SCHEME OF
NATIONAL ACTION PLAN
FOR DRUG DEMAND REDUCTION

Government of India

Ministry of Social Justice and Empowerment

(Revised w.e.f 01-04-2020)

PREFACE

Substance use disorders are serious problem adversely affecting the social fabric of the country. Dependence to any substance not only affects the individual's health but also disrupts their families and the whole society. Regular consumption of various psychoactive substances leads to dependence of the individual. Some substance compounds may lead to neuro-psychiatric disorders, cardiovascular diseases, as well as accidents, suicides and violence. Therefore, substance use and dependence needs to be viewed as a psycho-social-medical problem.

2. The Ministry of Social Justice & Empowerment has been implementing the Central Sector Scheme for Prevention of Alcoholism and Substance (Drug) Abuse since 1985-86 with the objective of creating awareness and educate people about the ill-effects of alcoholism and substance abuse and for providing a whole range of community based services for identification, motivation, counselling, de-addiction, after care and rehabilitation for Whole Person Recovery (WPR) of substance and alcohol users.

3. Ministry of Social Justice and empowerment has conducted the first National Survey on Extent and Pattern of Substance Use in India through National Drug Dependence Treatment Centre (NDDTC) of the All India Institute of Medical Sciences (AIIMS), New Delhi during 2018. The report of the survey was released in February, 2019. As per the report, Alcohol is the most common psychoactive substance used by Indians followed by Cannabis and Opioids.About 16 Crore persons consume alcohol in the country, 3.1 Crore individuals use cannabis products and 2.26 Crore use opioids.More than 5.7 Crore individuals are affected by harmful or dependent alcohol use and need help for their alcohol use problems, about 25 lakh suffer from cannabis dependence and approximately 77 lakh individuals are estimated to need help for their opioid use problems. In order to prevent the Substance use and dependence in the Country, the Ministry formulated and enacted National Action Plan for Drug Demand Reduction (NAPDDR) (2018-2025)

4. The objectives and activities of the Scheme of Prevention of Alcoholism and Substance (Drug) Abuse form a subset of the objectives of the NAPDDR, which is the main scheme under which all the initiatives towards DRUG DEMAND REDUCTION in the country can be carried out through Government of India, State/UT Governments, implementing agencies like PRIs,NGOs,Trusts, ULBs, Autonomous organisations, Technical Forums, Hospitals, Prison Administrations and so on. In order to have an umbrella scheme under which projects and

schemes can be implemented through both modes of funding as in a central sector and a centrally sponsored scheme, the Scheme of Assistance for Prevention of Alcoholism and Substance (Drug) Abuse has been merged into NAPDDR. The resultant scheme of NAPDDR is an umbrella scheme under which all the projects, components and interventions would be converged and implemented in a focussed manner with flexible utilization of funds allocated and human resources engaged for the scheme

5. The Revised Scheme shall be effective from 1stApril, 2020.

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1. BACKGROUND

1.1 Article 47 of the Constitution provides that “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.”

1.2 India is a signatory to the three UN Conventions namely, Single Convention on Narcotic Drugs, 1961, Convention on Psychotropic Substances, 1971 and Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. Article 38 of the Single Convention on Narcotic Drugs, 1961 and Article 20 of the Convention on Psychotropic Substances, 1971 obligates countries for taking all practicable measures for the prevention of harmful use of drugs/psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and also for promoting training of personnel in these areas.

1.3 The Government of India has enacted the Narcotic Drugs and Psychotropic Substances (NDPS) Act in the year 1985 to make stringent provisions for the control and regulation of operations relating to narcotic drugs and psychotropic substances. Section 71 of the NDPS Act, 1985 (Power of Government to establish centres for identification, treatment, etc., of addicts and for supply of narcotic drugs and psychotropic substances) states that “The Government may establish, recognize or approve as many centres as it thinks fit for identification, treatment, management, education, after-care, rehabilitation, social re-integration of addicts and for supply, subject to such conditions and in such manner as may be prescribed, by the concerned Government of any narcotic drugs and psychotropic substances to the addicts registered with the Government and to others where such supply is a medical necessity.”

1.4 The Government of India has also brought out a National Policy on Narcotic Drugs and Psychotropic Substances (NDPS) in 2012 to serve as a guide to various Ministries/Departments, State Governments, International Organisations, NGOs, etc. and re-assert India's commitment to combat the drug menace in a holistic manner. The Policy, inter-alia, states the role of the Government for treatment, rehabilitation and social reintegration of individuals with substance dependence. For the purpose of drug demand reduction, the Policy lists out the roles of various Ministries/Departments which include conducting National Survey on Drug Abuse, training of doctors in Government Hospitals in de-addiction, supporting other hospitals in setting up de-addiction and treatment facilities, establishing separate facilities for female patients, developing minimum standards of care to be followed by de-addiction centres, inclusion of rehabilitation and social reintegration programmes for victims of substance use/ dependence in all Government run treatment centres etc. The Policy also noted that several de-addiction centres have come up in the private sector and states that the Central Government shall lay down standards and guidelines for these de-addiction centres to follow and shall recognize such centres as are found to be meeting the standards and guidelines.

2. **Extent and Pattern of Substance Use in India**

2.1 Ministry of Social Justice and empowerment has conducted the first National Survey on Extent and Pattern of Substance Use in India through the National Drug Dependence Treatment Centre (NDDTC) of the All India Institute of Medical Sciences (AIIMS), New Delhi during 2018. The report of the survey was released in February, 2019. The report of the Survey presents the major findings in terms of proportion of Indian population using various substances and those affected by substance use disorders.

2.2 As per the report, Alcohol is the most common psychoactive substance used by Indians followed by Cannabis and Opioids.

2.3 About 16 Crore persons consume alcohol in the country, 3.1 Crore individuals use cannabis products and 2.26 Crore use opioids.

2.4 More than 5.7 Crore individuals are affected by harmful or dependent alcohol use and need help for their alcohol use problems, about 25 lakh suffer from cannabis dependence and approximately 77 lakh individuals are estimated to need help for their opioid use problems.

3. OBJECTIVES

Substance use disorders are serious problem adversely affecting the social fabric of the country. Dependence to substances not only affects the individual's health but also disrupts their families and the whole society. Of late, the menace of substance dependence in the younger generation has been rising all over the world and India is no exception to it.

i. The prime objective is to focus on preventive education, awareness generation, identification, counselling, treatment and rehabilitation of individuals with substance dependence, training and capacity building of the service providers through collaborative efforts of the Central and State Governments and Non-Governmental Organizations

ii. Create awareness and educate people about the ill-effects of substance dependence on the individual, family, workplace and the society at large and reduce stigmatization of and discrimination against, groups and individuals dependent on substances in order to integrate them back into the society

iii. Develop human resource and build capacity to

- Provide for a whole range of community based services for the identification, motivation, counselling, de-addiction, after care and rehabilitation for Whole Person Recovery (WPR) of dependents ;
- Formulate and implement comprehensive guidelines, schemes, and programmes using a multi-agency approach for drug demand reduction;

- Undertake drug demand reduction efforts to address all forms of illicit use of any substances;
- Alleviate the consequences of substance dependence amongst individuals, family and society at large.
- Facilitate research, training, documentation, innovation and collection of relevant information to strengthen the above mentioned objectives;

4. **SCOPE OF ACTIVITIES** to be undertaken under the NAPDDR are given at **Appendix-I**

5. COMPONENTS ADMISSIBLE FOR FINANCIAL ASSISTANCE

The following components are admissible for financial assistance under the NAPDDR:

i. Preventive Education and Awareness Generation
ii. Capacity Building
iii. Treatment and Rehabilitation
iv. Setting quality standards
v. Focused Intervention in vulnerable areas
vi. Skill development, vocational training and livelihood support of ex-user/ dependent.
vii. Survey, Studies, Evaluation, Research and Innovation on the subjects covered under the Scheme.
viii. Programmes for Drug Demand Reduction by States/UTs
ix. Programme Management
x. Any other activity or item which will augment/strengthen the implementation of NAPDDR

6. Preventive Education and Awareness Generation

6.1 Preventive education and awareness generation programmes to address specific target groups (vulnerable and at risk groups) in their neighbourhood, educational institutions, workplace, slums etc. with the purpose of sensitising the target groups and the community about the impact of substance dependence and the need to take professional help for treatment. The programmes would be carried out through collaborative efforts of other Central Ministries, State Governments, Universities, Training Institutions, NGOs, other voluntary organizations etc.

6.2 Though NAPDDR lists out an indicative list of programmes to address specific target groups (Appendix-I), the implementing agencies may devise other innovative interventions for early prevention of substance use and dependence. Efforts should be made to develop a prevention strategy that is based on scientific evidence, both universal and targeted, in a range of settings. With an aim to expand the outreach and specifically focus on vulnerable groups, the implementing agencies may consider the following:

a) Programmes should start at the school level and continue with college students.

b) Parents/teachers should be sensitised to develop skills to understand the psychology of the youth and to help them keep away from substance use and to accept the need for treatment if initiated.

c) High-risk groups like commercial sex workers, mobile population like tourists and truck drivers, children of alcohol and other substance dependents, children of HIV affected parents, street children, prisoners and school dropouts should specifically be addressed through these programmes.

d) Awareness programme should be appropriate to the local culture and in the local language. Utilization of audio visual aids such as OHPs, slides, CDs, Power Point, films, TV and Radio Spots etc. and use of innovative methods like street plays, puppet shows, seminars, group discussions are to be included.

e) People holding positions of respect and credibility like Panchayat leaders, school/college Principals/teachers/Lecturers etc. should be associated with the programmes.

6.3 **Eligible Organizations:** Financial assistance shall be provided for carrying out preventive education and awareness generation programmes in collaboration with the following organizations/institutions:

i. University Grants Commission (UGC) and All India Council for Technical Education (AICTE) for the higher educational institutions;
ii. Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULBs), organizations/institutions fully funded or managed by State/ Central Government or a local body;
iii. Nehru Yuva Kendra Sangathan (NYKS), National Service Scheme (NSS);
iv. Universities, Social Work Institutions, other reputed educational institutions, Association of Indian Universities, Kendriya Vidyalaya Sangathan (KVS), NCERT, SCERT;
v. State Level Coordinating Agencies (SLCAs earlier RRTCs) and IRCAs of Ministry of Social Justice and Empowerment working in the field of drug demand reduction with good track in performance;
vi. Organizations/Institutions associated with Awardees who have been conferred National Awards for outstanding services in the field of prevention of alcoholism and substance (drugs) abuse;
vii. Any other organization/institution considered fit and appropriate by the Project Management Committee of the Ministry.

6.**4** **Norms for Financial Assistance:** An Annual Action Plan (AAP) will be prepared during each financial year for carrying out preventive education and awareness generation programmes in collaboration with organizations/institutions specified in Para 6.3. Financial assistance would then be provided as per AAP to the NISD and/or State Governments or other organizations.

6.4.1 Institutions would be eligible to receive Grants up to 100% for conducting the programmes.

6.4.2 Every organization/institution receiving funds under this component shall submit Utilization Certificates (UCs) as per provisions of GFR.

6.5 **Media Publicity:** Preventive Education and Awareness generation through media publicity would also be accorded adequate focus for which a well-targeted media campaign to spread the message against ill effects of drug abuse through social, electronic, print, digital and online media will be launched.

7 Capacity Building

7.1 Training is an important component for capacity building and skill development of various stakeholders and the service providers. Training is important to ensure effective prevention, appropriate treatment and for holistic management of individuals with substance dependence. It is also important to have exposure to the new trends regarding the kind of substances used, associated medical and psychiatric problems, treatment models/approaches through participation in training programmes and conferences.

7.2 Capacity building programmes would be undertaken to provide intensive training to personnel in the identification, treatment, after-care, rehabilitation and social reintegration of substance dependents. To create a pool of trained human resources personnel and service providers, the following list of programmes have been enlisted under the NAPDDR:

i. Training of teachers and counsellors on different assessment tools for early identification of substance use and associated factors

ii. Workshops, Seminars and interactions with parents

iii. Training programmes on de-addiction counselling and rehabilitation for social workers, functionaries of IRCAs, working professionals etc.

iv. Orientation Courses in the field of substance use prevention for functionaries of IRCAs including nurses and ward boys

v. Training Course for service providers, both in Government, Semi-Government and Non-Government Settings

vi. Training programmes for representatives of PRIs and ULBs, police functionaries, paramilitary forces, judicial officers, bar council etc. on substance use prevention

vii. Training of staff in Prisons and Juvenile Homes and ICPS functionaries in order to ensure respectful, non-judgmental and non-stigmatizing attitude of the staff and for ensuring appropriate referrals and treatment.

viii. Basic Training Course in awareness of substance use and dependency associated health problems and various treatment approaches so as to develop a core group of peer educators, counsellors etc. to assist in dissemination of accurate information about various substances, their use, issues of dependency, treatment options and for overall improvement of behavioural issues associated with substance use.

ix. Specialized training for those who work with vulnerable groups, such as patients with psychiatric co-morbidities, children and women, including pregnant women.

x. Any other training/skill development which furthers the objectives of NAPDDR.

7.3 Ministry of Social Justice and Empowerment has established a National Centre for Drug Abuse Prevention (NCDAP) at National Institute Social Defence, New Delhi (NISD) to serve as an apex body for training, research and documentation in the field of alcoholism and drug demand reduction.

7.4 Ministry have designated Organisations/Institutions of repute with adequate experience in the field of Drug Demand Reduction and having consistently good

track record as Regional Resource Training Centre (RRTC) following the procedure prescribed by it. RRTCs so designated are essentially being responsible for devolution of the mandate of NCDAP in their jurisdictional area. Now these already designated RRTCs and to be further selected in future shall be called as a State Level Coordinating Agency (SLCA). Following are the roles and responsibilities of these SLCAs-

i. These SLCAs shall act as technical support group to the State Government.

ii. These SLCAs will help the State Government for preparing their Annual Action Plan.

iii. To coordinate with the State Government in proper implementation of the Annual Action Plan.

iv. To prepare an annual action plan for their activities which should include visits, capacity Building, Monitoring and evaluation exercise (IRCAs, Agencies implementing ODIC & CPLI).

v. To report their field visit on the E- Anudaan portal, uploading the photograph and their observation as and when the visit carried out. This will help to the Ministry in taking decision for renewal of project.

7.5 Eligible Organizations: Capacity building programmes would be carried out as specified in Para 7.2 by NISD in collaboration with the concerned Ministries/Departments/Organizations/Institutions of the Government of India as well as the State Governments such as SCERTs/DIETs, educational institutions, SLCAs, Medical Institutions etc.

7.6 Norms for Financial Assistance: An Annual Action Plan (AAP) will be prepared during each financial year for carrying out the above programmes. Financial assistance shall be provided as per the AAP to NISD and/or to the State Government or other organizations on the basis of their proposals.

Financial Assistance to SLCAs (formerly known as RRTCs) will be provided as per the approved Cost Norms (Appendix-IV).

7.6.1 Institutions would be eligible to receive grant up to 100% for conducting the programmes.

7.6.2 Every organization/institution receiving funds under this component shall submit Utilization Certificates (UCs) as per provisions of GFR.

8.0 Treatment and Rehabilitation

8.1 Under the NAPDDR, the Ministry of Social Justice and Empowerment would provide financial assistance for Drug Treatment Clinics for outpatient treatment while for inpatients it will be provided for running and maintenance of Integrated Rehabilitation Centres for Addicts (IRCAs). At presents about 480 IRCAs are supported by the Ministry, majorly operated by NGOs. These IRCAs provide services for identification of individuals with harmful use and dependence of any substance, motivational counselling, detoxification/de-addiction and Whole Person Recovery, after care and reintegration into the social mainstream. Renewal of existing IRCAs will be done as per the following guidelines-

8.1.1 For the release of grant-in-aid, an Organization/Institution, shall apply online on the website http://grants-msje.gov.in/ngo-login and forward their application along with the relevant documents and the utilisation certificate (UC) of expenditure till 31st March of the previous financial year (to be uploaded along with the application) before first week of May every year to the Ministry of Social Justice & Empowerment (Social Defence Division), Government of India, New Delhi. Incomplete applications shall be liable to be rejected for renewal.

8.1.2 Implementation of EAT module will be mandatory for the organizations desirous of seeking renewal of grant-in-aid.

8.1.3 Organizations are required to submit beneficiary's data on e-Anudaan portal on daily basis along with profile of beneficiaries in Drug Abuse Monitoring System (DAMS) maintained by NISD.

8.1.4 Renewal of the applications will be considered based on the performance of the organization as reflected on the e-Anudaan/ online portal (for previous year/current year), on compliance with public disclosure norms/ guidelines and will be decided before end of May each year.

8.1.5 The total annual grant will be released in two equal half-yearly instalments, first of which will be released along with the renewal order, before the second week of June each year. The second instalment will be released before end of December, after observing the performance during the current year and considering the utilization of funds. The second Instalment shall be released on the basis of following formula-

Patients benefited	Eligible GIA
Less than 30% of annual targeted beneficiaries	Nil
30% to 40% of annual targeted beneficiaries	50 % of remaining GIA
Between 40%- 50% of annual targeted beneficiaries	100 % of remaining GIA

8.1.6 If any IRCA provided treatment to less than 75% of their annual targeted beneficiaries as mentioned in **Appendix-II** then Grant will be stopped in subsequent financial year and that IRCA will be deregistered from the Scheme.

8.1.7 All institutions which have been set up with the grant-in–aid shall proactively disclose the performance on their website and also on the e-Anudaan/online portal. For this purpose, there shall be on online portal. This portal shall allow updating of the information on all the given performance criteria at regular intervals. Apart from this, in every institution there shall be closed circuit cameras

from where live feed shall be available on the Organisation's website. The rights to view can be restricted in specific cases by the Ministry. Financial support for setting up of these cameras and for their live feed will be provided as per the norms of the Ministry.

8.1.8 IRCAs which are taking GIA under the scheme must be open for Social Audit Framework as per the guidelines issued by the Ministry/NISD.

8.2 For a New Project of IRCA

8.2.1 No proposals will be called for supporting new IRCAs by the Ministry. Ministry will provide financial assistance for Addiction Treatment Facilities (ATFs) in Government hospitals through NDDTC AIIMS in uncovered (where no IRCA exists) vulnerable districts as per the approved proposal of NDDTC AIIMS in the Ministry.

8.2.2 **In future, the scope for treatment and rehabilitation under this scheme would be:**

i. Establishing and assisting de-addiction centres in Government Hospitals and Medical Colleges either through NDDTC, AIIMS, New Delhi or through State Governments
ii. Establishing and assisting de-addiction centres in closed settings such as Prisons and Juvenile Homes and for special groups such as women and children in need for care and protection etc. through State Government. **(Norms in Appendix-V,VI AND VII)**
iii. Establishing and assisting residential rehabilitation and stabilization programmes by setting up Model Rehabilitation Centres through State Governments.

8.**2.3 Eligible Organization:** Treatment and rehabilitation facilities as specified in Para 8.2.2 would be provided in collaboration with the Ministry of Health and Family Welfare, National Drug Dependence Treatment Centre (NDDTC), AIIMS,

State Governments, National AIDS Control Organization (NACO) and Institutions under Integrated Child Protection Scheme (ICPS).

8.2**.4 Norms for financial assistance:** The Ministry of Social Justice and Empowerment would apportion a certain amount in the internal budgetary allocation for establishing and assisting de-addiction centres as given above. Funds would be provided to the States/UTs/Organizations for financial support to the eligible agencies/organizations.

8.2.5 For IRCAs being run by NGOs/VOs financial assistance will be given up to 90 percent of the approved cost on recurring and non-recurring expenditure (95% in-case of NE States, J&K, Ladakh and Sikkim). 10% of the expenditure would be borne by the organizations themselves (5% in-case of NE States, J&K, Ladakh and Sikkim). In case of IRCAs being run by State Governments the financial assistance will be given up to 100 percent of the approved cost on recurring and non-recurring expenditure.

*8.2.*6 Every organization/institution receiving funds under this component shall submit Utilization Certificates (UCs) as per provisions of GFR.

*8.2.*7 Every organization/institution receiving funds under this component shall follow minimum standards regarding infrastructure required, treatment protocol, aftercare and follow-up services, food for the inmates and documents etc., as enumerated in the Manual of Minimum Standards of Services (2009) prepared by NISD or as revised from time to time.

9.0 Setting Quality Standards

9.1 Efforts to develop modules for treatment of substance dependents of different categories and age groups in order to create uniformity in treatment

protocol across the country will be undertaken under the NAPDDR. While developing such modules, emphasis should be given on integrating scientifically established mechanisms for diagnosis of substance use disorders as well as integrating pharmacological (such as detoxification and opioid agonist and antagonist maintenance) and psychosocial (such as counselling, cognitive behavioural therapy and social support) interventions based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration.

9.2 A Manual of Minimum Standards of Services would also be developed to bring about standardization and quality control in services being delivered by various government as well as private de-addiction centres. A Manual of Minimum Standards of Services (2009) has already been prepared by NISD regarding infrastructure required, treatment protocol, aftercare and follow-up services, food for the inmates and documents etc., to be followed in the Ministry supported de-addiction centres, and are still applicable. They will be revised from time to time as required.

9.3 Organisation which would be taking GIA for the De-addiction/treatment facility mentioned in Para 8 must follow minimum standard developed and Module prepared by the NISD in collaboration with NDDTC, AIIMS or any other Institute authorized by the Ministry.

9.4 With an aim to standardize and improve the quality of the drug addiction treatment facilities across the country, efforts for recognition of de-addiction centres by resorting to third party accreditation through an appropriate Agency/Authority such as National Accreditation Board for Hospitals and Healthcare Providers (NABH) will be undertaken.

9.5 From 2021-22 onwards, renewal of assistance to the organisations running centres with grants under this scheme would be dependent on securing third party accreditation.

10.0 Focused Intervention in vulnerable areas

10.1 Substance use and related disorders are major problems affecting children and youth in school and out of school/college. This problem impacts negatively on the academic, social, psychological, economical and physiological development among the users. It is seen that substance use among the youth are influenced by adverse childhood experiences, literacy level, peer pressure, curiosity or urge to experimentation, availability of substance etc. The vulnerability of injecting drug users (IDUs) to get co-infected with HIV/AIDS, due to sharing of needles and syringes and risky sexual behaviour makes the problem of substance dependence even more serious.

10.2 Presently, the National AIDS Control Organization (NACO), Ministry of Health and Family Welfare is implementing Targeted Interventions Programme to offer prevention and care services to high risk populations such as Female Sex Workers (FSWs), Male having Sex with Male (MSM) and IDUs within communities by providing them with the information, means and skills they need to minimize HIV transmission and improving their access to care, support and treatment services. These programmes have been found to be a resource-effective way to implement HIV prevention and care programmes in settings with low-level and concentrated HIV epidemics. They are also a cost-effective method of reaching people who are most at risk in more generalized epidemics.

10.3 Similarly, the Ministry of Social Justice and Empowerment would also undertake focussed intervention programmes in vulnerable districts across the country with an aim to increase community participation and public cooperation in

the reduction of demand for dependence-producing substances and promote collective initiatives and self-help endeavour among individuals and groups vulnerable to addiction or found at risk including persons who have undergone treatment at IRCAs as a follow up measure. For this purpose, vulnerable districts would be identified in the country based on studies/surveys, identified seizure routes by Narcotics Control Bureau and feedback from IRCAs and other stakeholders. Apart from the opening up new ATFs in these districts, the following additional intervention programmes would also be carried out in:

10.4 Community based Peer led Intervention (CPLI) for early Drug Use Prevention among Adolescents

10.4.1 Community based Peer led Intervention programmes would be launched in the many more identified districts depending upon the requirement. Through these programmes, youth would be trained as Peer Educators to lead peer led community intervention and implement early prevention education especially for vulnerable adolescents and youth in the community. This programme would also provide as referral and linkage to counselling, treatment and rehabilitation services for substance dependents identified in the community. The activities under this programme include:

a) Community Mapping and Assessment.
b) Outreach activities in the community among vulnerable children and adolescents.
c) Identification and Training of adolescents as Peer Educators to lead Peer led community intervention.
d) Life skill sessions: particularly designed for prevention of substance use in Communities by selected and trained Peer Educators.
e) To initiate Behavioural change communication sessions
f) Ensure Referral and Linkage activities.
g) Providing psychosocial therapies.

h) Follow-up care services.

10.4.2 The following strategies would be adopted under this programme:

a) Peer Educators will focus on creating awareness among the community members especially among adolescents and youth on prevention of substance use.
b) Peer Educators will do life skill training sessions among the peer volunteers on regular basis.
c) Peer Educators will be supported by coordinator and trainer adequately trained in the delivery of evidence-based early prevention interventions on substance use.
d) Render psychosocial interventions including educational sessions on ill effects of substance use, risk assessment on substance use among youth and linkage for treatment and rehabilitation

10.4.3 An Operational Manual for Community Based Peer-Led Intervention (CPLI) would be developed to bring about standardization and quality control in services being delivered by implementing agencies.

10.5 Outreach and Drop In Centres (ODIC)

10.5.1 Outreach and Drop In Centres (ODICs) would be established in more identified districts to conduct outreach activities in the community for prevention of substance use with a special focus on youth who are dependent on substances. The ODICs would provide safe and secure drop-in space for substance users in the community. These centres shall have the provision of screening, assessment and counselling and would provide referral and linkage to treatment and rehabilitation services for substance dependents. Activities that would be carried out by ODICs are given below:

a) Outreach activities in the community among young vulnerable population.
b) Behaviour Change Communication (BCC) one to one / group sessions in community by Outreach Workers.

c) Screening and assessment of clients on substance use disorder.
d) Drop-in-Centre facility for people vulnerable/dependent on any substance.
e) Individual, group and family counselling.
f) Provision of consultation with doctor for referral and linkage with treatment facility.
g) Safe and secure space for substance dependent youth accessible, in the community.
h) Complimentary therapies including art, music & dance for early recovery.
i) Follow up care including family counselling.

10.5.2 The following strategies would be adopted under this programme:

a) The centre will be led by trained staff, staffed by multidisciplinary team adequately trained in the delivery of evidence-based interventions.
b) Comprehensive outreach, screening and counseling system comprising of evidence-based and integrated psychosocial interventions will be provided.
c) Basic services including outreach, drop-in and counseling support to clients.
d) Render psychosocial interventions including brief intervention, motivational interviewing, CBT and linkage for treatment, rehabilitation and vocational training.

10.5.3 An Operational Manual for Out Reach Drop In Centre (ODIC) would be developed to bring about standardization and quality control in services being delivered by implementing agencies.

10.6 Application and Sanction

10.6.1 For a New Project (CPLI or ODIC)

10.6.1.1 Any request for new **CPLI or ODIC** should be sent online on the website http://grants-msje.gov.in/ngo-login of the Ministry of Social Justice & Empowerment, Government of India, accompanied with the relevant documents (to be uploaded along with the application form). The receipt of such an application would not *suo moto* entitle an organisation/Institution to the sanction of grants. The Ministry of Social Justice & Empowerment, Government of India, shall consider the

release of financial support, in each case, on the basis of the procedure prescribed by it from time to time and proposals complete in all respect, as per norms of the scheme.

1) Ministry will call proposals in February each year (or any specified date as decided by the Ministry) for selected districts/areas in every year in e-Anudaan portal from the eligible Institute/Organisation through various Media communication. Eligible Institutions/ Organizations may apply within six weeks from the date of opening of e-Anudaan portal.
2) As soon as a proposal is uploaded in e-Anudaan portal, it would be notified automatically to the State Government and the District Administration concerned for examining the proposals at their level.
3) Proposals received would be considered by the Screening Committee constituted in the Ministry for this purpose in such a way that decisions are taken before 30th April (or within six weeks from last date of receipt of proposal) each year for new sanctions for that financial year.
4) The Screening Committee shall have the Principal Secretary/Secretary or authorized representatives of the concerned State Government as its members. The State Government does due diligence at their level about the correctness, performance, requirement, suitability and the eligibility of each proposal before coming for the meeting. There shall be no formal reference for report of the State Government before considering the proposal; and the State Government stand would be considered during the Screening Committee meeting.
5) The following parameters shall be taken into consideration by the screening committee for recommending an organization to be eligible to receive grant from the Ministry.(except in case of Government Hospitals/Government organisations)
    i. Those organizations solely concentrating on de-addiction shall be given preference over others undertaking multiple social activities. (10 **weightage** point out of 100)

ii. Performance of IRCA/De-addiction centre run by Organisation reflected in terms of number of addicts treated in previous years. (40 **weightage** point out of 100)

iii. NGOs who have done any Research and Development (R&D) or any innovation in the field of drug demand reduction shall be given preference. (15 **weightage** point out of 100)

iv. NGOs who have received any award from Central Government or State Government in the field of prevention of and substance shall be given preference. (15 **weightage** point out of 100)

v. Funds generated from other sources such as community/CSR/donations in case of NGO based organisation. (10 **weightage** point out of 100)

vi. Organisation having own website for the purpose of proactive disclosure of their activities to the Public. (10 **weightage** point out of 100).

6) Total annual grant will be released in two equal half-yearly instalments, first of which will be released along with the sanction order, before the second week of May (or within one month from the decision of Screening Committee) each year. Second instalment will be released before the end of December, after observing the performance and considering the utilization of funds.

7) Organization/institution/establishment shall, before it receives assistance from the Ministry of Social Justice & Empowerment, execute a bond in a prescribed proforma. The transfer of funds would be done only after acceptance of the Bond by the competent authority in the Ministry. The requirements regarding indemnity bond and pre stamped receipt and transfer of funds shall be fulfilled by the organization/institution/establishment as per the extant instructions of the Ministry in this regard.

10**.6.1.2 Eligible Organization:** Organisations which are already running MoSJE supported IRCA or State Government supported De-addiction Centre/Government Hospital or any private run De-Addiction centre registered

under Mental Healthcare Act, 2017 would be eligible for applying for CPLI and ODIC. Experience of at least 2 years shall be mandatory. For sanctioning new Centres by the same NGO, the Centre should have been opened already and should be running for at-least one year before any financial assistance can be considered. However, for the State Government agencies, this will not apply. New Centres will be sanctioned for the same capacity for which it has the infrastructure capacity.

10**.6.1.3 Financial Norms**

1) The financial norms for CPLI are at **Appendix-VIII** and the financial norms for setting up of ODICs are at **Appendix-IX.**
2) The quantum of assistance shall be 100% of the budget norms on the admissible items enumerated under CPLI and ODIC.
3) All such assistance shall be as per the provisions of the General Financial Rules, 2017 (Government of India).

10.6.2 **For Ongoing Programmes (already sanctioned by NISD during 2019-20)**

10.6.2.1 For the renewal of grant-in-aid under the Scheme, an Organization/Institution, shall register themselves online on the website http://grants-msje.gov.in/ngo-login and forward their application along with the relevant documents and the utilisation certificate of expenditure till 31st March of the previous financial year (to be uploaded along with the application) before first week of May every year to the Ministry of Social Justice & Empowerment (Social Defence Division), Government of India, New Delhi. Incomplete applications shall be liable to be rejected for renewal; and applications received after the deadline would not be considered.

10.6.2.2 Implementation of EAT module will be mandatory for the organizations desirous of seeking renewal of grant-in-aid.

10.6.2.3 Organizations are required to submit beneficiary's data on e-Anudaan portal/ online on daily basis. In case of ODIC, feeding of profile of beneficiary's data is also mandatory in Drug Abuse Monitoring System (DAMS) maintained by NISD.

10.6.2.4 Renewal of the applications will be considered based on the performance of the organization as reflected on the e-Anudaan/ online portal (for previous year/current year), and will be decided before end of May each year.

10.6.2.5 All institutions which have been set up with the grant-in-aid shall proactively disclose the performance on their website and also on the e-Anudaan/online portal. The online portal will call for updating of the information on all the given performance criteria daily.

10.6.2.6. Every project shall set up closed circuit cameras from where live feed shall be available on their website. The rights to view can be restricted in specific cases. The financial support for setting up of these cameras and for their live feed will be provided as per the norms of the Ministry.

10.6.2.7 The renewal applications are processed based on the data provided by the organisations without any prior inspection. However, the organisations would be responsible for the data provided and if it is found that wrong data has been submitted, the NGO so submitting the wrong data would be barred from any further assistance from the Ministry. Such organisations would also be derecognised from the NGO Darpan database of the NITI Aayog.

10.6.2.8. The organisations which are found to have complied with the proactive disclosures and the CCTVs with live footage, only will be considered for renewal.

10.6.2.9. Total annual grant will be released in two equal half-yearly instalments, first of which will be released along with the renewal order, before second week of June each year. Second instalment will be released before end of December, after observing the performance and considering the utilization of funds. The second installment shall be released on the basis of following formula-

Service provided	Eligible GIA
Less than 30% of annual targeted beneficiaries	Nil
30% to 40% of annual targeted beneficiaries	50 % of remaining GIA
Between 40%- 50% of annual targeted beneficiaries	100 % of remaining GIA

If any CPLI/ODIC has provided services to less than 75% of their annual targeted beneficiaries, then Grant will be stopped in subsequent financial year and that CPLI/ODIC will be deregistered from the Scheme.

Annual Target Beneficiaries for CPLI- 1200 (Adolescents)

(Includes 800 Peer Volunteers to be trained by PEs, 400 beneficiaries receiving other services through the project)

Annual Target Beneficiaries for ODIC-4200

(Includes 1200 clients benefiting from Drop-In-Centre, 3000 clients benefiting through one to one and group interactions)

10.6.2.10. Projects which are taking GIA under the scheme must be open for Social Audit Framework as per the guidelines issued by the Ministry/NISD.

11. Skill Development, vocational training and livelihood support of ex-drug addicts

11.1 In order to promote meaningful livelihood activities and employment to instil a sense of purpose and self-esteem in individuals to steer them away from drugs, programmes for skill development, vocational training and livelihood support of ex-drug addicts would be carried out through National Backward Classes Finance and other Development Corporations of the Ministry of Social Justice and Empowerment. In addition to this, vocational training and livelihood programmes would also be carried out in collaboration with Ministry of Women and Child Development, Ministry of Skill Development and Entrepreneurship and its affiliated institutes and State Governments.

11.2 Norms for financial assistance/Eligible Organizations: Financial assistance shall be provided to National Backward Classes Finance and other Development Corporations of Ministry of Social Justice and Empowerment, affiliated institutes of Ministry of Skill Development and Entrepreneurship and State Governments on the basis of their proposals.

12. State/UT Specific Interventions

12.1 Addressing the problem of drug abuse will require concerted action at different levels of the Government. The responsibility for actions at the field level lies within the purview of the State/ UT Government. Thus, States and UTs, with the support of Central Government, may like to plan and take specific initiatives, taking into account their local considerations. They may devise specific and suitable strategies for drug demand reduction in their identified areas. In this context, the States/UTs may send proposals which meet the objectives of NAPDDR.

12.2 Organization/Institution/Department: Concerned Departments of State Governments/UT Administrations.

12.3 Norms for financial assistance: The Ministry would apportion a certain amount from the internal budgetary allocation for drug demand reduction programmes to be carried out by States/UTs and release as per the proposals.

13. Surveys, Studies, Evaluation, Research and Innovations on the subjects covered under the Scheme

13.1 With an aim to develop measures based on scientific evidence that are relevant to different socio-cultural environments and social groups, continuous research and studies would be undertaken in collaboration with other apex institutions on drug use pattern and relevant areas.

13.2 To expand the coverage and quicken the process of treatment and rehabilitation, testing and implementation of innovative ideas shall be supported under NAPDDR.

13.3 Eligible Organization/Norms for financial assistance: Financial assistance shall be admissible to NISD, other government and private institutions and eligible organizations for the activities to meet the objectives given in the Scheme based on the merit of the proposal to be approved by the Steering Committee.

14. Programme Management

14.1 A National Consultative Committee on De-addiction and Rehabilitation (NCCDR) under the chairpersonship of Minister for Social Justice & Empowerment has been constituted in July, 2008. The Committee has representation of various stakeholders including agencies dealing with supply and demand reduction. It is meant to advise the Government on issues connected with drug demand reduction, education/awareness building, de-addiction and rehabilitation of drug-addicts. It shall thus act as a mechanism for reviewing the implementation of NAPDDR at the National level.

14.2 A Steering Committee has been constituted under the chairpersonship of the Secretary, Department of Social Justice and Empowerment including representatives from Ministries of Health and Family Welfare, Human Resource Development, Women and Child Development, Home Affairs, Skill Development and Entrepreneurship, Department of Revenue, NISD, State Governments and NGOs/Experts in this area. The Committee shall hold quarterly meetings to consider and approve proposal when required and monitor effective implementation of the NAPDDR and establish coordination mechanism for achieving the goals and objectives envisaged in the NAPDDR.

14.3 A Project Management Committee would be constituted under the chairpersonship of the Joint Secretary (SD), Department of Social Justice and

Empowerment to monitor the implementation of components under this Scheme on day to day basis. The Committee would include Director (DP), Department of Social Justice and Empowerment, Director, NISD, head of TSU. The chairperson of the committee would be authorized to invite representatives of any other Ministry/ Department of the Government of India, State Government, NGOs and experts for the Meeting.

14.4 The Ministry would decide notional allocation for each of the components under this Scheme at the beginning of each financial year.

14.5 Programme Management Unit at NISD

14.6 As mentioned in Para 7.3 NCDAP serve as an apex body for training, research and documentation in the field of alcoholism and drug demand reduction. For implementation of the NAPDDR, NCDAP in the NISD has been identified as a nodal agency which would serve as a focal point for carrying out drug demand reduction activities in a mission mode with identified timelines and targets.

14.7 The NCDAP would work as a Project Management Unit (PMU) for implementation of the NAPDDR. It would be responsible for conceptualizing, framing and implementing the activities of the NAPDDR across the country and liason with various stakeholders for conduction of programmes covered under the NAPDDR. For this purpose, experts/consultants on the subject would be engaged by NISD as per prevailing norms of the Government of India.

14.8 Technical Support Unit (TSU) for Monitoring and Evaluation

14.9 A Technical Support Unit (TSU) will be engaged by the NISD for monitoring the activities being carried out under the NAPDDR during the period 2018-2023. The TSU will serve as a monitoring, evaluation, research and capacity building arm of the NISD.

14.10 **Eligible Organization**: A suitable agency shall be hired by the NISD as TSU on the basis of extant rules and procedure of the Government of India.

14.11 **Norms of financial assistance**: Funds shall be transferred to the NISD depending upon the requirement.

14.12 Director, NISD is authorized to approve and release entire fund for different projects/programmes under various components of the NAPDDR, beyond the delegation of power mentioned in bylaws of NISD, for which fund has been transferred by the Ministry of Social Justice and Empowerment to the NISD.

14.13 The Ministry of Social Justice and Empowerment and NISD would formulate and establish any further monitoring mechanisms for effective implementation of various activities under the Scheme.

14.14 Similarly, the Ministry of Social Justice and Empowerment/NISD would carry out Impact/Assessment Studies on effectiveness of the programmes being carried out under this Scheme.

14.15 The Ministry of Social Justice and Empowerment would review and modify the guidelines and implementation arrangements based on progress of implementation of NAPDDR, whenever deemed necessary.

14.16 Every organization/institution receiving funds under this Scheme shall submit Utilization Certificates (UCs) as per GFR, 2017.

15. Any other activity or item which will augment/strengthen the implementation of NAPDDR

15.1 Financial assistance would also be admissible to the activities/programmes recommended by the NCCDR, Steering Committee and the State Governments for strengthening the overall objective of the Scheme.

APPENDIX-I

ACTIVITIES TO BE UNDERTAKEN UNDER THE NAPDDR

S. No	Actionable Point	Outcome
1.	**Prevention**	
1.1	Awareness generation programmes in schools involving students, teachers and parents	▪ Awareness Building on the ill-effects of substance use ▪ Early identification of the problem ▪ Reducing stigmatization of children.
1.2	Awareness generation programmes in Colleges and Universities involving students, NSS volunteers and faculties	▪ Weaning away youth from drug abuse. ▪ Enhanced academic performance.
1.3	Persuading Principals/ Directors/ Vice Chancellors & others of Educational Institutions to ensure that no drugs are sold within/nearby the campus.	Prevention of substance use
1.4	Increasing community participation and public cooperation in the reduction of demand for dependence producing substances by involving Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULBs), Nehru Yuva Kendra Sangathan (NYKS), National Service Scheme (NSS) and other local groups like Mahila Mandals, Yuvak Mandals, Self	▪ Intensifying sensitization programmes in villages and urban areas etc. ▪ Involvement of stakeholders at community level to deliver drug demand reduction programmes. ▪ Involvement of youth in preventive education programmes.

	Help Groups etc.	
1.5	Awareness generation programmes in high risk and vulnerable areas	Coverage of high risk and vulnerable areas where prevalence of substance use is more widespread with an expanded outreach.
1.6	Awareness generation programmes at workplaces including corporate offices	Reduced instances of substance use at workplaces and increased productivity of employees
1.7	Awareness generation programmes for police functionaries, law enforcement agencies, paramilitary forces, judicial officers, BAR council etc.	Sensitization of law enforcement agencies
1.8	Awareness generation through social, print, digital and online media and engagement of celebrities to spread social message against substance use.	Spreading message against ill-effects of substance use through intensive outreach and well targeted campaigns.
1.9	Strengthening of National Toll Free Helpline for Drug Prevention	▪ Creating awareness among people through widespread publicity. ▪ Counseling Services through helpline
1.10	Coordination with implementing agencies for controlling sale of sedatives/ painkillers/ muscle relaxant drugs and checking online sale of substances by stringent monitoring by the cyber cell	Reducing the sale of drugs
2.	**Capacity Building**	

2.1	Strengthening of National Centre for Drug Abuse Prevention (NCDAP) in National Institute of Social Defence (NISD) and making it a focal point for drug demand reduction programmes	▪ Implementation of NAPDDR in mission mode. ▪ Intensive training of personnel in the identification, treatment, after-care, rehabilitation and social reintegration of drug addicts. ▪ Creating a pool of trained human resources personnel and service providers to strengthen the service delivery mechanisms. ▪ Delivering prevention programmes based on scientific evidence, both universal and targeted, in a range of settings (such as schools, families, the media, workplaces, communities, health and social services and prisons)
2.2	Workshops, Seminars and interactions with parents	To provide forums for parents and equip them with necessary skills
2.3	Training of teachers and counsellors on different assessment tools	Early identification of substance use and associated factors
2.4	Training programmes on de-addiction counselling and rehabilitation for social workers, functionaries of IRCAs, working professionals etc.	Capacity building of people who work with victims of drug abuse
2.5	Orientation Courses in the field of drug abuse prevention for functionaries of IRCAs including	Capacity building of staff of IRCAs

	nurses and ward boys	
2.6	Training of staff in Prisons and Juvenile Homes	▪ Respectful, non-judgmental and non-stigmatizing attitude of the staff. ▪ To carry out drug demand reduction measures that are based on scientific evidence and are ethical
2.7	Basic Training Course in awareness of substance use and dependency associated health problems and various treatment approaches to prisoners.	Developing a core group of peer educators to assist in dissemination of accurate information about substances, their use, and issues of dependency, treatment options and for overall improvement of behavioural issues associated with substances, within the prison environment.
2.8	Specialized training for those who work with vulnerable groups, such as patients with psychiatric co-morbidities, children and women, including pregnant women.	Focus upon specific needs of vulnerable groups for drug de-addiction treatment
2.9	Training programmes for police functionaries, paramilitary forces, judicial officers, bar council, representatives of PRIs and ULBs on substance use prevention	Capacity building of various agencies on substance use prevention
3.	**Treatment and Rehabilitation**	
3.1	Availability of Integrated Rehabilitation Centres for Addicts (IRCAs) supported by MSJE as per prevalence of substance dependence	Easily accessible and affordable services

3.2	Conversion of IRCAs into treatment clinics	Indoor and Outdoor treatment facility to patients to enhance availability of services
3.3	Establishing and assisting de-addiction centres in District Government and Private Hospitals/Medical Colleges	Fill gaps in treatment services and to enhance availability of services
3.4	Establishing and assisting de-addiction centres for women and children in Hospitals and other establishments	Focussed attention towards women and children so as to respond best to their needs.
3.5	Model treatment and rehabilitation centres in highly affected areas for stabilised/residential facilities	Such centres will create a benchmark in drug demand reduction services and eventually share expertise with the existing service providers.
3.6	Establishing and assisting de-addiction centres in prisons, Juvenile Homes, slum areas, factories, major railway stations and other highly affected areas	▪ Will help in de-addiction of prisoners and juveniles and bring them into mainstream. ▪ Reducing transmission of infectious diseases in prisons ▪ Reduced instances of substance use at workplaces and increased productivity of employees
3.7	Linkage of IRCAs with Opioid Substitution Therapy (OST) Centres of National AIDS Control Organization (NACO)	Networking and sharing of expertise among service providers.
4.	**Setting up quality standards**	
4.1	Developing Module for re-treatment, ongoing treatment and	▪ Uniformity in treatment protocol across the country

	post treatment of dependents of different categories and age groups	▪ Integrating scientifically established mechanisms for diagnosis of substance use disorders ▪ Integrating pharmacological (such as detoxification and opioid agonist and antagonist maintenance) and psychosocial (such as counselling, cognitive behavioural therapy and social support) interventions based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration
4.2	Updating existing Minimum Standards of Services for treatment and rehabilitation of addicts as per present scenario	Standardization and quality control in services being delivered
4.3	Accreditation of IRCAs supported by this Ministry and others	Standardization of treatment facilities across the country
4.4	Persuading States to regulate Private De-addiction Centres by framing appropriate rules under the NDPS Act, 1985.	▪ Laying down standards and guidelines for private de-addiction centres to follow and recognize such centres as are found to be meeting the standards and guidelines. ▪ Emphasizing human rights and dignity in the context of drug demand reduction efforts
5.	**Focussed intervention in vulnerable areas**	
5.1	Identification of vulnerable areas based on study/survey and feedback from the IRCAs and	Focussed intervention in these areas for drug demand reduction

	other stakeholders	
5.2	Working with NGOs, NYKS, NSS etc. in the identified vulnerable areas for drawing a comprehensive strategy for demand reduction and de-addiction at all levels to achieve results in a time bound manner	▪ Intensifying preventive education and sensitization programmes ▪ Increase in availability and quality of treatment services and rehabilitation
6.	**Skill Development, Vocational Training and Livelihood**	
6.1	Skill development, vocational training and livelihood support of ex-drug addicts through National Backward Classes Finance and other Development Corporations	▪ Promoting meaningful livelihood activities and employment to instil a sense of purpose and self-esteem in individuals to steer them away from drugs ▪ Reduction in social stigma and economic rehabilitation
6.2	Linkage of IRCAs with Pradhan Mantri Kaushal Vikas Yojana Training Centres of the Ministry of Skill Development and Entrepreneurship for providing industry relevant training to ex-drug addicts.	▪ Promoting meaningful livelihood activities and employment to instil a sense of purpose and self-esteem in individuals to steer them away from drugs ▪ Reduction in social stigma and economic rehabilitation
6.3	Vocational training and livelihood programmes in Juvenile Homes	Will help in reduction in crime by children and shaping up their future
7.	**Extent, trend and pattern of substance use**	
7.1	Conducting National Survey on Extent and Pattern of Substance Use in every five years	To assess the extent, trend and pattern of substance use

7.2	Continuous research, studies and innovation on substance use pattern and relevant areas	Will help in developing measures based on scientific evidence that are relevant to different socio-cultural environments and social groups
7.3	Maintaining Drug Abuse Monitoring System (DAMS) and establishing database on substance use	Keeping a check on emerging trends of substance use
8.	**Coordination, Monitoring and Evaluation**	
8.1	Coordination with all collaborating agencies and regular monitoring	For effective implementation of National Action Plan for Drug Demand Reduction (NAPDDR)
8.2	Evaluation of NAPDDR through third party	Ascertaining the outcome envisaged in the NAPDDR

APPENDIX-II

Type of Intervention / Items	IRCA (Norms in appendix-III)	IRCA with Outpatient and Inpatient facility Norms in Appendix-III	De-addiction Centre for female Norms in Appendix-VI	De-addiction Centre for Male Children Norms in Appendix-VII	De-addiction Centre for Prison Settings Norms in Appendix-VIII
Recurring Grant (annually)	Rs 2746200/- (15B/U) Rs 2782200/-(15B/R) Rs3904800/-(30B/U) Rs3940800/-(30B/R) Rs5210400/-(50B/U) Rs5246400/-(50/R)	Rs 3640200/- (15B) Rs 4900800/- (30B) Rs 6272400/- (50B)	Rs4486000/- (20 Bed In-Patients+ Out Patients)	Rs4608000/- (20 bedded In-Patients + Out-Patients facility)	Rs2790800/-
Non-Recurring Grant (one time) *	Rs245000/- (15B) Rs320000/- (30B) Rs395000/- (50B)	-	Rs250000/-	Rs250000/-	-
Targeted beneficiaries (Annually)	180 (15 Bed) 360 (30 Bed) 600 (50 Bed)	Inpatients 180 (15 Bed) 360 (30 Bed) 600 (50 Bed) 6000 Outpatients	240 In- patients and 2400 Out-Patients	300 In- patients and 2000 Out-Patients	180

Appendix-III

1. NORMS FOR SETTING UP OF A 15-BEDDED INTEGRATED REHABILITATION CENTRE FOR ADDICTS [IRCA]

S. No.	Name of the Post	No. of Posts	Monthly Expenditure(Rs.)	Yearly Expenditure(Rs.)	Minimum Qualifications
A. RECURRING EXPENDITURE **a. Administrative:**					
1.	Project Coordinator cum- Vocational Counsellor	1	18,000	2,16,000	Graduate with experience of managing such centres for a minimum period of 3 years or demonstrable capability for running such centres and having working knowledge of computers.
2.	Accountant cum Clerk	1	10,000	1,20,000	Graduate with knowledge of accounts and working knowledge of computers.
3.	Cook	1	8,000	96,000	
4.	Chowkidar	2	2x 8000= 16,000	1,92,000	
5.	House Keeping Staff	1	8,000	96,000	
b.	**Medical:**				
1.	(a) Doctor (Part time)	1	13,500 (Urban Areas) 16,500 (Rural Areas)	1,62,000 (Urban Areas) 1,98,000 (Rural Areas)	Doctors should essentially be qualified as MBBS and also hold a Training Certificate in Addiction Medicine from a recognized institute.
	(b) Doctor (Full time)#		55,000	6,60,000	

2.	Counsellor /Social Worker /Psychologist $$	2*	2 x 12,500 = 25,000	3,00,000	Graduate in any discipline with three years' experience in the field. He/She must hold a Certificate of three months Training Course in de-addiction counseling by NISD and should have knowledge of English as well as one regional language.
3.	Yoga therapist/ Dance Teacher/Music Teacher/ Art Teacher (Part time)	1	5,000	60,000	
4.	Nurse $$	2	12,000 x 2 = 24,000	2,88,000	Nurses should be qualified as Auxiliary Nurse Midwife (ANM) and trained by a recognized government medical institution.
5.	Ward Boys	2	11,000 x 2 = 22,000	2,64,000	VIII th Class pass preferably experienced in such centres. Ward Boy employed in an IRCA must be trained by NISD.
6.	Peer Educator	1	9,000	1,08,000	Should be literate; Ex-drug user with 1-2 years of sobriety, Willing to work among drug using population as well as is possessing qualities like empathy, communication skills. Willing to get trained; Agrees to refrain from using, buying, or selling drugs; Ready to work for the prevention of harmful drug use and relapse
	TOTAL	**15**			

* It would be the discretion of the organization to allocate the remuneration amongst the incumbents within the overall financial allocation.

Fulltime doctor for IRCA with Outpatient treatment facilities.

% Support for one additional (Counsellor /Social Worker /Psychologist) and Nurse will be provided for IRCA with Outpatient treatment facilities.

B. Recurring Expenditure (Other than Staff remuneration)			
S.No.	**Item**	**Monthly Expenditure (Rs.)**	**Annual Expenditure (Rs.)**
1.	Rent	18,000	2,16,000
2.	Medicines ##	9,000	1,08,000
3.	Contingencies (Stationery, water, electricity, postage, telephone, maintenance and replacement of bed, linen etc.)	6,000	72,000
4.	Transport/Petrol and Maintenance of Vehicle.	3600	43,200
5.	In house Kitchen expenditure @ Rs. 75 per day for 3 meals per day to 15 inmates	33,750	4,05,000
	TOTAL		
	TOTAL A + B	228850 (Urban Areas) 231850 (Rural Areas)	2746200 (Urban Areas) 2782200 (Rural Areas)

- 20% of re-appropriation of expenditure amongst medicines, contingencies, transportation heads would be permissible within the total admissible allocation
  ## Financial assistance of Rs 2,10,000 will be provided for medicines to IRCAs with Outpatient treatment facilities.

NOTE-

C. NON-RECURRING EXPENDITURE **(Admissible during the setting-up of the Centre and also after a period of five years subject to condition that they have been receiving grants continuously)**

20 beds, tables, 3 sets of linen, blankets/office furniture/ equipments/computer/refrigerator etc	Rs. 2,25,000
Aadhaar based Biometric Attendance System	Rs. 20,000
Total	**Rs. 2,45,000**

- 10% of the expenditure would be borne by the organizations themselves. However, in case of NE States, J&K, Laddakh and Sikkim the organisations will bear 5% of the expenditure.

- In case of self-owned buildings, no rent would be admissible. However, 10% of the admissible rent would be payable as 'maintenance' charges

2. NORMS FOR SETTING UP OF A 30-BEDDED INTEGRATED REHABILITATION CENTRE FOR ADDICTS [IRCA]

S. No.	Name of the Post	No. of Posts	Monthly Expenditure(Rs.)	Yearly Expenditure(Rs.)	Minimum Qualifications
A. RECURRING EXPENDITURE **a. Administrative:**					
1.	Project Coordinator cum- Vocational Counsellor	1	18,000	2,16,000	Graduate with experience of managing such centres for a minimum period of 3 years or demonstrable capability for running such centres and having working knowledge of computers.
2.	Accountant cum Clerk	1	10,000	1,20,000	Graduate with knowledge of accounts and working knowledge of computers.
3.	Cook	1	8,000	96,000	
4.	Chowkidar	2	2x 8000= 16,000	1,92,000	
5.	House keeping Staff	1	8,000	96,000	
b.	**Medical:**				
1.	(a) Doctor (Part time)	1	13,500 (Urban Areas) 16,500 (Rural Areas)	1,62,000 (Urban Areas) 1,98,000 (Rural Areas)	Doctors should essentially be qualified as MBBS and also hold a Training Certificate in Addiction Medicine from a recognized institute.
	(b) Doctor (full time)#		55,000	6,60,000	
2.	Counsellor /Social Worker /Psychologist %	4*	4 x 12,500 = 50,000	6,00,000	Graduate in any discipline with three years' experience in the field. He/She must hold a Certificate of three months Training Course in de-addiction counseling by NISD and should have knowledge of English as well as one regional language.

3.	Yoga therapist/ Dance Teacher/Music Teacher/ Art Teacher (Part time)	1	5,000	60,000	
4.	Nurse %	3	12,000 x 3 = 36,000	4,32,000	Nurses should be qualified as Auxiliary Nurse Midwife (ANM) and trained by a recognized government medical institution.
5.	Ward Boys	2	11,000 x 2 = 22,000	2,64,000	VIIIth Class pass preferably experienced in such centres. Ward Boy employed in an IRCA must be trained by NISD.
6.	Peer Educator	1	9,000	1,08,000	Should be literate; Ex-drug user with 1-2 years of sobriety, Willing to work among drug using population as well as is possessing qualities like empathy, communication skills. Willing to get trained; Agrees to refrain from using, buying, or selling drugs; Ready to work for the prevention of harmful drug use and relapse
	TOTAL	**18**			

* It would be the discretion of the organization to allocate the remuneration amongst the incumbents within the overall financial allocation.

Fulltime doctor for IRCA with Outpatient treatment facilities.

% Support for one additional (Counsellor /Social Worker /Psychologist) and Nurse will be provided for IRCA with Outpatient treatment facilities.

B. Recurring Expenditure (Other than Staff remuneration)			
S.No.	**Item**	**Monthly Expenditure (Rs.)**	**Annual Expenditure (Rs.)**
1.	Rent	30000	3,60,000
2.	Medicines	18,000	2,16,000

3.	Contingencies (Stationery, water, electricity, postage, telephone, maintenance and replacement of bed, linen etc.)	8400	1,00,800
4.	Transport/Petrol and Maintenance of Vehicle.	6000	72,000
5.	In house Kitchen expenditure @ Rs. 75 per day for 3 meals per day to 30 inmates	67,500	8,10,000
	TOTAL		
	TOTAL A + B	325400 (Urban Areas) 328400 (Rural Areas)	3904800 (Urban Areas) 3940800 (Rural Areas)

- 20% of re-appropriation of expenditure amongst medicines, contingencies, transportation heads would be permissible within the total admissible allocation.

NOTE-

C. NON-RECURRING EXPENDITURE **(Admissible during the setting-up of the Centre and also after a period of five years subject to condition that they have been receiving grants continuously)**

20 beds, tables, 3 sets of linen, blankets/office furniture/ equipments/computer/refrigerator etc	Rs. 3,00,000
Aadhaar based Biometric Attendance System	Rs. 20,000
Total	**Rs. 3,20,000**

- 10% of the expenditure would be borne by the organizations themselves. However, in case of NE States, J&K, Ladakh and Sikkim the organisations will bear 5% of the expenditure.
- In case of self-owned buildings, no rent would be admissible. However, 10% of the admissible rent would be payable as 'maintenance' charges.

3. NORMS FOR SETTING UP OF A 50-BEDDED INTEGRATED REHABILITATION CENTRE FOR ADDICTS [IRCA]

S. No.	Name of the Post	No. of Posts	Monthly Expenditure(Rs.)	Yearly Expenditure(Rs.)	Minimum Qualifications
A. RECURRING EXPENDITURE **a. Administrative:**					
1.	Project Coordinator cum- Vocational Counsellor	1	18,000	2,16,000	Graduate with experience of managing such centres for a minimum period of 3 years or demonstrable capability for running such centres and having working knowledge of computers.
2.	Accountant cum Clerk	1	10,000	1,20,000	Graduate with knowledge of accounts and working knowledge of computers.
3.	Cook	1	8,000	96,000	
4.	Chowkidar	2	2x 8,000= 16,000	1,92,000	
5.	House Keeping Staff	1	8,000	96,000	
b.	**Medical:**				
1.	(a) Doctor (Part time)	1	13,500 (Urban Areas) 16,500 (Rural Areas)	1,62,000 (Urban Areas) 1,98,000 (Rural Areas)	Doctors should essentially be qualified as MBBS and also hold a Training Certificate in Addiction Medicine from a recognized institute.
	(b) Doctor (Full time)#		55,000	6,60,000	
2.	Counsellor /Social Worker /Psychologist %	6*	6 x 12,500 = 75,000	9,00,000	Graduate in any discipline with three years' experience in the field. He/She must hold a Certificate of three months Training Course in de-addiction counseling by NISD and should have knowledge of English as well as one regional language.

3.	Yoga therapist/ Dance Teacher/Music Teacher/ Art Teacher (Part time)	1	5,000	60,000	
4.	Nurse %	4	12,000 x 4 = 48,000	5,76,000	Nurses should be qualified as Auxiliary Nurse Midwife (ANM) and trained by a recognized government medical institution.
5.	Ward Boys	2	11,000 x 2 = 22,000	2,64,000	VIIIth Class pass preferably experienced in such centres. Ward Boy employed in an IRCA must be trained by NISD.
6.	Peer Educator	1	9,000	1,08,000	Should be literate; Ex-drug user with 1-2 years of sobriety, Willing to work among drug using population as well as is possessing qualities like empathy, communication skills. Willing to get trained; Agrees to refrain from using, buying, or selling drugs; Ready to work for the prevention of harmful drug use and relapse
	TOTAL	**21**			

* It would be the discretion of the organization to allocate the remuneration amongst the incumbents within the overall financial allocation.

Fulltime doctor for IRCA with Outpatient treatment facilities.

% Support for one additional (Counsellor /Social Worker /Psychologist) and Nurse will be provided for IRCA with Outpatient treatment facilities.

B. Recurring Expenditure (Other than Staff remuneration)			
S.No.	**Item**	**Monthly Expenditure (Rs.)**	**Annual Expenditure (Rs.)**
1.	Rent	40,000	4,80,000
2.	Medicines	30,000	3,60,000
3.	Contingencies (Stationery, water, electricity, postage, telephone, maintenance and replacement of bed, linen etc.)	10,800	1,29,600
4.	Transport/Petrol and Maintenance of Vehicle.	8,400	1,00,800
5.	In house Kitchen expenditure @ Rs. 75 per day for 3 meals per dayto 50 inmates	1,12,500	13,50,000
	TOTAL		
	TOTAL A + B	4,34,200 (Urban Areas) 4,37,200 (Rural Areas)	5210400 (Urban Areas) 5246400 (Rural Areas)

- 20% of re-appropriation of expenditure amongst medicines, contingencies, transportation heads would be permissible within the total admissible allocation.

C. NON-RECURRING EXPENDITURE **(Admissible during the setting-up of the Centre and also after a period of five years subject to condition that they have been receiving grants continuously)**

20 beds, tables, 3 sets of linen, blankets/office furniture/ equipments/computer/refrigerator etc	Rs. 3,75,000
Aadhaar based Biometric Attendance System	Rs. 20,000
Total	**Rs. 3,95,000**

- 10% of the expenditure would be borne by the organizations themselves. However, in case of NE States, J&K, Ladakh and Sikkim the organisations will bear 5% of the expenditure.

- In case of self-owned buildings, no rent would be admissible. However, 10% of the admissible rent would be payable as ‘maintenance’ charges.

Appendix-IV

NORMS FOR SETTING UP OF A SLCA

A. Recurring (Staff)	**Nos**	**Per Month (Rs.)**	**Annual Expenditure (Rs.)**	
Coordinator	1	**20,000**	**2,40,000**	
Documentation Officer	1	**15,000**	**1,80,000**	
Field Staff	2*	**2 x 11,000 = 22,000**	**2,64,000**	
Accountant-cum-Computer Operator	1	**10,000**	**1,20,000**	
Total (A)	5	**67,000**	**8,04,000**	
B. Recurring (others)				
Rent		**18,000**	**2,16,000**	
Communication		**6,000**	**72,000**	
Contingencies		**5,000**	**60,000**	
Library Books		Lump sum	**10,000 (per annum). This fund may be utilized for printing of IEC material.**	
Travel Support (for monitoring visit and meetings with State Govt./Central Govt. officials)			**No. of IRCAs under jurisdiction**	**Amount**
			1-20	**60,000**
			21-40	**90,000**
			More than 40	**1,20,000**
Total (B)			**No. of IRCAs under jurisdiction**	
			1-20	**418000**
			21-40	**448000**
			More than 40	**478000**
Total grant payable to SLCA (A+B)			**No. of IRCAs under jurisdiction**	
			1-20	**1222000**
			21-40	**1384000**
			More than 40	**1414000**
Inspection of IRCAs (On the directions of Ministry)			**4,000 per inspection (will be reimbursed in the next financial year)**	

GRANT ADMISSIBLE DURING SETTING UP OF RRTC (ONE TIME)			
1	Office, equipments, computer, printer, telephone, furniture, etc		2,50,000
2	Biometric Attendance System		20,000

* In case more than 20 IRCAs are there under the jurisdiction of the SLCA, then field staffs will be 3.

Note:-

1. In case of self-owned buildings, no rent would be admissible. However, 10% of the admissible rent would be payable as 'maintenance' charges.

SLCAs are required to visit each IRCA under their jurisdiction in a particular financial year and furnish the monitoring visit report with respect to each IRCA to the Ministry.

Appendix-V

Annual Budget for De-addiction Centre for female

	Budget: for – Inpatient (20 Bedded) + Outpatient services (Annual, in Rs.)					
S. No.	**Budget Head**	**Description**	**Unit Cost**	**No.**	**Duration**	**Total**
1	Infrastructure Refurbishment / Furniture / Equipment	One time	250000	1	1	250000
2	Project Coordinator	Local norms for Central Sector Scheme	20000	1	12	240000
3	Salary – Doctor (minimum qualification: MBBS)	To be paid as per the NHM / Local norms for Central Sector Scheme	60000	1	12	720000
4	Salary – Nurse/ward attendant	To be paid as per the NHM / Local norms for Central Sector Scheme	20000	3	12	720000
6	Salary - Counsellor	To be paid as per the NHM / Local norms for Central Sector Scheme	20000	2	12	480000
7	Salary – Accountant/Data Manager	To be paid as per the NHM / Local norms for Central Sector Scheme	15000	1	12	180000
9	Chowkidar	Local norms for Central Sector Scheme	8000	3	12	288000
11	Yoga /Dance / Music /Art therapist	Local norms for Central Sector Scheme	5000	1	12	60000
	Life skills trainer/ teacher		20000	2	12	480000
	Gynecologist on-call		5000	1	12	60000
	Support for children of residents		2000	1	12	24000
	Nutritional support	@ Rs 100 per person per day for 15 persons	45000	1	12	540000
	Personal health and hygiene supplies (includes clothes, toiletries, sanitary items, etc.)	@Rs 500 per person per month for 15 persons	7500	1	12	90000
12	Contingency, Communication / Stationery					72000
13	Medicines*					250000
	Rent		25000	1	12	300000
	Conveyance & POL. Support for transporting and producing Children to CWC, Phone & Internet etc.		16000	1	12	192000
16	Gross Total					4946000

NB: All staff employed in the centre must be females

Appendix-VI

Annual Budget for De-addiction Centre for Male Children

Sl. No.	Cost Head	No. of Units	Monthly unit cost (in INR)	Monthly budget (in INR)	Annual Budget (in INR)
A.	**Staff**				
1	Project Coordinator-cum-counseller (with minimum additional two years experience of working with children)	1	25000	25000	300000
2	Psychologist/Counsellor (with minimum additional two years experience of working with children)	1	20000	20000	240000
3	Doctor (Part time) (Minimum qualification MBBS) + Visiting paediatrician (MD, Paediatrics)	1	25000	25000	300000
4	Health Attendant/ Ward boy/Nurse	3	15000	45000	540000
5	Social Worker/Teacher/ Life Skill Trainer	3	20000	60000	720000
6	Accountant	1	10000	10000	120000
7	Outreach Worker	1	10000	10000	120000
8	Yoga, Art, Music and Dance Therapists	Lump sump	20000	20000	240000
9	Security Guards	3	8000	240000	288000
10	Support Staff for preparing children's cases for CWC/JJB	1	15000	15000	180000
B.	**Recurring Expenses**				
11	Nutrition for children (Meals @ Rs 100 per child per day)***** * Meals include breakfast, lunch, morning/ evening tea & dinner; for children living at the centre	25	3000	75000	900000
12	Medicines	12	9000	9000	108000
13	Personal Shoes, Sanitation (Clothes toiletries etc.) @ Rs. 200/- per person for 25 children required monthly	25	200	5000	60000

C.	**Office Expenses**				
14	Conveyance & POL. Support for transporting and producing Children to CWC, Phone & Internet etc.	25	16000		192000
15	Rent	25	25000		300000
	Grand Total				**4608000**

D.	**One Time Expenditure**				
	One time Expenditure on Office Equipment (Furniture, Computer, Games, TV) & Library Equipment(Books, Shelves, AV equipment)	1 time	*25		250000

Appendix-VII

Annual Budget for De-addiction Centre for Prison Settings

S. No.	Name of the Post	No.of Posts	Monthly Expenditure (Rs.)	Yearly Expenditure (Rs.)
A. RECURRING EXPENDITURE [ESTT] a. Administrative:				
1.	Project Coordinator	**1**	30,000	**3,60,000**
2.	Accountant cum Clerk (Part time)	**1**	18,000	**2,16,000**
3.	Cook	**1**	Provided by Prison Authority	
4	Chowkidar	**2**	Provided by Prison Authority	
5	Sweeper	**1**	Provided by Prison Authority	
b. Medical:				
1.	Medical Officer (Part time)	**1**	Provided by Prison Authority	
2.	Counsellor/ Social Worker /Psychologist /Community Worker	**2**	3x25,000= 75,000	**9,00,000**
3.	Nurse/Ward Boys	**2***	4x20,000= 80,000	**9,60,000**
4.	Peer Educator	**1**	10,000	**1,20,000**
	Sub. Total	**12**	**1,41,800**	**25,56,000**

B. RECURRING EXPENDITURE [OTHER THAN ESTT.]*			
S. No.	**Item**	**Monthly Expenditure (Rs.)**	**Annual Expenditure (Rs.)**
1.	Rent	Provided by Prison Authority	
2.	Medicines	9,500	1,14,000
3.	Contingencies	10,000	1,20,000
4.	In house Kitchen expenditure	Provided by Prison Authority	
	Sub. Total	**70,350**	**2,28,000**
C. Non Recurring Expenditure			
1	Non- Recurring Expenses (One Time)	.....	**2,45,000**
	TOTAL		**2,45,000**
	TOTAL A + B + C	**2,12,150**	**27,90,800**

APPENDIX –VIII

NORMS FOR COMMUNITY BASED PEER LED INTERVENTION FOR EARLY DRUG USE PREVENTION AMONG ADOLESCENTS					
S. No	**Budget Head**	**Nos**	**Rate**	**Duration**	**Amount**
A. Human Resource Costs					
(i)	Honorarium to Area Coordinator	1	20000	12	240000
(ii)	Honorarium to Trainer cum Supervisor*	2	15000	12	360000
(iii)	Honorarium to Peer Educators (PE) 1 PE will take 1 session of 2 hours duration @Rs. 150 per session over 60 sessions /Quarter	20	150	240 sessions	720000
(v)	Nutritional/ Refreshment support @Rs. 10 per day per child for 60 sessions/ quarter	200	10	240 sessions	480000
(vi)	Life skills educational kit printing cost including flex material / games / scrolls	100 sets	1000		100000
B. Training Costs of PEs and Staff (One time for 15 days duration through NISD)					
(i)	Honorarium to Trainers for ToT @Rs. 1500 per session	4	1500	15	90000
(ii)	Lunch, two Tea with Refreshment @Rs.175 per day (20 PEs, 3 staff and Resource Person (5 extra Peers trained)	25	175	15	65625
(iii)	Stationery @Rs. 150 per Training including	20	150		3000
(iv)	Training Venue & AV equipment hiring	1	2500	15	37500
C. Office Expenditure Cost					
(i)	Up keeping of documentation	1	4000	12	48000
(ii)	Project Site Office Rent Cost	1	10000	12	120000
(iii)	Office Expenses	1	12000	12	144000
	Grand Total (A+B+C)				**24,08,125**

*It would be the discretion of the organization to allocate the remuneration amongst the incumbents within the overall financial allocation

Note: 20% of re-appropriation of expenditure would be permissible within the total admissible allocation

APPENDIX –IX

NORMS FOR OUTREACH AND DROP IN CENTER (ODIC)					
S.No	**Budget Head**	**Nos**	**Rate**	**Duration**	**Amount**
A. One-time fixed set up cost					
(i)	Furniture, chairs, almira, recreational equipment for Drop In Center	One-time Cost			1,00,000
B. Human Resource Costs					
(i)	Honorarium to Center In-charge Cum Counsellor	1	20000	12	2,40,000
(ii)	Honorarium to Outreach Worker*	3	15000	12	5,40,000
(iii)	Honorarium for Part time Doctor	1	20000	12	2,40,000
C. Training Costs of ORWs and Staff (One time for 15 days duration through NISD)					
(i)	Honorarium to Trainers for ToT @Rs. 1500 per session	4	1500	15	90000
(ii)	Lunch, two Tea with Refreshment @Rs.175 per day (20 PEs, 3 staff and Resource Person (5 extra Peers training)	25	175	15	65625
(iii)	Stationery @Rs. 150 per Training including	20	150		3000
(iv)	Training Venue & AV equipment hiring	1	2500	15	37500
D. Admin. and Operational Costs					
(i)	Honorarium for Part Time Account & M & E Officer	1	5000	12	60,000
(ii)	Drop in Center - Rent	1	15000	12	1,80,000
(iii)	Medicine		6000	12	72,000
(iv)	Communication & Transportation for Outreach Workers*	3	2000	12	72,000
(v)	BCC/ IEC material printing cost	1	5000	12	60,000
(vi)	Office Expenses	1	12000	12	1,44,000
Grand Total (B+C+D)					**18,04,125**

*It would be the discretion of the organization to allocate the remuneration amongst the incumbents within the overall financial allocation

Note: 20% of re-appropriation of expenditure would be permissible within the total admissible allocation.