



FROM PREVENTION TO RECOVERY: COMMUNITY, INSTITUTIONAL, POLICY AND REHABILITATION RESPONSES TO DRUG USE IN MEGHALAYA

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Article DOI: <https://doi.org/10.36713/epra29098>

DOI No: 10.36713/epra29098

ABSTRACT

Drug-use responses increasingly require movement beyond isolated prevention campaigns and punitive approaches toward integrated systems encompassing prevention, early intervention, treatment, rehabilitation, harm reduction, recovery, social reintegration and community participation. This article examines the prevention, treatment, rehabilitation, recovery, legal, policy and institutional responses to drug use in Meghalaya within the wider Indian framework. Drawing on government policies, national programmes, empirical research and Meghalaya-specific initiatives, the article analyses the extent to which existing responses address the multidimensional nature of substance use. It focuses on school-based prevention, community-based interventions, the National Action Plan for Drug Demand Reduction, Nasha Mukta Bharat Abhiyaan, the Meghalaya Drug Abuse Prevention Policy 2020, and the Drug Reduction Elimination & Action Mission (DREAM). The article further examines treatment accessibility, rehabilitation infrastructure, social reintegration, vocational support, relapse prevention, ethical standards, client rights and barriers to treatment. The evidence indicates that India has developed a broad institutional architecture for drug-demand reduction. Still, significant gaps remain in service accessibility, continuity of care, workforce capacity, social reintegration, and community-level treatment support. In Meghalaya, the emergence of DREAM represents an effort to coordinate social mobilisation, recovery pathways, and drug-regulation mechanisms. Community institutions such as Dorbar Shnongs, Nokmas, Village Health Councils, youth organisations, and other local actors provide important opportunities for locally grounded prevention. However, these mechanisms require sustained institutional coordination, professional capacity, adequate financing and rights-based oversight. The article argues for a continuum-of-care model in which prevention, treatment, rehabilitation, livelihood support, community reintegration and long-term recovery are treated as interconnected rather than separate interventions.

KEYWORDS: Drug Prevention, Rehabilitation, Recovery, Meghalaya, Community Participation and Social Reintegration.

1. INTRODUCTION

In 2023, there were 316 million drug users and it was also estimated that just one in 12 users received treatment for their drug use; it was also stated that drug use disorder places a considerable burden on individuals, communities, and healthcare systems. (United Nations Office on Drugs and Crime [UNODC], 2025). In Meghalaya, it witnessed an increase in the number of drug users from approximately 2 lakh in the previous year to 3 lakh in 2024 (HP News Service, 2024b). The review also shows that drug initiation in Meghalaya started as early as 10 years old. In contrast, in other states in North East India such as Manipur and Nagaland, the initiation of drug use started at an average age of 22. According to the 128 respondents of the survey in Meghalaya, access to drugs is considered to be easy and curiosity, pressure from their peers, family problems and a source of relief from stress were stated as the reasons for the initiation of drug use (Press Trust of India, 2025).

In this regard, the contemporary drug-use problem requires responses that extend beyond law enforcement. Substance-use disorders affect health, family relationships,

education, employment, social participation and community well-being. The World Health Organisation (WHO) plays an important role in addressing the global drug problem by emphasising five major areas of action: prevention, treatment, harm reduction, access to controlled medicines, and monitoring and evaluation (United Nations, n.d.). Consequently, effective responses must incorporate prevention, treatment, rehabilitation, harm reduction, recovery and India has developed a broad institutional framework for addressing substance use. The National Action Plan for Drug Demand Reduction (NAPDDR) incorporates treatment facilities, community-based peer interventions, outreach and drop-in centres, addiction treatment facilities, district de-addiction centres, awareness programmes, and capacity building (Ministry of Social Justice & Empowerment, 2023a, 2023b). The Ministry of Social Justice and Empowerment identifies NAPDDR as an umbrella framework for sustained and coordinated action against substance abuse.

The Nasha Mukta Bharat Abhiyaan (NMBA), initially launched in 272 vulnerable districts in 2020, was subsequently extended across districts in India. Its approach combines



awareness, identification of dependent populations, counselling and treatment, rehabilitation, and capacity building.

At the state level, Meghalaya has developed the **Meghalaya Drug Abuse Prevention Policy, 2020** and subsequently established the **Drug Reduction Elimination & Action Mission (DREAM)**. The Meghalaya Government approved DREAM in January 2023 as a mission-mode approach that incorporates social mobilisation, support systems, rehabilitation, counselling and drug-regulation mechanisms.

Against this institutional background, this article examines the continuum from prevention to recovery. It considers the roles of schools, communities, treatment and rehabilitation services, national and state policy frameworks, law enforcement, ethical oversight, and social reintegration. It also examines the barriers and facilitators that shape access to treatment and long-term recovery.

2. PREVENTION AND EARLY INTERVENTION

Prevention should not be understood merely as communicating the dangers of drugs. Contemporary prevention requires interventions that address individual capabilities, family relationships, peer environments, school engagement, community conditions, and structural vulnerabilities.

Latimore et al. (2023) emphasise the socio-ecological nature of health outcomes and the importance of interventions that operate beyond individual behaviour. Accordingly, drug prevention should combine education with life skills, social support, structured activities, family engagement, early identification and accessible counselling.

Within this framework, prevention is a continuum. **Primary prevention** seeks to prevent initiation among individuals who have not begun using substances. **Secondary prevention** focuses on identifying early or risky use and intervening before dependence becomes established. **Tertiary prevention** involves reducing harm, supporting treatment, preventing relapse, and promoting social reintegration among people with established substance-use disorders. This continuum provides a more useful framework than a simple distinction between "drug users" and "non-users."

Schools represent an important setting for early prevention because adolescence is a period of heightened vulnerability. The *Towards No Drug Abuse* (TND) programme illustrates how school-based interventions can combine information with social and behavioural skills. Griffin and Botvin (2010) reported reductions in hard-drug use alongside improvements in other behavioural outcomes.

Similarly, the Meghalaya Drug Abuse Prevention Policy, 2020 recommends life-skills interventions, teacher and counsellor training, awareness programmes, strengthening youth organisations, increased vigilance around educational institutions, anonymous surveys to identify patterns of substance use, counselling facilities in schools and colleges and offering holistic treatment: from detoxification to rehabilitation and aftercare.

These measures indicate a movement from information-based prevention toward **institutional prevention capacity**. The

DREAM framework also seeks to integrate school health, adolescent health, counselling, awareness, life-skills education, sports, extracurricular activities, and referral systems (Social Welfare Department, Government of Meghalaya, 2023). The key policy question is therefore not simply whether schools should provide drug education, but whether they have sufficient trained personnel, referral pathways, counselling infrastructure and mechanisms for early identification.

Community participation provides another important dimension of prevention. This is particularly relevant in Meghalaya because local institutions have historically played significant roles in community governance. The Meghalaya Drug Abuse Prevention Policy, 2020 assigns roles to institutions such as Dorbar Shnongs and Nokmas, including participation in training and community awareness activities.

The DREAM initiative similarly seeks to mobilise community structures and local stakeholders. The Government of Meghalaya's December 2023 community accord under DREAM explicitly brought together government departments and community stakeholders to strengthen collective action against drug addiction.

Community-based interventions can help identify vulnerable individuals, reduce stigma, provide family support, encourage treatment-seeking, monitor community-level risks, refer to formal services, and support reintegration after treatment. In fact, DREAM has supported traditional institutions, such as the Mawlai Town Dorbar, in implementing anti-drug initiatives. As part of this effort, the first instalment provided counselling services and livelihood support to approximately 30 individuals affected by drug use (HP News Service, 2024a). The Mawlai Town Dorbar's involvement in anti-drug activities shows how traditional institutions can support prevention and rehabilitation.

The broader implication is that community institutions should not merely be used as instruments of surveillance. Their role can extend to **support, early identification, referral, social reintegration and recovery protection**. At the same time, community participation must operate through clear referral mechanisms and professional partnerships so community surveillance does not replace clinical assessment.

3. INSTITUTIONAL AND POLICY RESPONSES IN INDIA AND MEGHALAYA

India's NAPDDR provides a broad framework for demand reduction. Its components include Integrated Rehabilitation Centres for Addicts, Community-Based Peer-Led Interventions, Outreach and Drop-In Centres, Addiction Treatment Facilities, District De-Addiction Centres and awareness programmes.

The framework is significant because it recognises that treatment cannot be reduced to detoxification. NAPDDR includes identification, motivation, counselling, treatment, aftercare, rehabilitation, skill development and livelihood support. The framework also seeks to reduce stigma and discrimination and promote reintegration into society.

The *Nasha Mukta Bharat Abhiyaan* extends this institutional architecture through prevention and awareness



activities. The Government of India reports that NMBA has expanded from 272 districts to all districts since August 2023.

These national mechanisms create an important policy foundation for states such as Meghalaya. However, their implementation depends on local infrastructure, workforce availability, service accessibility, continuity of care, and coordination between central, state, district, and community institutions.

At the state level, the **Meghalaya Drug Abuse Prevention Policy, 2020** conceptualises drug and substance abuse as a socio-economic and human-rights concern requiring prevention, treatment, rehabilitation and reintegration. This places substance use within a broader social framework rather than treating it solely as an issue of individual behaviour or criminality.

DREAM subsequently developed this approach into a mission-mode strategy. The Government of Meghalaya describes DREAM as a comprehensive strategy built on culture and community and organised around social mobilisation, enabling support systems, and drug-regulation law procedures.

DREAM therefore represents an attempt to connect three domains that are frequently treated separately:

Prevention → Recovery and Care → Regulation and Enforcement

This framework matters because it seeks coordination across these domains, not any single intervention.

4. TREATMENT, REHABILITATION AND RECOVERY

Treatment is a critical component of the response because prevention cannot eliminate all substance-use disorders. The national rehabilitation framework has evolved from awareness-oriented programmes toward community-based identification, motivation, counselling, detoxification, rehabilitation, aftercare and whole-person recovery.

The national survey found substantial unmet treatment needs among people using alcohol, cannabis, and opioids (Ministry of Social Justice & Empowerment, 2023a). This treatment gap highlights the importance of assessing rehabilitation infrastructure not only by the number of facilities but also by coverage, quality, continuity, affordability and accessibility.

In Meghalaya, the existing framework includes privately operated centres, centres supported by the Ministry of Social Justice and Empowerment, state-supported centres, Addiction Treatment Facilities, Outreach and Drop-In Centres, and Community and Peer-Led Interventions (Social Welfare Department, Government of Meghalaya, 2023). The state has also proposed financial assistance for eligible individuals requiring treatment outside Meghalaya.

Rehabilitation, however, extends beyond detoxification. Long-term recovery requires attention to employment, education, family relationships, housing, mental health, social support, community acceptance, relapse prevention and meaningful participation in society.

Souza et al. (2016) emphasise the importance of vocational and educational support. Employment can provide not only income but also routine, social identity, purpose and social inclusion. Meghalaya's proposal to incorporate skill-development activities into rehabilitation services therefore addresses an important dimension of recovery. The state has recognised the need to connect treatment with livelihood opportunities (Northeast News, 2024).

The policy significance is substantial: **rehabilitation should not end when an individual leaves a treatment centre.**

Recovery should consequently be conceptualised as an ongoing process rather than a single treatment event. Kelly et al. (2019) emphasise the chronic and recurrent nature of substance-use disorders. Ogilvie and Carson (2024) similarly distinguish recovery from simple abstinence and emphasise self-directed change, self-efficacy, recognising triggers and developing sustainable lifestyles.

The concept of recovery protection is particularly relevant. Rather than placing the entire responsibility on an individual to resist drugs, recovery-oriented systems attempt to create environments in which healthy choices become sustainable. This requires:

Clinical Treatment + Family Support + Employment + Social Inclusion + Community Support + Continuing Care.

A rehabilitation system that provides detoxification but does not address unemployment, social stigma, family conflict and peer environments may leave individuals vulnerable to relapse.

5. TREATMENT ACCESSIBILITY, BARRIERS AND FACILITATORS

Multiple structural, individual, and social barriers shape access to treatment. Owens et al. (2018) identified perceived absence of a problem, privacy concerns and admission difficulties as important barriers. As indicated in the data presented in the article, in 2023, approximately one in every twelve people living with a drug use disorder received treatment. This means that, of the estimated 64 million people with drug use disorders globally, only a small proportion had access to treatment for their drug use (United Nations, n.d.).

Farhoudian et al. (2022) identified structural barriers as particularly numerous, including provider-related problems, legal barriers and policy-related constraints. Individual barriers included misconceptions, fears, personal characteristics and psychiatric comorbidities, while social barriers included stigma and inadequate social support.

Adeniran et al. (2023) also identified barriers related to finance, confidentiality, legal concerns, staffing, leadership, resources, referral networks and programme capacity. These findings are relevant to Meghalaya, where stigma and limited treatment infrastructure may interact to delay treatment-seeking.

Stigma operates at several levels. At the individual level, it may produce shame and self-blame; at the family level, it may encourage concealment and social isolation; at the community level, it can result in rejection and discrimination; and at the



institutional level, it can contribute to discriminatory treatment or inadequate services.

The Meghalaya Social Welfare Department has recognised that stigma and discrimination can cause individuals to deny dependence, conceal drug use, delay treatment, or become involved in risky and criminalised behaviours (Social Welfare Department, Government of Meghalaya, 2020). Reducing stigma is therefore directly related to treatment accessibility and recovery.

Treatment access is strengthened when systems are trusted, accessible, adequately staffed and responsive. Farhoudian et al. (2022) identified structural facilitators including supportive treatment settings, logistical assistance and favourable policies. Social facilitators included family, friends and treatment-team support, while individual motivation also played a role.

Chattopadhyay et al. (2022) found that family responsibility, desire for a better future, recognition of the consequences of drug use, quality healthcare, effective treatment and improved socioeconomic conditions could support treatment engagement.

For Meghalaya, these findings suggest the importance of designing treatment systems around trust, accessibility and continuity rather than admission and discharge alone.

6. HARM REDUCTION, ETHICS AND RIGHTS

Harm reduction forms an important component of contemporary drug responses. This is especially relevant for people who inject drugs because unsafe injecting practices increase the risks of HIV, hepatitis B, hepatitis C, and overdose.

WHO and UNODC's Stop-Overdose-Safely initiative illustrates how naloxone training and community-based overdose response can reduce mortality (WHO & UNODC, 2021). India's national response also incorporates harm-reduction activities through the health system and the National AIDS Control Organisation.

For Meghalaya, where injecting drug use concerns have been documented, harm reduction should therefore be treated as complementary to prevention and treatment rather than as an alternative to recovery.

Ethical standards are equally important because individuals receiving treatment can be particularly vulnerable to coercion and institutional abuse. The Minimum Standards of Services developed under the national programme emphasise non-discrimination, dignity, confidentiality, informed participation, safety, access to information, grievance mechanisms and professional conduct (National Institute of Social Defence & Regional Resource and Training Centres, 2009).

The Mental Healthcare Act, 2017 further establishes rights-oriented principles concerning mental-health care and rehabilitation (Government of India, 2017).

These standards require rehabilitation institutions to provide more than physical confinement. They require professionally appropriate treatment environments in which clients retain dignity, confidentiality, information rights and complaint mechanisms.

In an undercover research study, Beetham contacted 600 residential treatment facilities and found that most were for-profit rehabilitation programs more concerned with non-medical issues. Most callers are not nurses or therapists; they act like salespeople, demanding large upfront payments without thoroughly evaluating patients' actual healthcare needs. Studies show that quality medical care significantly affects long-term recovery and overall health (Mann, 2021).

The evidence therefore indicates that expanding rehabilitation capacity must be accompanied by quality assurance, professional standards, client protection, and independent oversight.

7. LAW ENFORCEMENT, COMMUNITY GOVERNANCE AND LOCAL IMPLEMENTATION

The Narcotic Drugs and Psychotropic Substances Act, 1985 provides the central legal framework governing narcotic drugs and psychotropic substances in India. Law enforcement remains necessary to disrupt trafficking networks and illicit markets. However, enforcement operates alongside prevention, treatment and rehabilitation rather than replacing them.

The Meghalaya context illustrates this dual requirement. Police records reported 189 NDPS cases in 2023, compared with 116 in 2022, 69 in 2021, and 76 in 2020 (Meghalaya Police, 2023a). District-level differences were also substantial, with East Khasi Hills recording the highest number of cases in 2023, followed by East Jaintia Hills, Ri Bhoi, and West Garo Hills (Meghalaya Police, 2023b).

These data can help identify enforcement patterns, but they should not automatically be interpreted as direct measures of prevalence. Registered cases reflect both drug-related activity and institutional detection.

This distinction is important for policy analysis because enforcement statistics and public-health indicators measure different dimensions of the drug problem. A comprehensive response therefore requires coordination between law enforcement, health services, social welfare institutions, schools, community organisations and rehabilitation providers.

One significant opportunity in Meghalaya is incorporating local institutions into prevention and recovery. The Meghalaya policy explicitly recognises the role of Dorbar Shnongs and Nokmas. DREAM has further encouraged collaboration among government agencies, communities, health services, educational institutions, and other stakeholders.

The role of community institutions can extend across the recovery continuum:

Awareness → Early identification → Referral → Family support → Treatment → Reintegration → Relapse prevention

The participation of organisations such as the Hynniewtrep Youth Council in discussions concerning drug monitoring, treatment accessibility, skill development, and community awareness illustrates the growing role of civil-society actors (The Shillong Times, 2024b).

Community participation, however, should be structured through clear referral mechanisms and professional partnerships



so that community surveillance does not replace clinical assessment or rights-based treatment.

8. DISCUSSION

The evidence reviewed in this article indicates that drug-use responses in Meghalaya need to be understood as an interconnected system rather than as a collection of independent programmes. Prevention addresses initiation and risk; early intervention identifies emerging problems; treatment addresses established substance-use disorders; rehabilitation supports functional and social recovery; and reintegration supports sustained participation in family, employment and community life.

The literature also indicates that gaps can emerge when these components operate independently. Prevention without early identification may miss emerging substance use. Early identification without accessible treatment may create unmet demand. Treatment without rehabilitation may leave socioeconomic vulnerabilities unresolved. Rehabilitation without employment and community reintegration may leave recovery vulnerable to social and economic pressures. Similarly, law enforcement without adequate prevention and treatment may address aspects of drug supply without addressing the wider conditions associated with substance use.

Community participation adds another dimension to this continuum. Traditional institutions, youth organisations and local governance structures can contribute to awareness, early identification, referral and social reintegration. However, community participation must connect to professional health and rehabilitation services. Otherwise, identification may not translate into appropriate treatment.

Meghalaya's DREAM framework provides an institutional opportunity to connect these domains through a coordinated response to substance use. The State's official formulation incorporates community mobilisation, rehabilitation, counselling, enabling support systems, and drug regulation within a mission-oriented framework. The Community Accord undertaken under DREAM also reflects an effort to engage multiple community stakeholders in addressing drug-related concerns. However, the available evidence does not yet provide sufficient basis to determine the programme's longer-term contribution to changes in drug-use patterns, access to treatment, continuity of care, relapse prevention, or sustained recovery. Further empirical research is therefore needed to examine DREAM's implementation, coverage, service delivery, inter-sectoral coordination, and follow-up mechanisms across different contexts. These areas represent important research gaps and underscore the need for systematic evaluation to understand better the programme's reach, implementation processes, outcomes, and areas requiring further strengthening.

9. POLICY AND PRACTICE IMPLICATIONS

The evidence reviewed suggests several areas for strengthening drug-use responses in Meghalaya.

1. **District-level treatment networks:** Treatment services should be mapped according to population needs,

geographic accessibility, substance-use patterns and referral requirements.

2. **Continuity of care:** Treatment should incorporate aftercare, family intervention, vocational support and community reintegration rather than ending at discharge.
3. **School-based early intervention:** Counsellors, teachers, health workers and youth organisations require systematic training, supported by appropriate referral mechanisms.
4. **Institutionalised community participation:** Dorbar Shnongs, Nokmas, Village Health Councils, youth organisations and civil-society groups can contribute to prevention and referral while operating within professionally defined roles.
5. **Rights-based oversight:** Rehabilitation centres require transparent standards, grievance mechanisms, confidentiality safeguards, professional staffing and independent monitoring.
6. **Integration of livelihood support:** Skill development and employment pathways should link to rehabilitation so socioeconomic stability supports recovery.
7. **Improved evidence and evaluation:** Meghalaya requires systematic monitoring of treatment access, treatment retention, relapse, reintegration, service quality and community-level outcomes. Such evidence would allow assessment of the effectiveness of programmes such as DREAM beyond activity or enforcement statistics.

10. CONCLUSION

Drug-use policy in Meghalaya requires a coordinated continuum encompassing prevention, early intervention, treatment, rehabilitation, harm reduction, recovery and social reintegration. India has developed substantial institutional infrastructure through NAPDDR and NMBA, while Meghalaya has established a state-specific policy framework through the Meghalaya Drug Abuse Prevention Policy, 2020 and DREAM.

The evidence reviewed suggests that the principal challenge is not simply the existence of programmes, but their accessibility, coordination, professional capacity, continuity and quality. Prevention initiatives require links to early identification and referral. Treatment needs to be connected with rehabilitation and aftercare services. Rehabilitation requires vocational and social reintegration support. Harm reduction needs to operate alongside treatment and recovery. Law enforcement needs to function within a broader public-health and social-response framework.

For Meghalaya, community participation represents an important institutional resource. Traditional institutions, schools, health services, youth organisations, government departments, civil society and law-enforcement agencies can contribute different forms of expertise. Their roles, however, need to be coordinated so prevention, enforcement, treatment, and recovery reinforce one another rather than operate independently.

Ultimately, a comprehensive drug-response system should be assessed through multiple indicators, including prevention and



initiation patterns, treatment access, treatment retention, health outcomes, relapse, employment, family stability and sustainable social reintegration. A continuum-of-care approach therefore provides a framework to connect and more systematically evaluate Meghalaya's existing institutional and community responses.

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