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Review Article:

Addressing the Rising Burden of Drug and Narcotic Abuse in India: A Multidisciplinary Review

Rohit DVRS*, Imran Sabri**, Jeneth Kumar Karmakar***

Affiliations:

* Senior Resident (Academic), Department of Forensic Medicine and Toxicology, All India Institute of Medical Sciences (AIIMS), Raipur, Chhattisgarh, India

** Faculty Member, Division of Forensic Medicine, Department of Biomedical Sciences, College of Medicine, King Faisal University, Al-Ahsa, Saudi Arabia

*** Assistant Professor, Department of Forensic Medicine and Toxicology, Tomo Riba Institute of Health and Medical Sciences, Naharlagun, Arunachal Pradesh 791110, India

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Correspondence:
Dr Imran Sabri
Faculty Member, Division of Forensic Medicine,
College of Medicine King Faisal University, Al-Ahsa, Saudi Arabia
Email: ikhan@kfu.edu.sa

Abstract

Drug and narcotic abuse in India has emerged as one of the most pressing public health crises of the twenty-first century. The 2019 national survey on the magnitude of substance use, commissioned by the Ministry of Social Justice and Empowerment and executed by the National Drug Dependence Treatment Centre (NDDTC) at the All India Institute of Medical Sciences (AIIMS), New Delhi, documented that approximately 14.6% of Indians aged 10–75 years are current users of alcohol, 2.8% have used cannabis in the past year, and 2.1% are current opioid users—figures that translate into tens of millions of affected individuals. This review synthesises contemporary epidemiological, clinical, sociological, and policy-oriented evidence to examine the drivers of this surge, the health and societal consequences of substance use disorders (SUDs), and the adequacy of existing regulatory and treatment infrastructure. Contributing factors include socio-economic distress, peer and familial influence, rapid urbanisation and globalisation, cross-border trafficking along the "Golden Crescent" and "Golden Triangle", and persistent gaps in the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 and subsequent policy instruments. Health consequences range from HIV and hepatitis C transmission among people who inject drugs to co-morbid mental illness and premature mortality. A coordinated, evidence-based response is proposed, anchored in demand reduction through school- and community-based prevention, expansion of opioid agonist therapy and psychosocial rehabilitation, harm-reduction services, destigmatisation, and targeted policy reform. Strengthening family and community support networks, integrating de-addiction services with primary and mental-health care, and reorienting legal frameworks toward public-health principles are essential to mitigate this epidemic.

Keywords: Drug abuse; Narcotics; Addiction; India; Opioids; Cannabis; Amphetamine-type stimulants; NDPS Act; Youth substance use;; De-addiction; harm reduction; Rehabilitation; Stigma; public health policy; epidemiology

Introduction: Substance use disorders (SUDs) constitute a global health emergency of extraordinary proportions. The United Nations Office on Drugs and Crime (UNODC) estimates that around 292 million people worldwide used drugs in 2022, a 20% increase over the preceding decade[1]. India, the world's most populous nation, sits at a geographically precarious

junction between the "Golden Crescent" (Afghanistan, Iran, Pakistan) and the "Golden Triangle" (Myanmar, Laos, Thailand), making it both a transit corridor and a consumer market for illicit substances[2,3]. Compounding this, the country is one of the largest licit producers of opium and a major pharmaceutical manufacturer, facilitating diversion of narcotic and psychotropic substances into illicit channels[4].

The 2019 Magnitude of Substance Use in India survey the most comprehensive national assessment to date... estimated that approximately 16 crore (160 million) individuals in India use alcohol, and that more than 3 crore (30 million) use cannabis. Approximately 2.26 crore individuals use opioids, including heroin and pharmaceutical opioids; 1.18 crore use sedatives and inhalants; and nearly 60 lakh use cocaine and amphetamine-type stimulants5. Substance use is especially concerning among adolescents and young adults; school-based and community surveys have consistently documented early initiation—often before the age of 15—to tobacco, alcohol, inhalants, and cannabis[6,7].

This paper defines, for the purposes of this review, *drug abuse* as the excessive, maladaptive, or dependence-producing use of psychoactive substances for non-therapeutic purposes, consistent with the framework of the International Classification of Diseases, 11th Revision (ICD-11)[8]. Under section 2 of the Narcotic Drugs and Psychotropic Substances Act, 1985, *narcotic drug* is defined to include coca leaf, cannabis (hemp), opium, poppy straw, and all manufactures, derivatives, preparations, and salts thereof, along with any other substance the Central Government may declare to be a narcotic drug[9].

This review has three aims: first, to describe the current epidemiology and emerging trends of drug and narcotic abuse in India; second, to analyse the socio-economic, cultural, familial, and policy drivers that underpin this surge; and third, to outline an evidence-based, multidisciplinary framework for prevention, treatment, rehabilitation, and policy reform. The discussion is intended to inform clinicians, public-health professionals, policymakers, law-enforcement agencies, educators, and community stakeholders.

Historical and Cultural Background:

Psychoactive substance use in India has a documented history extending over several thousand years. Cannabis preparations - bhang, charas, and ganja - have been woven into Hindu religious practice since at least the

second millennium BCE, referenced in the Atharva Veda as one of five sacred plants. Colonial-era monopolies over opium production and trade subsequently embedded the crop into the rural economy of states such as Rajasthan, Madhya Pradesh, and Uttar Pradesh—areas that continue to be the only licit opium-producing regions in the country today[4,10]. The post-independence regulatory architecture culminated in the Narcotic Drugs and Psychotropic Substances Act (NDPS) of 1985, which harmonised Indian law with the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic[9,11].

Since the 1960s, counter-cultural influences, demographic transition, and market-driven urbanisation have altered the profile of substance use[12]. Traditional ritual and agrarian patterns of consumption have increasingly been displaced by recreational poly-substance use, driven by globalised youth cultures and evolving supply chains[13]. Contemporary concerns—such as pharmaceutical opioid diversion, injection drug use, and the emergence of new psychoactive substances (NPS)—require responses grounded in the synthesis of public-health, social-science, and legal expertise[14,15].

Scope and Objectives

This multidisciplinary review integrates epidemiological data from the NDDTC 2019 national survey, peer-reviewed literature indexed in PubMed and Scopus (2015–2024), reports of the UNODC and WHO, and grey-literature publications of the Narcotics Control Bureau (NCB), National Crime Records Bureau (NCRB), and relevant Indian ministries. The objectives are to: (i) quantify the current burden and regional variation of substance use; (ii) identify key demand- and supply-side drivers; (iii) examine health, social, and economic consequences; (iv) appraise prevention and treatment interventions; and (v) recommend policy and service-delivery reforms aligned with international best practice[5,11,16].

2. The Current Scenario of Drug and Narcotic Abuse in India

2.1 Epidemiology, Statistics, and Trends

The Ambekar *et al.* 2019 national survey remains the most comprehensive source of Indian substance-use data and provides the figures summarised in this section[5]. Alcohol is the most prevalent psychoactive substance (14.6%; approximately 16 crore current users), followed by cannabis (2.8%; approximately 3.1 crore past-year users) and opioids (2.1%; approximately 2.3 crore current users, of whom roughly 0.7 crore have

dependence). Inhalant use is notably higher among children than among adults (1.17% vs 0.58%), highlighting the need for targeted adolescent interventions. Use of sedatives and stimulants, though lower in overall prevalence (approximately 1.08% and 0.18% respectively), has been rising[5,17].

The survey also revealed pronounced gender asymmetry: across all categories, men consumed substances more frequently than women, with male-to-female ratios exceeding 10:1 for most substances[5]. Geographically, the states of Punjab, Uttar Pradesh, Haryana, Delhi, Maharashtra, Rajasthan, Andhra Pradesh, Gujarat, Madhya Pradesh, and Bihar jointly account for a disproportionate share of users for specific substances. North-eastern states and Punjab report the highest prevalence of opioid use, reflecting proximity to cross-border trafficking routes[5,18].

Enforcement data echo these epidemiological findings. The National Crime Records Bureau recorded 133,134 cases under the NDPS Act in 2022, compared with 59,806 in 2020—a more than two-fold rise in two years[19]. Seizure data from the Narcotics Control Bureau show steady increases in the interception of heroin, methamphetamine, and pharmaceutical opioids such as tramadol and buprenorphine[20]. The COVID-19 pandemic temporarily disrupted supply chains but catalysed online procurement, courier-based distribution, and shifts to pharmaceutical and synthetic substances[21].

2.2 Commonly Abused Substances

The principal substances of abuse in India may be classified according to pharmacological action rather than colloquial categorisation. *Depressants* include alcohol, opioids (heroin, opium, and pharmaceutical opioids such as tramadol, buprenorphine, and codeine-containing cough syrups), benzodiazepines, and volatile inhalants (solvents, adhesives, fuels). *Cannabinoids* (bhang, ganja, charas, hashish) remain the most widely used illicit substances. *Stimulants* include tobacco (nicotine), caffeine, and amphetamine-type stimulants (ATS) such as methamphetamine and ephedrine derivatives. *Hallucinogens* and *dissociatives* (ketamine, LSD, psilocybin) account for a small but growing share of urban recreational use[5,22].

Poly-substance use is increasingly common, with combinations of alcohol and cannabis, opioids and benzodiazepines, and stimulants and alcohol being particularly hazardous owing to synergistic effects on respiratory depression, cardiovascular stress, and cognitive

impairment[23]. Injection of heroin, pharmaceutical opioids, and buprenorphine–antihistamine combinations is an established pattern in the north-east and metropolitan pockets, with concomitant transmission of HIV and hepatitis C virus (HCV)[24,25]. The rise of new psychoactive substances—including synthetic cannabinoids and cathinones purchased through online channels—poses additional diagnostic and regulatory challenges[15].

3. Factors Contributing to the Rise of Drug and Narcotic Abuse

The determinants of substance use operate at multiple levels: individual, familial, community, societal, and structural. A bio-psycho-social-environmental framework is therefore most appropriate for analysing these drivers[26].

3.1 Socioeconomic Determinants

Poverty, unemployment, low educational attainment, and rural-to-urban migration are consistently associated with elevated risk of substance-use disorders in India and globally[27,28]. Systematic reviews show a strong inverse gradient between socio-economic position and opioid-related overdose mortality[28]. Within India, substance use is not confined to the economically disadvantaged: higher-income strata show greater use of alcohol and recreational drugs, while lower-income groups carry a disproportionate burden of opioid and inhalant dependence because such substances are cheaper and more accessible[5,29]. Unstable employment, piecework, and the expansion of the informal economy have been linked to increased alcohol consumption and psychotropic misuse among men in their twenties and thirties[30]. For women, socio-economic marginalisation, domestic violence, and intimate-partner substance use are critical determinants of initiation and relapse[31].

3.2 Familial, Peer, and Cultural Influences

The family is the primary socialising agent for attitudes toward psychoactive substances. Parental substance use, permissive household norms, weak parental monitoring, and exposure to intra-familial violence strongly predict adolescent initiation[32,33]. Conversely, warm, authoritative parenting and consistent family rituals confer protective effects[32].

Peer networks replace family influence during adolescence and are among the most robust predictors of substance-use initiation. Longitudinal social-network studies demonstrate both peer-selection (users befriend users) and peer-socialisation (friends become more similar over time) effects for alcohol, tobacco, and cannabis[34]. Media

portrayals—particularly in films, streaming platforms, and user-generated short-video content—normalise substance use among youth and should be addressed through media literacy in school curricula[35].

Cultural acceptability mediates these effects. Where alcohol or cannabis use is culturally sanctioned (as at festivals such as Holi or in certain religious contexts), prevalence is higher, although ritualised use is not equivalent to problematic dependence[10,36]. Tobacco and alcohol advertising—despite partial regulation—continues to reach adolescents through sponsorship, surrogate products, and digital media, reinforcing pro-substance norms[37].

3.3 Supply-Side Drivers and Policy Gaps

Supply-side determinants include the proximity of production zones in Afghanistan, Myanmar, and the Bay of Bengal shipping corridor; trafficking routes through Punjab, the North-East, and coastal Maharashtra and Gujarat; and diversion of licit opium and pharmaceutical opioids[2,3,20]. Online cryptomarkets and courier-based distribution have emerged as additional vectors, particularly for synthetic stimulants and new psychoactive substances[15,21].

From a policy perspective, the NDPS Act, 1985 has been criticised for its emphasis on criminal penalties over public-health measures, for ambiguities in distinguishing users from traffickers, and for insufficient integration with mental-health services[11,38]. The 2014 NDPS Amendment improved access to essential narcotic medicines for palliative care but did not fundamentally re-orient the framework toward demand reduction and treatment[11]. The Mental Healthcare Act, 2017 formally recognises substance-use disorders as mental disorders and creates a rights-based entitlement to treatment, yet implementation remains uneven[39].

4. Impacts of Drug and Narcotic Abuse

4.1 Health Consequences

Substance use is a leading contributor to India's non-communicable and communicable disease burden. Alcohol-attributable mortality includes liver cirrhosis, hepatocellular carcinoma, haemorrhagic and ischaemic stroke, cardiomyopathy, and road-traffic injury; the Global Burden of Disease 2019 study attributed approximately 2.6 million deaths globally per year to alcohol[40]. Tobacco use accounts for nearly 1.3 million deaths annually in India, chiefly from cardiovascular disease, chronic obstructive pulmonary disease, and cancers of the oral cavity, lung, and oesophagus[41].

People who inject drugs (PWID) experience disproportionate

rates of blood-borne infections: in Indian PWID cohorts, HIV prevalence ranges from 5% to over 30% depending on location, and hepatitis C seroprevalence frequently exceeds 50%[24,25]. Overdose is the leading cause of premature mortality in this group, with respiratory depression from opioids compounded by concurrent benzodiazepine or alcohol use[42]. Co-occurring psychiatric disorders—most commonly depression, anxiety disorders, post-traumatic stress disorder, and primary psychotic illness—are reported in 30–60% of treatment-seeking adults with substance use disorders and complicate recovery[43].

Maternal substance use—particularly of alcohol, tobacco, and opioids—is associated with neonatal abstinence syndrome, foetal alcohol spectrum disorders, low birth weight, and adverse neurodevelopmental outcomes[44]. Adolescents face unique vulnerabilities because continuing brain development until the mid-twenties renders the prefrontal cortex and limbic system especially susceptible to the neurotoxic effects of early substance exposure[45].

4.2 Social and Economic Consequences

Substance use disrupts family functioning, educational attainment, and workforce participation. A 2021 multi-country WHO analysis estimated the cost of alcohol-related harm at 1.5–2.6% of GDP in low- and middle-income countries, encompassing productivity loss, healthcare expenditure, and justice-system costs[46]. In India, household surveys have linked alcohol and opioid dependence to catastrophic health expenditure, indebtedness, and impoverishment[47].

Substance-use disorders are strongly associated with interpersonal and family violence, both as risk factors and as consequences; women and children in affected households bear an especially heavy toll[48]. The link between substance use and acquisitive crime (theft, burglary) and predatory violence is well-documented, although causality operates in both directions and is modulated by socio-economic context[49]. Stigma—from healthcare workers, employers, and communities—further impedes help-seeking, treatment retention, and reintegration, and must be targeted directly through public-education campaigns and anti-discrimination policy[50].

5. Interventions, Solutions, and the Way Forward

An effective national response requires balanced attention to *demand reduction* (prevention, treatment, rehabilitation), *supply reduction* (law enforcement, border control,

pharmaceutical regulation), and *harm reduction* (interventions that minimise the health and social consequences of use without necessarily requiring abstinence)[51].

5.1 Preventive Measures

Primary prevention is most cost-effective when initiated before the typical age of substance-use initiation. Evidence-based school curricula—such as the Unplugged and Life Skills Education programmes—improve refusal skills, normative beliefs, and decision-making and have been adapted for Indian settings[52,53]. The Ministry of Social Justice and Empowerment's Nasha Mukt Bharat Abhiyaan (Drug-Free India Campaign), launched in 2020, targets 272 most-affected districts with a combination of awareness, community outreach, and rehabilitation activities[54].

Family-based interventions that enhance parenting skills, improve parent–child communication, and address intra-familial risk factors have demonstrated sustained reductions in adolescent substance use and should be scaled through the anganwadi, ASHA, and school-health systems[55]. Universal prevention must be complemented by selective interventions for at-risk groups—children of parents with substance-use disorders, street-connected children, out-of-school adolescents, and incarcerated youth—and indicated interventions for those already showing signs of problematic use[53].

5.2 Treatment and Rehabilitation

Substance-use disorders are chronic, relapsing conditions best managed through long-term, integrated care. The core components are detoxification and stabilisation; pharmacotherapy (opioid agonist therapy with buprenorphine or methadone; naltrexone; disulfiram, acamprosate, and naltrexone for alcohol-use disorder); evidence-based psychotherapies (motivational interviewing, cognitive-behavioural therapy, contingency management, 12-step facilitation); and aftercare with relapse-prevention support[56,57].

In India, the Drug De-Addiction Programme (DDAP) of the Ministry of Health and Family Welfare operates through 122 drug-treatment clinics (DTCs) and augmented district-level services, while the Ministry of Social Justice and Empowerment supports over 340 Integrated Rehabilitation Centres for Addicts (IRCAs) run in partnership with NGOs[54,58]. Opioid agonist therapy (OAT), integrated with HIV care, has been shown to retain patients in treatment and reduce illicit opioid use, injection frequency, and HIV transmission, and should

be urgently scaled—particularly in the north-east and north-west of the country[59].

Rehabilitation should be community-based wherever possible, combining vocational training, peer-support groups, family counselling, and gradual social reintegration. Tele-psychiatry and digital cognitive-behavioural interventions have expanded access to remote and under-served populations, especially since the COVID-19 pandemic[60].

5.3 Harm Reduction

Harm-reduction services—including needle and syringe programmes (NSP), targeted HIV interventions, naloxone distribution for overdose reversal, supervised consumption sites, and low-threshold drop-in centres—are supported by a strong international evidence base and are endorsed by the WHO, UNAIDS, and UNODC[16]. India has been an early adopter in South Asia through the National AIDS Control Programme's Targeted Intervention (TI) projects for PWID, yet coverage remains below the 40% threshold recommended by the WHO for population-level impact[61]. Expansion of take-home naloxone, incorporation of hepatitis C treatment (direct-acting antivirals) into OAT services, and legal protections for harm-reduction workers are priority reforms[62].

5.4 Policy Reform and Multi-Sectoral Coordination

A reorientation of the NDPS Act toward a public-health model—including clearer distinctions between small-quantity possession for personal use and trafficking, proportionate sentencing, and statutory access to treatment for people who use drugs—has been advocated by Indian scholars and international bodies alike[11,38]. Integration of SUD services with primary care under the Ayushman Bharat Health and Wellness Centres would dramatically increase reach and reduce stigma[63]. Strong inter-ministerial coordination between the Ministries of Health and Family Welfare, Social Justice and Empowerment, Home Affairs, Finance, and Education—alongside state governments and civil-society organisations—is essential[11,54].

6. Conclusion

Drug and narcotic abuse in India is a complex, evolving public-health crisis with deep social, economic, and medical ramifications. Contemporary epidemiological data establish that alcohol, cannabis, and opioids affect tens of millions of Indians, with particular vulnerability among adolescents, young men, economically marginalised populations, and people who inject drugs in border states. No single measure—whether penal, clinical,

or educational—will suffice; only an integrated strategy that combines prevention, treatment, harm reduction, and policy reform can reverse current trends.

Priority actions include: (i) expansion and standardisation of school- and community-based preventive programmes, with rigorous evaluation; (ii) scaling of opioid agonist therapy and integrated HIV–HCV services, particularly in highly affected states; (iii) integration of substance-use care into primary-care and mental-health services; (iv) re-orientation of the NDPS Act toward a public-health and human-rights framework, including diversion of low-level users from the criminal-justice system to treatment; (v) targeted reduction of stigma through media campaigns, professional training, and anti-discrimination measures; and (vi) investment in high-quality research, including a regularly updated national substance-use survey, health-system costing studies, and implementation research on locally adapted interventions.

The ultimate goal is a society in which individuals affected by substance-use disorders are treated with dignity, receive effective evidence-based care, and are supported in their reintegration into family, community, and economic life. Achieving this goal will require sustained political commitment, adequate financing, and genuine collaboration among government agencies, healthcare providers, civil-society organisations, and the communities most affected by this epidemic.

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