

# Youth Substance Abuse: Contrasting The Indian Experience With Developed Nations in Community Roles, Education, Legislation and Rehabilitation " The First and Greatest Victory Is To Conquer Yourself." — Plato

Beatify Lyngdoh<sup>1</sup>, Dr. Aruno Raj Singh<sup>2</sup>

<sup>1</sup>Research scholar, Royal School of Law and administration, The Assam Royal Global University, Guwahati, India. E-mail : beatifylynz@gmail.com

<sup>2</sup>Assistant Professor (Selection Grade), Royal School of Law and Administration, The Assam Royal Global University, Guwahati, India. E-Mail : arunorajsingh@gmail.com

## ABSTRACT

This study explores how substance abuse among Indian youths reflects the Indian experience relative to those of developed countries by examining community, education, legislation, and rehabilitation roles. Utilising a broad spectrum of literature, theory, and comparative policy analysis, in this research, sociocultural factors, policy environments, and community structures are interrogated to determine how the youth substance abuse system unfolds across the world. With unique cultural dynamics, differential public awareness, and traditional vs. modern influences, India faces a dilemma between prevention and intervention strategies. In contrast, developed nations tend to have well-established community support arrangements, clear educational measures, and stringent legislation. This research provides an overview of the efficacy of these approaches and the failings with regard to the rehabilitation system in India, which has gaps and inconsistent enforcement of law in the country. It also describes best practices from the developed world that may assist India in formulating holistic strategies. Utilising both theoretical observations and lived experience, this study proposes interventions based on recommendations for better effective prevention, policy, and rehabilitation mechanisms tailored for the Indian environment and context. Therefore, this study will contribute to the international conversation surrounding youth substance abuse through a comparative and interpretative framework and will inform future research and practice.

**KEYWORDS:-** Youth Substance Abuse, India, Developed Nations, Community Roles, Education, Rehabilitation

## 1. INTRODUCTION: CONTEXTUALIZING YOUTH SUBSTANCE ABUSE

Substance abuse in youth is a globally widespread and complex problem that affects societies everywhere. Substance abuse among young people. Based on the harmful or dangerous exposure to psychoactive substances such as alcohol or illicit drugs, substance abuse not only compromises the health of young persons but also causes significant social, economic, and legal concerns (World Health Organisation [WHO], 2018). The problem is not restricted to one area or demographic, or sector; it crosses cultural, financial, or national boundaries, so that sensitive and context-specific attention is needed from a policymaking context, and from community- and healthcare system-level activities. Indian youth, with its huge and diverse demographic group, is increasingly getting involved in substance abuse; it is increasingly problematic among youth. Current figures also indicate that almost 14.6% of India's population from ages 10 to 75 years is among the current users of alcohol, with a significant portion beginning use during adolescence and early adulthood (Ambekar et al., 2019). The increased substance use among youth has been attributed to factors including urbanisation, peer influence, socio-economic pressure and an increase in drug availability (Rao, 2018). India's demographic profile is notable, where almost 65% of the population is below 35, making youth-targeted interventions paramount, and these trends are especially worrisome. By contrast, the United States, the UK and Australia, among developed nations, have long struggled with youth substance abuse and introduced a variety of strategies to reduce it (Johnston et al., 2021). Substance use prevalence is still a concern in these countries, but successful measures (such as community support, educational and rehabilitation opportunities, comprehensive policies, etc.) have resulted in measurable gains in prevention and harm reduction (Room, 2022). The disparity in the Indian experience vis-à-vis those in developed countries is influenced by a wide range of factors. Attitudes towards substances in general, family and community support systems, accessibility and quality of education interventions, as well as rigorous policies on legal control of substances, are also key drivers of youth behaviour and outcomes (Gupta et al., 2020). Stigma against substance abuse in India often results in denial, delayed intervention, and inadequate support of affected individuals and families (Chavan & Arun, 2019). By contrast, in developed countries, open dialogue, early referral and community-based support are more commonly part of the response to youth drug-taking. Education is another vital point of divergence. In most developed countries, substance abuse prevention is included in school curricula with the support of evidence-based practice centred on the life skills, resilience and knowledge of well-informed decision-making (Durlak et al., 2011). Such efforts are routinely augmented by educational programs and communication materials aimed at encouraging parents and teachers. In India, national interventions and in-school provision are available but generally constrained by resource constraints, irregular execution and

missing culturally specific material (Kumar, 2021). Legislation also represents an important point of comparison. In contrast, developed countries tend to have extensive legal mechanisms in place for the sale, distribution and consumption of psychoactive substances, including protocols for the prevention, treatment and rehabilitation of these substances. Enforcement tools are more comprehensive, and young people's rights and welfare are highlighted more (Room, 2022). In India, there are laws like the Narcotic Drugs and Psychotropic Substances Act (1985), but enforcement of said laws is inconsistent and, rather than rehabilitate people, often follows punitive approaches (Gupta et al., 2020). Rehabilitation and reintegration are also one of the areas where there are inconsistencies. This service line includes a range of rehabilitation programs in developed countries, including individual and outpatient, individual and community-based, insurance- and state-funded post-treatment care (Johnston et al., 2021). Limited access to rehabilitation in India is a result of geographical, financial and social barriers; the majority of rehabilitation facilities are focused on urban areas and generally out of reach for marginalised subjects (Ambekar et al., 2019). Youth substance abuse is complex and requires a holistic, multi-sectoral response. This approach cannot solve many of the factors that lead to substance use and its consequences among youth. Through a comparison of the experience of India and those of developed countries, this study attempts to shed light on the challenges and prospects of community engagement, education, legislation and rehabilitation. This type of analysis is important for recognising not only best practices which can be translated to the Indian setting but also to demonstrate that culture-sensitive and data-informed approaches that focus on prevention, early intervention and the well-being of youth are required. This chapter aims to provide a context for a detailed examination of the youth substance abuse topic, providing a comparative perspective to analyse the value and drawbacks of national interventions. Lastly, our goal in mind was to make an impact on contemporary youth substance abuse dialogue and to support policy, practice and future research, both in India and internationally.

## **2. RESEARCH GOALS AND RESEARCH QUESTIONS**

### **Research Objectives**

The primary objective of this research is to closely assess and compare responses to youth substance abuse in India and in a number of developed countries, focusing on the involvement of communities, education systems, legislative frameworks, and rehabilitation models. In particular, this study aims to:

- I. Analyse the cultural, social, and historical factors influencing youth substance abuse in India and developed countries.
- II. Evaluate the effectiveness of community-based interventions and educational strategies in preventing substance abuse among youth.
- III. Compare legislative approaches and policy implementations concerning youth substance abuse in India and developed nations.
- IV. Assess rehabilitation models, their accessibility, effectiveness, and cultural relevance across different contexts.
- V. Identify challenges, gaps, and innovative practices that can inform future policy and intervention strategies in India.

### **Research Questions**

The study aims to achieve these objectives by answering the following research questions:

- A. What are the key cultural, social, and historical determinants of youth substance abuse in India, and how do they compare with those in developed nations?
- B. How do community roles and educational initiatives differ in their approach and effectiveness in addressing youth substance abuse?
- C. What legislative frameworks govern youth substance abuse in India and developed countries, and how do their enforcement and outcomes compare?
- D. How accessible and effective are rehabilitation and reintegration models for youth in India versus developed nations?
- E. What are the main challenges and gaps in current approaches, and what best practices from developed nations could be adapted to the Indian context?

## **3. GLOBAL OVERVIEW: LITERATURE PERSPECTIVES ON YOUTH SUBSTANCE ABUSE**

Youth substance abuse is a problem that the global population experiences continuously and constantly changes, and which has drawn significant attention from scholars. The World Health Organisation (WHO, 2018) defines substance abuse as the harmful or dangerous use of psychoactive substances - including alcohol and illicit drugs. Early adolescence and young adulthood form critical periods for initiation, with patterns of behaviour in this period often continuing into older adulthood (Johnston et al., 2021).

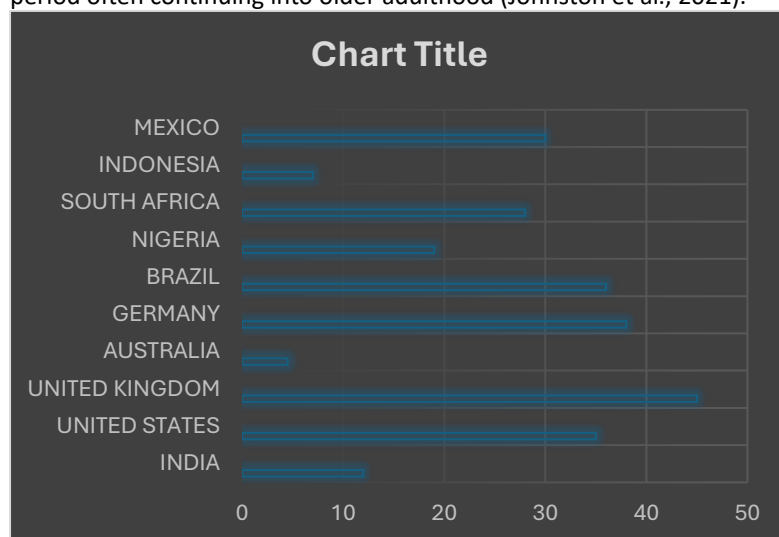


**Figure 1.** Prevalence of Alcohol Use Among Youth (Ages 15–19) in Selected Countries (Data adapted from World Health Organisation, 2018; ESPAD Group, 2020; Ambekar et al., 2019; UNODC, 2021)

Global evidence from across the literature highlights the interaction among social, cultural, economic, and psychological influences affecting youth substance use in different regions. However, prevalence data suggest that substance abuse in youth is prevalent, but rates and patterns differ per region and by substance type. Alcohol and cannabis are the most commonly used substances among adolescents in North America and Europe, with lifetime prevalence rates for alcohol use exceeding 80% in some populations (ESPAD Group, 2020; Johnston et al., 2021). There have been some declines in adolescent cigarette smoking, but there is a corresponding increase in vaping and cannabis use over the past 10 years. In comparison, prevalence rates in Asian and African countries have commonly been lower; however, such figures may be underestimated as a result of cultural stigmatisation and underreporting (UNODC, 2021). Multiple risks for youth substance use are presented in the literature. Peer influence, family history of substance abuse, academic pressure, financial hardship, deprivation, and mental illness were repeatedly associated with risk (Degenhardt et al., 2016). A social learning theory of adolescent substance use suggests that adolescents will be more likely to use substances if it is modelled by peers and even family members (Bandura, 1977). Also, globalisation and urbanisation have increased both the accessibility and acceptability of substances, especially in low- and middle-income countries (Room, 2022). Culture is an important factor that has an impact on attitudes and behaviour toward the use of substances. Experimentation with alcohol/cannabis during adolescence is in many Western cultures considered normative, albeit hazardous, behaviour (Room, 2022). On the other hand, in a traditional society, substance use might be stigma-related among youth, resulting in secrecy, denial and obstacles to help-seeking behaviour (Gupta et al., 2020). Gender norms also matter in patterns of use, with males reporting overall higher rates of substance use in most of the world (except for some high-income countries, where the gender gap is narrowing; ESPAD Group, 2020). There are wide differences in the prevention and intervention strategies used in diverse countries. Evidence-based prevention systems in schools have gradually been used in developed countries to promote social skills, choice orientation, and resistance to peer influence (Durlak et al., 2011). Such programmes, underpinned by community engagement and mass media campaigns, have shown modest but meaningful decreases in substance use initiation. There has been an acceptance of harm reduction approaches, especially needle exchange programs and supervised consumption sites, in some countries, reflecting a shift from punitive policies to health-based policies (Room, 2022). In contrast, many low- and middle-income countries, including India, struggle to implement the same preventive and treatment measures owing to limited resources, healthcare infrastructure, and sociocultural barriers (Ambekar et al., 2019). From the literature, culturally sensitive interventions that are sensitive to local risk factors and capitalise on community resources are identified as needed (Gupta et al., 2020). The impact of substance abuse in youth is serious internationally. This can be due to higher risk of accidents and injuries, impaired academic performance, mental health issues, criminal activity and permanent dependency (Degenhardt et al., 2016). The impact on public and social health and economic development is severe (WHO,

2018) and is not limited to the individual. To conclude, the global literature highlights the multifaceted nature of youth substance abuse as influenced by multiple cultural and socio-economic contexts. Efforts to improve evidence-based prevention and harm reduction have demonstrated success in some contexts, but huge hurdles still exist in low-resource settings. Examining similar studies, such as the current study, is crucial for best practices, to tailor interventions to different contexts and to influence global policies on alleviating adolescent substance abuse.

#### **4. THE INDIAN PARADIGM: CULTURAL, SOCIAL, AND HISTORICAL DIMENSIONS**

India has experience with youth substance abuse, influenced by a distinct mixture of historical, cultural, and social forces. Unlike in much of the West, where contemporary substance use patterns began to emerge alongside burgeoning industrialisation and rapid urbanisation, India's attitude was shaped long before psychoactive substances. Alcohol, cannabis (bhang), and opium in India have historical social roles as part of traditional practices in Indian society that were both ritualistic and recreational (Ambekar et al., 2019). Ancient texts include references to soma and other intoxicants in sacred rituals, reflecting a long-standing and ambivalent cultural association with substances changing the mind (Chavan & Arun, 2019). This was to be replaced by the landscape of substance use in India under colonial rule, which changed this landscape dramatically. British rules criminalised some substances while commercialising others, introducing legal ambiguities and new social stigmas. The British, for instance, established excise policies to raise revenue from alcohol and opium while also curbing their use among Indian people (Varma, 2019). These colonial histories endure into modern-day attitudes and legal systems towards substance use and abuse. The changes in socio-economic conditions since independence are a contributing factor in an already changing environment for youth in India regarding substance use. Urbanisation, migration, and the disintegration of traditional joint family structures have caused erosion of some traditional control systems (Gupta et al., 2020). It seems that urbanisation has increased the exposure to peer pressures, availability of drugs, and increases in stress (Rao, 2018), and that adolescents are increasingly the most vulnerable. In India, India has high social taboo towards drug and alcohol use amongst both the young and women. Honour of the family, reputation in society is highly appreciated, and substance use is considered to be an issue not only of self-esteem but also of the whole family (Chavan & Arun, 2019). The stigma can foster secrecy and denial to seek intervention and support. It further implies that a considerable proportion of the substance abuse amongst youth is concealed, thereby hindering the appropriate assessment and intervention (Ambekar et al., 2019). Religious beliefs further shape attitudes toward substance use. For instance, alcohol is strictly prohibited in Islam, and many Hindu and Sikh communities also discourage its use. Nonetheless, cultural acceptance of certain substances, such as cannabis during religious festivals like Holi or Shivratri, continues in some regions (Ambekar et al., 2019). This duality demonstrates the diversity between prohibition and acceptance in India. Family is especially significant in India. Family has an enduring protective quality that tends to provide emotional and practical assistance to younger people; in particular, boys and girls are also raised within families. However, changes in family pattern, such as higher rates of family conflict, parental substance use and lack of supervision, are associated with increased risk for adolescent substance use (Gupta et al., 2020). The peer groups are also very influential, especially in the urban or semi-urban areas where westernisation and media influence are more popular (Kumar, 2021). Socioeconomic inequality makes the situation even messier. Youth from lower socioeconomic groups may use substances to cope with issues related to stress, unemployment, or lack of opportunity. On the other hand, the affluent youth have potentially more access to market items and an impact of globalised youth culture (Rao, 2018). Such dual pressures of hard times and fast modernisation present a multifaceted landscape on which youth grapple through the trials and tribulations of adolescence and young adulthood. The Indian youth substance abuse paradigm is thus one that is not only a product of historical and societal legacies but also an expression of rapidly modernising societies. A landscape that is both demanding and unique, shaped by stigma, family influence, religious belief, and socio-economic factors. So a response which is effective, be it prevention, intervention, or rehabilitation, must follow the subtleties of these cultural and historical structures, recognising the ingrained socio-cultural dimensions through which youth's lives and choices are informed.

#### **5. COMMUNITY ENGAGEMENT: THEORETICAL APPROACHES AND COMPARATIVE ANALYSIS**

Community engagement is well regarded as a constitutive activity of viable prevention and interventions for young adolescent substance abuse. Theoretical conceptual models—such as the Social Ecological Model and Social Capital Theory—emphasise the significance of community-level factors—such as family relationships, peers, schools and local institutions—in how youth behave (Bronfenbrenner, 1979; Putnam, 2000). These paradigms suggest that individuals' choices are embedded within webs of relationships and prevailing

community norms that require collective action and local engagement to really work. Community engagement in India has historically focused on family, religious institutions, and local leaders. Family, neighbourhood networks, and village councils (panchayats) used to serve as social control and advocacy platforms for youth (Gupta et al., 2020). The structures are still prevalent, but are weakly consolidated, in many urban and semi-urban regions, resulting from migration, modernisation, and social values shift (Rao, 2018). In India, community-based interventions often involve non-governmental organisations (NGOs) encouraging local actors to become aware of the issue and to help the community, counselling and access rehabilitation services (Ambekar et al., 2019). However, these interventions often face limitations in resources and funding, and a societal stigma attached to substance use. Whereas, developed countries have institutionalised such involvement, such as through community coalitions, public health networks and school-based prevention mechanisms. The Communities That Care (CTC) model is one widely adopted way in the United States and Australia that brings local agencies, schools, parents, and those children who grow up together to evaluate community needs and then implement policies based on existing evidence (Hawkins et al., 2009). Through data-driven planning, professional training, and constant assessment, this can be accomplished through continuous participation. Similarly, community policing, youth clubs and after-school programs are all expressions of rich and sophisticated forms of engagement used in developed settings of life (Room, 2022). The institutional support and acceptance of open discussions of substance use are two notable contrasts between India and developed countries. In most Western countries, community participation is facilitated by policy frameworks, revenue sources, and a health concern perspective that is designed to mitigate stigma and encourage early intervention (Room, 2022). In India, the social stigma, fear of social ostracisation, and lack of policy integration, on the other hand, inhibit community work, which particularly affects rural and marginalised communities (Gupta et al., 2020). Even with these challenges in the region, there are great examples of community-based effective initiatives in India, like peer educator programs, self-help groups, and faith-based ones based on local cultural strengths (Ambekar et al., 2019). These are indicative of the need for culturally contextualised, participatory interventions that facilitate community ownership of prevention and support. The paper emphasises that, while community engagement is both important and required for specific circumstances, from a theoretical standpoint, at least, and from a comparative perspective, such engagement needs to be contextual. For India, tapping into traditional social networks, reducing stigma, and integrating community efforts with formal policy can be critical to making prevention and intervention strategies for youth substance abuse work.

## **6. EDUCATION AND AWARENESS: CONCEPTUAL FRAMEWORKS AND POLICY ANALYSIS**

Preventing drug and alcohol use by youth is very important for a lot of reasons. The Social Cognitive Theory and the Health Belief Model stress the importance of knowledge, attitudes, and perceived norms in predicting youth health behaviours (Bandura, 1986; Rosenstock, 1974). These theories imply that education should not only be a source of information but also a way to cultivate cognitive readiness, confidence, and support for those young people who, through critical thinking and self-efficacy, learn to refuse to use drugs. Education-based prevention strategies are regularly embedded in formal school curricula in this same model in the developed world, beginning early and reaching adolescence. Such prevention mechanisms to engage in social competence-enhancing programs like Life Skills Training (LST) and the Good Behaviour Game have shown success in facilitating decreases in the use of substances (Durlak et al., 2011; Faggiano et al., 2014). Typically, policies that require health education, provide for teacher training, and involve parents are put in place to support such initiatives. Public awareness campaigns on mass media, social media and community outreach serve to reinforce school-based programs by altering societal views on drug use (Room, 2022). On the other hand, India's education about and efforts to bring up awareness about substance abuse are rather a work in progress. National plans, including the NAPDDR, emphasise the importance of prevention through education; this may vary in its execution across various areas and may be influenced by resources (Ambekar et al., 2019). Many schools in India do not have a proper health education curriculum, and teachers may fail to be provided sufficient training in substance abuse prevention (Kumar, 2021). Cultural taboos and stigma further inhibit open discussion of substance use, which in turn limits awareness efforts. Policy analysis implies that, in the Indian context, there is a set of problems and even opportunities. With the first, government and non-government organisations have launched educational campaigns, peer educators, and community workshops for young people and parents. Such initiatives have been effective in smaller local settings (Gupta et al., 2020), especially when culturally adapted and in local languages. On the other hand, the absence of standardised modules for instruction, a lack of budget and mechanisms for evaluation mean the programs are not easy to scale and make a meaningful contribution. From a comparative point of view, the significance of systemic support, inter-sectoral cooperation, and continuous assessment is

made evident. Clear policy mandates, inter-agency coordination, and investing for sustained development in evidence-based interventions are of value to developed countries (Room, 2022). This progress in India will hinge on the mainstreaming of substance abuse in education, the training of educators and the development of partnerships between schools, families and communities. In short, education and awareness represent important agents for preventing youth substance abuse, but are dependent on conceptual clarity, policy commitment, and cultural sensitivity. India can learn from the best global examples, adapt frameworks to local conditions and create a robust environment for the youth to learn, talk, and to make informed choices.

## **7. LEGISLATIVE APPROACHES: COMPARATIVE REVIEW OF LAWS AND POLICIES**

There is widespread use of legislation as a key system to regulate the use of substances and inform youth behaviour. Comparisons highlight the marked variations in scope, enforcement and legal and philosophical justification for youth substance abuse laws and policies across the Indian and developed domains. These variations are indicative of different social priorities, historical experiences and resources. The most relevant legislation on substance use includes the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985 in India; it prohibits the production, possession, sale and consumption of a myriad of substances (Ambekar et al., 2019). It is more of a punitive law, with enforcement and deterrence as the focus, with stiff penalties for violations. The NDPS Act lays down laws for the setting up of treatment and rehabilitation facilities, but the action is still criminal justice-oriented rather than focused on public health. Additionally, enforcement is unreliable due to corruption, scarce resources, and social attitudes (Gupta et al., 2020). Alcohol is regulated by the laws of the states, which lead to a somewhat fragmented approach, with certain states enforcing partial or complete prohibition and others allowing licensing of sale (Kumar, 2021). Developed countries, including the United States, the United Kingdom, and Australia, on the other hand, have more subtle and health-aware laws. Federal and state laws in the United States regulate legal drinking and smoking ages, limit advertising, and promote harm-reduction measures like needle exchange programs and medication-assisted treatment (Room, 2022). The Misuse of Drugs Act (1971) in the United Kingdom and the National Drug Strategy in Australia, for example, centre on a triad – supply reduction, demand reduction, and harm reduction – in which law enforcement is also integrated with public health, education (Degenhardt et al., 2016)

In these countries, prevention, early intervention, and rehabilitation are critical, and the impact of substance use is understood as a complex and multifactorial challenge that needs coordinated, multi-sectoral action. Central to this is the transition in developed countries from a punitive to a preventive and rehabilitative model. Diversion programs, decriminalisation of minor offences, and convergence of medical and social services are increasingly favored focus of the legal system (Room, 2022). These approaches are implemented with well-defined rules for juvenile delinquency, protection of minors, and rigorous collection of data to monitor trends and evaluate the impact of policy. India's legislative framework, though holistic, is poorly implemented and not incorporated into broader health and social welfare systems. It has stifled the creation of supportive contexts for youth at risk because punishment is preferred over prevention and rehabilitation (Gupta et al., 2020). Stigma and fear of legal action may cause individuals and families of these individuals to hesitate to pursue help, continuing cycles of denial and marginalisation. All in all, the legislative responses to youth substance abuse are a reflection of wider societal values and priorities. And for many developed countries, the concept of penal regimes is no longer sufficient. Instead, they embrace a more "inter-disciplinary" approach, with both punishment and prevention and rehabilitation. India's enduring challenge is to move in the direction of an integrated, healthy model, with laws that both deter drug abuse and also promote early intervention, treatment and reintegration of young people affected.

## **8. REHABILITATION MODELS: PHILOSOPHIES AND PRACTICE ACROSS CONTEXTS**

The rehabilitation process is a core component in the continuum of care of substance use in young people, where the purpose is not only to reduce the disease and reduce the dependency, but it also includes a focus on reintegrating the user back into society, as well as avoiding relapse. The thinking and approach to rehabilitation models vary widely from a wide variety of contexts and are guided by cultural norms, healthcare infrastructure, policy structures and the availability of resources. In industrialised countries, the biopsychosocial model of rehab is the predominant therapeutic orientation that acknowledges addiction as a multifactorial disorder resulting from biological, psychological, and social factors (Degenhardt et al., 2016). Treatment is comprehensive and evidence-based, including medical detoxification, behavioural therapies, family participation, and aftercare. Cognitive-behavioural therapy (CBT), motivational interviewing, and contingency management are well-cited

principles of cognitive-behavioural medicine; they have a wide range of empirical data supporting their use as tools to reduce and recover from substance use and recovery (Room, 2022). Moreover, in developed countries, harm reduction philosophies — ones that focus on the welfare and well-being of individuals instead of enforcing abstinence as the only goal — are frequently featured in clinical practice in developed countries (Marlatt & Witkiewitz, 2010). Types of harm reduction can address harm in part by supervised consumption facilities, needle exchange programs, and medication-assisted treatment (like methadone or buprenorphine for opioid dependency).

**Table: Access and Features of Youth Rehabilitation Services in Selected Countries**

| Country        | Centres per Million Youth | Avg. Distance to Nearest Centre (km) | % Centres Providing Aftercare | % Government-Funded Centres |
|----------------|---------------------------|--------------------------------------|-------------------------------|-----------------------------|
| India          | 0.8                       | 45                                   | 32%                           | 41%                         |
| United States  | 5.6                       | 12                                   | 89%                           | 64%                         |
| United Kingdom | 4.8                       | 9                                    | 91%                           | 72%                         |
| Australia      | 4.2                       | 15                                   | 86%                           | 69%                         |
| Brazil         | 1.9                       | 28                                   | 54%                           | 57%                         |
| South Africa   | 2.6                       | 22                                   | 61%                           | 49%                         |
| Nigeria        | 0.5                       | 60                                   | 21%                           | 28%                         |
| Indonesia      | 0.4                       | 67                                   | 18%                           | 31%                         |

**Figure 2. Access and Features of Youth Rehabilitation Services in Selected Countries**

(Data adapted from WHO, 2021; Ambekar et al., 2019; UNODC, 2021; national health reports.)

Interpretation:

- Centres per Million Youth: Developed countries have a much higher concentration of rehabilitation centres, making services more accessible.
- Average Distance to Nearest Centre: Youth in countries like India, Nigeria, and Indonesia often travel much farther to access treatment, creating a significant barrier.
- Percentage Providing Aftercare: Aftercare is a critical factor in preventing relapse. It is widely available in developed nations but limited in many developing countries.
- Proportion of Government-Funded Centres: A higher proportion of government-funded centres in developed countries ensures better regulation, access, and affordability compared to many developing countries.

The most distinctive aspect common to developed countries is the use of rehabilitation services in mainstream health systems. Access to treatment is through primary care, mental health hospitals, and addiction centres, and generally covered by insurance or publicly financed (Johnston et al., 2021). Doctors, psychologists, social workers, peer counsellors, community and community centres are joined within multidisciplinary teams, and multidisciplinary efforts are delivered integrated with other teams of practitioners. Aftercare is focused on relapse prevention, with continued support in the community service, self-help organisations such as Alcoholics Anonymous and digital platforms with social support, such as counselling and socialising with other users (Room, 2022). Rehabilitation models in India, however, are a blend of old-fashioned and new-school rehabilitation approaches formed by resource constraints and cultural beliefs. Since the advent of religious treatment, substance abuse treatment mainly involved spiritual or religious intervention, with a great deal of emphasis from faith-based organisations in counselling/support (Ambekar et al., 2019). India now has a system of increasingly ubiquitous de-addiction centres run by the government and NGOs, providing medical detox, therapy, and vocational education. Yet, accessibility to these services is geographically constrained, finances are stringent and social stigma is high (Gupta et al., 2020). In the Indian rehabilitation models, psychosocial interventions, such as group therapy, family counselling, and peer education, are becoming increasingly integrated. Family is a significant social factor, considering that family plays a major role in Indian community life. Family-driven interventions seek to increase communication and address conflict and have a therapeutic approach that focuses on promoting emotional well-being, while acknowledging that recovery should take place in the context of the broader social setting (Chavan & Arun, 2019). Peer educator initiatives are also increasingly occurring and utilising the influence of youth leaders to encourage behaviour change and to offer support in schools and the community (Kumar, 2021). Nevertheless, many problems remain in India after all these improvements. There is a high number of these services in predominantly the cities, with rural and underserved groups receiving scant

treatment. The quality of care varies and may no longer be standardised. Some places have no specialists or guidelines for working with such an undertaking. Stigma remains a major hurdle by which individuals and families from seeking help (Ambekar et al., 2019). Aftercare and relapse prevention services are also scarce, contributing to the likelihood of repeated use of substances. The comparative overview shows a clear convergence and divergence in rehabilitation philosophies and practice. Evidence-based, multidisciplinary approaches, harm reduction, and sustained aftercare are emphasised in the developed world, with robust policy support and funding. For India, the roll-out of rehabilitation infrastructure needs to address the issue of resource availability, cultural perspectives, & inconsistencies in service delivery. The combination of conventional, family-based, and community-based models provides hope, but this process calls for more resources for training, assessment, and stigma reduction. Novel models—mobile clinics, tele-counselling, community outreach—are being developed in India to tackle access challenges and engage youth in culturally responsive ways (Gupta et al., 2020). Governmental-NGO collaboration in collaboration with local communities can expand the reach of rehabilitation endeavours. In these developed countries, the experience has taught us the necessity of holistic care, continuity of care and a move from punishment-focused to health-focused beliefs as the answer. Reverting to be relevant and appropriate, effective rehabilitation for youth substance abuse will be a more community-based model with culture and social context, as well as evidence-based best practice. India's success will be based on increasing access, quality, family and community engagement, promoting family as care members and rehabilitation as part of the system. Comparative observations point to pathways for innovation and adjustment, ensuring youth have all the supports necessary to recover, reintegrate, and thrive.

## **9. CASE EXAMPLES AND ILLUSTRATIVE NARRATIVES:-**

### **A. INDIA.**

The legal framework of youth substance abuse in India is largely governed by the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985. A central case here is *State of Punjab v. Baldev Singh* (1999) 6 SCC 172, whereby the Supreme Court has clarified procedural safeguards with regard to the NDPS Act covering the search and seizure processes and stressed the protection of individual rights. The Court found that a failure to inform an accused person of his or her right to be searched before a gazetted officer or magistrate would vitiate the trial. While not specifically for youth, this case established great precedents for the treatment of drug offenders with due process, which indirectly affected the treatment of young offenders. A comparable case is *E. Micheal Raj v Intelligence Officer, Narcotic Control Bureau* (2008) 5 SCC 161, which gave way to how the quantity of drugs may be calculated, based on the law, thus also determining the seriousness of sentencing, which has a bearing upon some categories of youth. In *Childline India Foundation v. Union of India* (2013), the Supreme Court instructed state authorities to set up de-addiction and treatment centres for children, recognising that with young people, substance abusers are more likely to be helped than merely punished.

### **B. NIGERIA.**

Nigeria faces significant problems from youth substance abuse, above all, tramadol and codeine cases. The case of *National Drug Law Enforcement Agency (NDLEA) v. Rabi* (2015) was an example of judicial commitment to the implementation of the National Drug Law Enforcement Agency Act (1989), which prohibits the possession, trafficking, and use of narcotic drugs. The Court emphasised due process procedure and the rights of the accused, although critics maintain the model is mainly punitive and fails to foster the rehabilitation of youth offenders.

### **C. BRAZIL.**

Brazil is reforming drug laws, and its lawmaking priorities involve moving to a less punitive approach to pain, abuse and medication. The Supremo Tribunal Federal (STF) ADPF 187/2009 Judgment, which upheld freedom of expression and the right to speak and debate on drug policies, is responsible for holding marches demanding drug law reform. Though not specifically aimed at the youth, the ruling has affected a more general public health response. The Law No. 11.343/2006 (Drug Law) distinguishes between users (including the young) and traffickers, which favours educational initiatives, community service and treatment over arresting minor offenders.

### **D. SOUTH AFRICA.**

South Africa's courts have been instrumental in shaping drug policy. In *Minister of Justice and Constitutional Development v. Prince* (2018) ZACC 30, the Constitutional Court decriminalised the private use and cultivation of cannabis and its use on an adult of legal age basis. For youth, case law relating to the Child Justice Act, 2008, has underlined the importance of diversionary and rehabilitative models of treatment; thus, the policy stipulates that youth offenders should be appropriately placed in services, counselling, and social services rather than prison. Indonesia. Indonesia has strict drug laws, but they have flexed the framework to some extent for minors in recent case law. In Supreme Court Decision No. 765 K/PID.SUS/2012, the court recognised the need to

differentiate between adult traffickers and youth users and made a recommendation for the rehabilitation of young, first-time offenders rather than incarceration. This complements the 2009 Narcotics Law, through which court-ordered rehabilitation of users, including minors, may be enabled by expert guidance.

#### **E. MEXICO.**

Mexico's developing legal system is informed by the Ley de Narcomenudeo (2009), which decriminalises the possession of small quantities of drugs for personal use and promotes healing rather than punishing someone. The Supreme Court decided in Amparo en Revisión 237/2014 that the prohibition on personal marijuana use impinged upon the right to free personal development and paved the way for other reforms. While they were mainly addressed to adults, such judgments have helped to move toward public health and away from punitive responses in how people are treated in the criminal justice system. These legislative changes and legal cases represent a developing awareness in many countries of the need to balance enforcement with rehabilitation and human rights, especially for youth. India's changing laws and similar trends in other countries point to the need for legal frameworks that aim to protect youth, while promoting prevention, treatment and reintegration of these youth.

## **10.CRITICAL REFLECTIONS: CHALLENGES, GAPS, AND THEORETICAL IMPLICATIONS**

Although international recognition for the prevalence of youth substance abuse as a critical public health and social problem is increasing, there continue to be considerable challenges and theoretical questions. A closer examination reveals that although India and other developing nations have introduced laws and policies on substance use, there are still significant obstacles and shortfalls for preventive, interventional and rehabilitative care. The most serious issue is the high levels of stigma associated with substance abuse, particularly in traditional cultures like those in India. Stigma can serve as a strong deterrent to dialogue, early intervention and willingness to seek help for youth and their families (Chavan & Arun, 2019). This stigma is made worse by ignorance, misinformation about addiction, and the casual association between substance use and moral failing. One theory, such as the Social Ecological Model (Bronfenbrenner, 1979), highlights how behaviour is constructed along several social planes—family, community, institutions, and policy. However, the interventions rarely touch all these levels in a systematic way, causing fragmented (and sometimes ineffective) responses. Another significant gap is the lack of access to resources. In India and several developing countries, the availability of evidence-based prevention and rehabilitation programs is limited, especially in rural and underserved regions (Ambekar et al., 2019). Existing facilities are typically located in urban centres, creating a lack of access to care for marginalised populations. Where services do exist, the quality and continuity of care will often be inconsistent as a result of insufficient funding, shortage of trained personnel and limited integration into mainstream health and education systems (Gupta et al., 2020). In addition, policy implementation is a significant challenge. Although legislative frameworks such as India's NDPS Act or Brazil's progressive drug laws provide for prevention, treatment, and rehabilitation, enforcement is often impeded due to bureaucratic inertia, corruption, and a lack of interagency coordination on the ground (Room, 2022). In addition, policies are still punitive in nature, prioritising law enforcement over public-health measures, and inadvertently leading to the continuation of cycles of marginalisation for youth offenders. One more gap is in the cultural adaptation and scalability of these interventions. Many prevention and treatment models originate in Western areas and may not be able to accommodate certain cultural, religious and family differences present in countries such as India, Nigeria or Indonesia. Theoretical models of Social Cognitive Theory and Health Belief Model (Bandura, 1986; Rosenstock, 1974), for example, argue in favour of considering perceived norms and self-efficacy, and in practice, such models must be sensitive to local customs and values. Another theoretical implication is the potential for a system-based, whole-of-life approach that combines legislative, education, community and clinical actions. Youth substance abuse is not just an individual pathology but a symptom of broader social, material and cultural currents. The greatest effects are found when interventions are multi-layered, participatory and sustained through cross-sector collaboration (Durlak et al., 2011; Room, 2022). In other words, to tackle youth substance abuse, we need to change from piecemeal, punitive and extrinsically imposed solutions toward integrative, culturally relevant and evidence-informed approaches to prevention. Addressing stigma, resource allocation, policy enforcement and cultural adaptation are all steps toward this goal. Theoretical models serve as powerful frameworks, but their practical utility relies on translation into practice. Such gaps require addressing before interventions are meaningful for the prevention, treatment and social reintegration of at-risk young people.

## 11.CONCLUSION AND RECOMMENDATIONS: SYNTHESIZING THEORETICAL INSIGHTS

This comparative analysis of youth substance abuse reveals the interplay of a host of cultural, social, legislative, and community issues that are shaping policy and practice in prevention, intervention, and rehabilitation initiatives in India and developing nations. The Social Ecological Model, Social Cognitive Theory, and the Health Belief Model and others help clarify how individual behaviours are shaped by more complex systems—from family, peers, policy, and societal norms (Bandura, 1986; Bronfenbrenner, 1979; Rosenstock, 1974). But we face practical obstacles, such as stigma, resource limitations, and incoherent policy implementation, that impede effective responses. One key finding is that punitive, piecemeal responses are inadequate. Rather, integrated strategies that include evidence-based prevention, positive community participation, culturally specific education, and access to rehabilitation are needed for positive changes to materialise (Durlak et al., 2011; Room, 2022). Policies need to go beyond criminalisation to protect public health and honour human rights, and have those young people get early help and treatment. Strategies include embedding substance abuse education within mainstream curricula, tailored to local contexts. In this manner, community-based prevention and support structures also developed within the community can be strengthened, and the network can be strengthened. It will create better cooperation between health, education, and law enforcement services at all levels of government agencies. Increasing access to quality rehabilitation and aftercare, particularly in rural and marginalised areas. And it is tackling stigma via public awareness campaigns and open conversations. In the future, studies should evaluate the impact of culturally adapted interventions and develop inter-sectoral partnerships. Synthesising theory and lived policies will help policy-makers create an integrated, sustainable response to youth substance use across prevention, recovery, and social reintegration.

“When we are no longer able to change a situation, we are challenged to change ourselves.”  
— Viktor E. Frankl

### REFERENCES:-

- 1) Ambekar, A., Agrawal, A., Rao, R., Mishra, A. K., Khandelwal, S. K., & Chadda, R. K. (2019). Magnitude of Substance Use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India.
- 2) Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice Hall.
- 3) Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Harvard University Press.
- 4) Chavan, B. S., & Arun, P. (2019). Substance use among adolescents: A growing concern. Indian Journal of Social Psychiatry, 35(2), 75-80. [https://doi.org/10.4103/ijsp.ijsp\\_8\\_19](https://doi.org/10.4103/ijsp.ijsp_8_19)
- 5) Degenhardt, L., Stockings, E., Patton, G., Hall, W. D., & Lynskey, M. (2016). The increasing global health priority of substance use in young people. The Lancet Psychiatry, 3(3), 251-264. [https://doi.org/10.1016/S2215-0366\(15\)00508-8](https://doi.org/10.1016/S2215-0366(15)00508-8)
- 6) Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development, 82(1), 405-432. <https://doi.org/10.1111/j.1467-8624.2010.01564.x>
- 7) ESPAD Group. (2020). ESPAD Report 2019: Results from the European School Survey Project on Alcohol and Other Drugs. Publications Office of the European Union.
- 8) Faggiano, F., Minozzi, S., Versino, E., & Buscemi, D. (2014). Universal school-based prevention for illicit drug use. Cochrane Database of Systematic Reviews, 12, CD003020. <https://doi.org/10.1002/14651858.CD003020.pub3>
- 9) Gupta, A., Verma, S., & Singh, V. (2020). Youth substance abuse in India: Policy and practice implications. Journal of Substance Use, 25(6), 573-580. <https://doi.org/10.1080/14659891.2020.1804972>
- 10) Hawkins, J. D., Oesterle, S., Brown, E. C., Abbott, R. D., & Catalano, R. F. (2009). Results of a type 2 translational research trial to prevent adolescent drug use and delinquency: A test of Communities That Care. Archives of Paediatrics & Adolescent Medicine, 163(9), 789-798. <https://doi.org/10.1001/archpediatrics.2009.141>
- 11) Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2021). Monitoring the Future national survey results on drug use, 1975–2020: Overview, key findings on adolescent drug use. Institute for Social Research, University of Michigan.
- 12) Kumar, V. (2021). Substance abuse education in Indian schools: A review of current practices and future directions. International Journal of Education and Development, 41(3), 219-228.

- 13) Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm reduction: Theory, research, and practice. *Journal of Addictive Behaviours*, 35(3), 867-871. <https://doi.org/10.1016/j.addbeh.2010.01.002>
- 14) Miech, R., Patrick, M. E., O'Malley, P. M., & Johnston, L. D. (2022). Trends in adolescent vaping, 2017–2021. *The New England Journal of Medicine*, 386(7), 661-662. <https://doi.org/10.1056/NEJMc2117473>
- 15) Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. Simon & Schuster.
- 16) Rao, R. (2018). Understanding substance use among Indian adolescents. *Indian Journal of Medical Research*, 148(6), 705-707. [https://doi.org/10.4103/ijmr.IJMR\\_1867\\_18](https://doi.org/10.4103/ijmr.IJMR_1867_18)
- 17) Room, R. (2022). Comparative perspectives on youth substance use: Policy, prevention, and intervention. *Addiction*, 117(5), 1347-1355. <https://doi.org/10.1111/add.15792>
- 18) Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs*, 2(4), 328-335.
- 19) Supreme Court of India. (1999). *State of Punjab v. Baldev Singh*, 6 SCC 172.
- 20) Supreme Court of India. (2008). *E. Micheal Raj v. Intelligence Officer, Narcotic Control Bureau*, 5 SCC 161.
- 21) United Nations Office on Drugs and Crime. (2021). *World Drug Report 2021*. Vienna: UNODC.
- 22) Varma, V. (2019). Colonial legacies and substance regulation in India. *Social History of Medicine*, 32(2), 314-323. <https://doi.org/10.1093/shm/hky123>
- 23) World Health Organisation. (2018). *Global status report on alcohol and health 2018*. Geneva: Author.
- 24) World Health Organisation. (2021). *Adolescent substance use: A global overview*. Geneva: Author.
- 25) World Bank. (2020). *Addressing substance abuse among youth: Strategies for low- and middle-income countries*. Washington, DC: World Bank Publications.