession is multidisciplinary and includes those who directly engage in the treatment of substance use disorders. 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, our findings indicate that several facilities lack the required 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, counselling staff shares 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 misemployed in the addiction treatment settings as the prerequisites to become a counsellor has been vague. Our findings insinuate that more severe violations such as physical abuse are linked to the counselling staff.

Minimum Standards of Care for Centres Providing Substance Use Disorder Treatment and Rehabilitation, 2018 for National Capital Territory of Delhi, defines 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” (30). 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” (31). 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 solely 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 as a qualification to be a de-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” (32). One year later, the same facility is being 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 fifteen months stated that “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 (27). Lack of required training and education, in many instances, is directly linked with various other unethical practices. To ensure an effective clinical governance, United Nations Office on Drugs and Crime and World Health Organization stipulates 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" (24).

As stated in the introduction, the 2019 survey report displays a concerning prevalence of SUDs in India. The magnitude of SUDs is disproportionately higher than that of all the other severe mental illnesses combined (36). This high prevalence necessitates the need to create addiction speciality in medical as well as in the psychology-related profession in India, similar to several other countries. In 2007, a proposal was forwarded to the Indian Psychiatric Society for creating addiction medicine speciality in psychiatry (36). At present, there are few institutes in India offering DM in addiction psychiatry and post-doctoral fellowship in addiction medicine. On the other side, there is rarely any Indian university offering a degree program in addiction studies or addiction counselling (28). The National Institute of Social Defence and NIMHANS offers few short term addiction certificate courses and training.

It has evolved, by 2019, . GCCC have few educational providers in India and certifies addiction professionals in the region. s 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 the individuals have the right to have privacy, stay in a safe and hygienic environment, and to have facilities for recreation while on treatment in a mental health establishment (14). Various state rules also insist on addiction treatment facilities to have such minimum 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" (30). 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 (33). Another centre did not provide proper accommodation to individuals undergoing treatment, and there was not enough space between beds, also no potable water facility, and insufficient toilet and bathroom facilities (34). Also, our findings give several references for de-addiction centres being over-crowded.

**Limitations**

selected There is a possibility that many related incidents might not have been reported in the newspaper. Also, newsworthiness, sometimes, depends on the extremity of the incidents and popularity & influence of the people and the institutions involved. Hence, the findings are limited to the newspaper items we have reviewed; it does not give a 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 thirteen states were included in the analysis, and about 40% of it was from the state of Punjab. and display several other concerning issues While duly considering the above limitations of the study, the better understanding of the ground realities derived through our findings would guide future researches in this area.

**Conclusions**

Worldwide, the approach to addressing addiction is shifting from social exclusion to social reintegration and aiming at restoring their dignity and respect. It can be achieved by employing the 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 pus-filled with the old. Hence, individuals with SUDs and other addictions still face degrading treatment in the country. Even though India does not endorse compulsory drug detention centres, our study indicates that serval treatment facilities in the country resemble such detention centres in many ways. 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 the ethical framework if the laws of the country are not followed in terms of registration & licensing of the treatment facility, staffing as per the minimum standards of care, and ensuring no human rights violations are happening within the treatment facility. Instead of being a place for healing, our study indicates that many of the treatment facilities, especially privately owned, becomes the place of torture. Inattention from the concerned government bodies, lack of regulation in the addiction profession, and to an extent, lack of service users’ awareness contribute to this crisis. The Indian addiction treatment system should thrive for not just bringing in evidence-based, but more importantly, rights-based and compassion-driven interventions.

Treatment centres, research organizations, and the concerned government departments should spare no effort in effecting section 20 of the Mental Health Care ACT, 2017; every individual with mental illness including substance use disorders should be “protected from cruel, inhuman or degrading treatment” in the name of treatment. Ethics training for the clinical and supporting staff should be made mandate. Treatment providers should give due importance to clinical supervision if not making it mandatory. Considering the dearth of education providers, it is recommended that every treatment provider must find provisions for their staff training. Indian universities should initiate steps to start degrees on addiction studies/science/counselling. Though it might appear to be a remote prospect, similar to 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.

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