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NCPCR

STANDARD OPERATING PROCEDURE (SOP)

Prevention and Response Framework for Drug and Substance Use among Children

Prepared in reference to the Joint Action Plan (JAP) on Prevention of Drug and Substance Abuse among Children and Illicit Trafficking

PREVENT
Educate. Empower. Protect.

IDENTIFY
Early recognition, Timely support.

RESPOND
Care. Counsel. Connect.

TREAT
Access to quality treatment.

REHABILITATE
Heal. Rebuild. Reintegrate.

REINTEGRATE
Inclusive communities. Brighter futures.

Together for a Drug-Free Childhood
Stronger Families. Safer Communities. Better Tomorrow.

List of Abbreviations

Abbreviation	Full Form
AFHC	Adolescent Friendly Health Clinic
AIIMS	All India Institute of Medical Sciences
ASHA	Accredited Social Health Activist
ATF	Addiction Treatment Facility
BNSS	Bharatiya Nagarik Suraksha Sanhita, 2023
BSF	Border Security Force
CCI	Child Care Institution
CCL	Child in Conflict with Law
CDSCO	Central Drugs Standard Control Organisation
CISS	Child in Street Situation
CNCP	Child in Need of Care and Protection
COTPA	Cigarettes and Other Tobacco Products Act, 2003
CPLI	Community Peer-Led Intervention
CWC	Child Welfare Committee
CWPO	Child Welfare Police Officer
DCPU	District Child Protection Unit
DDAC	District De-Addiction Centre
DEIC	District Early Intervention Centre
DEO	District Education Officer
DMHP	District Mental Health Programme
ERSS	Emergency Response Support System
ICDS	Integrated Child Development Services

Abbreviation	Full Form
ICP	Individual Care Plan
IEC	Information, Education and Communication
INCB	International Narcotics Control Board
IRCA	Integrated Rehabilitation Centre for Addicts
ISP	Individual Support Plan
JAP	Joint Action Plan on Prevention of Drugs and Substance Abuse among Children and Illicit Trafficking
JJB	Juvenile Justice Board
M-AFHC	Model Adolescent Friendly Health Clinic
MHA	Ministry of Home Affairs
MoHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
NAPDDR	National Action Plan for Drug Demand Reduction
NCB	Narcotics Control Bureau
NCORD	Narco-Coordination Centre
NCPCR	National Commission for Protection of Child Rights
NDDTC	National Drug Dependence Treatment Centre, AIIMS
NDPS	Narcotic Drugs and Psychotropic Substances Act, 1985
NIMHANS	National Institute of Mental Health and Neurosciences
NISD	National Institute of Social Defence
NMBA	Nasha Mukt Bharat Abhiyaan
NMV	Nasha Mukt Vidyalaya
ODIC	Outreach and Drop-in Centre
POCSO	Protection of Children from Sexual Offences Act, 2012

Abbreviation	Full Form
PTA	Parent-Teacher Association
RBSK	Rashtriya Bal SwasthyaKaryakram
RKSK	Rashtriya Kishor SwasthyaKaryakram
SCPCR	State Commission for Protection of Child Rights
SIR	Social Investigation Report
SJPU	Special Juvenile Police Unit
SMC	School Management Committee
SSB	Sashastra Seema Bal
SUD	Substance Use Disorder

Glossary of Key Terms

Term	Meaning
Best Interest of the Child	A primary consideration requiring that all actions concerning a child give paramount importance to the child's safety, welfare and development, consistent with the Juvenile Justice Act, 2015.
Vulnerable Districts	Specific regions identified as having the highest risk and prevalence of substance use and drug abuse.
Child in Need of Care and Protection (CNCP)	As defined under Section 2(14) of the Juvenile Justice (Care and Protection of Children) Act, 2015.
Child in Conflict with Law (CCL)	As defined under Section 2(13) of the Juvenile Justice (Care and Protection of Children) Act, 2015.
Child in Street Situation (CISS)	A child who, for reasons of survival, family circumstance or exploitation, spends significant time in street or public settings, and who is thereby exposed to heightened risk of substance use, trafficking and abuse.
De-addiction	The process of clinical and psychosocial intervention aimed at helping an individual overcome dependence on a substance.
Individual Care Plan (ICP)	A documented, periodically reviewed plan prepared for a child in institutional care, covering health, education, psychosocial support, family restoration and rehabilitation needs.
Referral	The process of directing a child to an appropriate service provider for assessment, treatment or protection, with informed consent.
Relapse	The recurrence of substance use following a period of treatment or abstinence.
Substance Use Disorder (SUD)	A clinical diagnosis made only by a qualified mental health professional under the DSM-5-TR, based on specified criteria occurring within a twelve-month period.

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CHAPTER 1: INTRODUCTION

1.1 Background

Children constitute nearly one-third of India's population and represent the foundation of the nation's future human capital. Ensuring their health, education, protection and holistic development is a constitutional obligation and a shared responsibility of families, communities, institutions and the State. The growing availability of narcotic drugs, psychotropic substances, tobacco products, alcohol, inhalants, prescription medicines and emerging synthetic substances has increased children's vulnerability to substance use, posing a significant challenge to child protection, public health and social development.

Substance abuse among children is increasingly recognised as a multidimensional issue extending beyond individual behaviour, closely associated with adverse childhood experiences, family dysfunction, school disengagement, mental health concerns, peer influence, online exposure, trafficking networks and socio-economic vulnerability. Children who initiate substance use early face heightened risk of dependence, academic underachievement, behavioural problems, exploitation, conflict with law and long-term health consequences. Addressing this therefore requires a coordinated, child-centred and preventive approach across multiple sectors, rather than isolated institutional responses.

Recognising this need for convergence, the National Commission for Protection of Child Rights (NCPCR), in collaboration with the Narcotics Control Bureau (NCB), launched the Joint Action Plan (JAP) on Prevention of Drug and Substance Abuse among Children in 2021 — a collaborative framework involving the Ministry of Women and Child Development, Ministry of Social Justice and Empowerment, Ministry of Health and Family Welfare, Ministry of Education, Ministry of Home Affairs and State Governments, to strengthen prevention, awareness, enforcement, rehabilitation and monitoring, with focused review of vulnerable districts.

While the Joint Action Plan establishes the institutional framework for coordinated action, implementation across States and districts requires clearly defined operational procedures for early identification, referral, protection, rehabilitation and follow-up. This Standard Operating Procedure (SOP) has therefore been developed to operationalise the Joint Action Plan by providing a uniform framework that clearly delineates the roles and responsibilities of all stakeholders. The principal stakeholders at the State and District level are set out, in quick-reference tabular form, at Annexure I, for functionaries who require an at-a-glance understanding of the institutional set-up before referring to the detailed procedures that follow.

1.2 Magnitude of the Problem and Recent Trends

Drug and substance use among children and adolescents is a significant public health and child protection concern in India. The National Survey on the Extent and Pattern of Substance Use in India, conducted by NDDTC, AIIMS, in 2018, estimated current substance use among children aged 10–17 years at 1.8% for opioids, 1.3% for alcohol, 0.9% for cannabis, 0.58% for

sedatives and 1.17% for inhalants. Inhalant use was higher among children and adolescents than among adults, indicating their particular vulnerability to these substances.

The NCPCR–AIIMS study, *Assessment of Pattern, Profile and Correlates of Substance Use among Children in India* (2013), covered 4,024 children across 135 sites in 27 States and 2 Union Territories, including school-going, out-of-school and street-connected children. Among these children, tobacco and alcohol were the most commonly used substances, followed by cannabis and inhalants. The study also highlighted greater vulnerability among street-connected and out-of-school children, including family disruption, higher inhalant use and physical, psychological, social and legal consequences. As the participants were children who had already used substances, these findings should not be interpreted as prevalence estimates for all children in India.

Another nationwide school-based survey of 5,920 students across 10 cities, published in 2025. found that 15.1% reported lifetime substance use, 10.3% past-year use and 7.2% past-month use. Past-year use included tobacco (4.0%), alcohol (3.8%), opioids (2.8%), cannabis (2.0%), inhalants (1.9%) and sedatives (0.6%). Substance use was associated with conduct problems, hyperactivity, emotional difficulties, psychosocial concerns and substance use among family members and peers. These findings demonstrate the need for early identification and intervention in schools.

The National Mental Health Survey of India, 2015–16 (NIMHANS) similarly found that mental and behavioural disorders due to psychoactive substance use accounted for a substantial share of the country's overall mental-health morbidity (Gururaj et al., 2016), consistent with subsequent research linking early substance use to co-occurring depression, anxiety, self-harm and behavioural difficulties.

A multicentre study published in *The Lancet Regional Health – Southeast Asia* in 2026, involving 6,168 adolescents across 108 schools in six Indian districts, found that 21.4% had moderate-to-high substance-use risk, including 10.3% at moderate and 11.1% at high risk. Substantial regional variation was observed, with higher risk associated with greater accessibility to substances, digital exposure and favourable attitudes towards substance use, underscoring the need for context-specific, school-based prevention, early identification and intervention.

On the supply side, the NCB's Annual Report 2025, released at the 10th NCORD Apex Meeting (2026), recorded the highest number of narcotics cases and preventive detentions in the preceding five years, with seizures crossing 1,200 tonnes and a rising share of synthetic drugs, diverted pharmaceuticals and newly emerging substances such as nitazenes (NCB, 2025). The International Narcotics Control Board similarly reported that methamphetamine seizures in South Asia, including India, rose from about 7.2 tonnes in 2013 to 20.4 tonnes in 2022 (INCB, 2024) — trends that reflect changing trafficking patterns and reinforce the need for preventive systems capable of responding to evolving drug markets while safeguarding children from exploitation by organised trafficking networks.

Collectively, these findings show that substance abuse among children is no longer confined to specific regions or socio-economic groups; it is a national child protection concern requiring coordinated preventive, protective, therapeutic and rehabilitative interventions across sectors.

1.3 Reasons and Risk Factors for Substance Use Among Children

Evidence and field experience indicate that children rarely take to substance use for a single reason; initiation and continued use typically result from an interaction of the following factors:

- Family-level factors — family dysfunction, parental substance use, neglect, abuse, or absence of supportive supervision;
- Peer and social influence — pressure or modelling from a peer group already engaged in substance use, and the desire for acceptance or belonging;
- School disengagement — declining academic interest, truancy, or an unsupportive school environment that increases exposure to risk situations;
- Mental health and emotional distress — untreated anxiety, depression, trauma or adverse childhood experiences for which substances are used as a coping mechanism;
- Online exposure — access to pro-substance content, encrypted marketplaces and unsupervised digital interaction that normalises or facilitates procurement;
- Socio-economic vulnerability and street situations — poverty, child labour, homelessness or institutional/street living that heightens exposure to trafficking networks; and
- Exploitation and trafficking — deliberate targeting of vulnerable children by trafficking networks for use as couriers, peddlers or consumers.

Recognising these overlapping causes is essential to designing prevention strategies that address root vulnerability rather than symptoms alone, and underpins the multi-sectoral approach adopted throughout this SOP.

1.4 Rationale for the SOP

The Government of India has established a comprehensive legal and policy framework to address drug demand reduction, child protection, public health and educational well-being. However, implementation responsibilities are distributed across multiple ministries, departments and statutory authorities, often resulting in variation in operational practice, referral mechanisms and inter-departmental coordination. The Joint Action Plan provides the strategic framework for convergence but does not itself prescribe detailed operational procedures for schools, Child Care Institutions (CCIs), District Child Protection Units (DCPUs), Child Welfare Committees (CWCs), healthcare facilities, police authorities and local administration.

This SOP also aligns with, and operationalises at field level, other ongoing Government initiatives, including the Nasha Mukt Bharat Abhiyaan (NMBA) of the Ministry of Social Justice

and Empowerment; the Nasha Mukt Vidyalaya (NMV) initiative of the Ministry of Education and Ministry of Home Affairs; the MANAS national narcotics helpline (1933) of the NCB; and the Vision Document on Narcotics Control (2026–2029), released by the Union Home Minister at the 10th NCORD Apex Meeting on 26 June 2026, which sets out a three-year national roadmap for demand reduction, supply reduction and rehabilitation across more than 40 Ministries, State Governments and district administrations, with whose stakeholder responsibilities this SOP aligns.

This SOP has accordingly been developed to:

- establish a uniform operational framework for prevention, early identification, referral, treatment support, rehabilitation and social reintegration of children affected by substance use;
- operationalise the Joint Action Plan by translating policy objectives into clearly defined institutional responsibilities and procedures;
- strengthen inter-sectoral convergence among child protection, education, health, social justice, law enforcement and local governance systems;
- facilitate timely intervention through standard referral pathways and coordinated case management;
- promote child-friendly, rights-based and non-stigmatising approaches to prevention and rehabilitation; and
- strengthen accountability through uniform documentation, reporting and monitoring.

By providing this common operational framework, the SOP seeks to ensure that every child at risk of, or affected by, substance use receives timely protection, appropriate care and opportunity for recovery, irrespective of geographical location or institutional setting.

1.5 Scope and Applicability

This SOP applies to all children below the age of eighteen years and serves as a guiding document for all stakeholders involved in the prevention and management of drug and substance abuse among children, including schools, Child Care Institutions, healthcare facilities, District Child Protection Units, Child Welfare Committees, Special Juvenile Police Units, law enforcement agencies, local administration, community organisations and other implementing agencies. It is to be read in conjunction with the Joint Action Plan on Prevention of Drug and Substance Abuse among Children (2021), relevant statutory provisions, and existing Government of India policies and schemes.

CHAPTER 2: LEGAL, POLICY AND INSTITUTIONAL FRAMEWORK

The prevention of drug and substance abuse among children is governed by a comprehensive framework of constitutional provisions, legislation, national policy, schemes and institutional mechanisms. This SOP will be implemented in accordance with the following legal and policy framework.

S. No.	Legal Instrument	Relevant Provisions	Key Relevance	Concerned Stakeholders
1	Constitution of India	Articles 21, 39(e), 39(f), 47	Guarantees the right to life and dignity; directs the State to protect children from abuse and exploitation and improve public health. Forms the constitutional basis for child protection and substance abuse prevention.	Union & State Governments
2	Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985	Sections 8, 21–27, 27A, 31A, 64A, 71	Prohibits production, possession, sale, purchase, transport and trafficking of narcotic drugs and psychotropic substances; provides for treatment/rehabilitation facilities and addresses illicit trafficking involving children.	NCB, State Police, Excise Departments, Judiciary
3	Juvenile Justice (Care and Protection of Children) Act, 2015	Sections 2(14), 27–30, 53–54, 74, 75, 77, 78	Provides care, protection, rehabilitation and restoration for children in need of care and protection; penalises giving intoxicants to children or using children to carry them.	MWCD, State WCD Departments, DCPUs, CWCs, SJPU
4	Juvenile Justice Model Rules, 2016	Rules on rehabilitation, case management and Individual Care Plans	Prescribes procedures for rehabilitation, restoration, counselling, follow-up and coordination among child protection institutions.	MWCD, State Governments, CCIs, DCPUs

S. No.	Legal Instrument	Relevant Provisions	Key Relevance	Concerned Stakeholders
5	Cigarettes and Other Tobacco Products (COTPA) Act, 2003	Sections 6(a), 6(b), 24	Prohibits sale of tobacco products to persons below 18 years and within 100 yards of educational institutions; supports tobacco-free educational environments.	State Health Departments, Police, Education Department, Local Authorities
6	Prohibition of Electronic Cigarettes Act, 2019	Sections 4–7	Prohibits production, manufacture, sale, storage, advertisement and distribution of electronic cigarettes, restricting children's access to vaping products.	MoHFW, State Enforcement Authorities
7	Drugs and Cosmetics Act, 1940	Licensing and prescription-related provisions	Regulates manufacture, distribution and sale of pharmaceutical drugs and controls misuse of prescription medicines.	CDSCO, State Drug Controllers
8	Mental Healthcare Act, 2017	Provisions on access to mental healthcare and rights	Ensures access to mental healthcare for children with substance use disorders and co-occurring mental health conditions.	MoHFW, State Mental Health Authorities
9	Rights of Persons with Disabilities Act, 2016	Provisions relating to psychosocial disabilities	Facilitates access to rehabilitation and support services where substance use coexists with psychosocial disabilities.	Department of Empowerment of Persons with Disabilities, State Authorities
10	Bharatiya Nyaya Sanhita, 2023 (where applicable)	Relevant penal provisions	Applicable to criminal acts associated with administration of intoxicants, trafficking, exploitation or offences against children.	Police, Judiciary

CHAPTER 3: CHILD SUBSTANCE USE PREVENTION AND RESPONSE PROTOCOL FOR SCHOOLS AND OTHER SETTINGS

Standard Operating Procedure on Prevention, Identification, Treatment, Rehabilitation and Referral of Children Affected by Drug and Substance Abuse and Illicit Trafficking

3.1 Introduction and Objective

Prevention is the foundational pillar of the response to drug and substance abuse among children and is to be accorded primacy over identification, treatment and rehabilitation. This Chapter lays down the operational framework for prevention through coordinated action across the school system, the health system and the child protection system, with the objectives of: (i) preventing initiation of substance use among children; (ii) building the capacity of teachers, counsellors and health functionaries to recognise early warning signs and respond appropriately; (iii) strengthening the health-system response for early identification, screening and referral; and (iv) establishing a standardised, child-centric referral pathway connecting the education, health, child protection, police and rehabilitation systems.

This Chapter should be read together with, and implemented in consonance with, the Juvenile Justice (Care and Protection of Children) Act, 2015 and the Model Rules thereunder, the NDPS Act, 1985, the COTPA, 2003, and other applicable Central and State policies, schemes and guidelines concerning child protection, school education and de-addiction services, including the National Action Plan for Drug Demand Reduction (NAPDDR) and the Nasha Mukt Bharat Abhiyaan (NMBA).

3.2 School-Based Prevention and Awareness

Every school — Government, Government-aided or private — should function as a primary site of prevention and should integrate drug and substance abuse prevention into its regular academic and co-curricular calendar, as set out below.

3.2.1 Annual Awareness Calendar

The School Management/Head of Institution should prepare and display, at the start of every academic session, an Annual Awareness Calendar providing, at minimum: one orientation session for students at the commencement of the session; at least one age-appropriate awareness activity per academic term (a minimum of three activities a year); observance of relevant days, including the International Day against Drug Abuse and Illicit Trafficking; and at least one annual sensitisation session for parents. Activities may include classroom sessions, assemblies, peer-education, competitions, street plays, sports events and screening of age-appropriate audio-visual material. A record of activities conducted — dates, participants and material used — should be maintained and made available for inspection by the Education Department.

3.2.2 Prahari Clubs

Every school needs to establish, or strengthen, a Prahari Club of student volunteers under the guidance of a designated nodal teacher, to lead peer-level prevention and awareness activities, disseminate age-appropriate IEC material, and serve as a safe, confidential channel through which students may report concerns. The Club should meet at least once a month, with activities documented and reviewed by the nodal teacher.

3.2.3 Tobacco-Free Educational Institutions

Every institution will be maintained and certified as a Tobacco-Free Educational Institution under the COTPA, 2003 and guidelines thereunder including prescribed signage, prohibition of tobacco sale within the prescribed radius, and prohibition of use within premises with a nodal teacher designated for compliance and periodic self-certification/renewal.

3.2.4 Life-Skills Education

Life-skills education including decision-making, refusal skills, coping with peer pressure, emotional regulation and help-seeking should be integrated into the curriculum or co-curricular schedule using material approved by the Education Department. Preventive education needs to be age-appropriate and factually accurate.

3.2.5 Awareness, Sensitisation and IEC Activities

Schools should conduct regular sensitisation sessions using standardised, age-appropriate IEC materials developed by the Education/Health Departments or existing IEC resources developed by the Ministry of Social Justice and Empowerment. Helpline and referral information, including the contact details of the school counsellor, should be prominently displayed in a child-friendly and easily accessible format.Schools may coordinate with local health facilities and other relevant stakeholders, as appropriate, to facilitate expert-led awareness, early identification, referral and access to appropriate support services, while ensuring child safety, privacy and confidentiality.

3.2.6 Participation of Parents, Teachers and Stakeholders

Schools need to undertake structured parent engagement through Parent-Teacher Meetings (PTMs) at least once every academic term, incorporating awareness on substance-use prevention, early warning signs observable at home, and mechanisms for accessing school-based and health-system support. Teachers, counsellors, School Management Committees (SMCs) and, where constituted, Parent-Teacher Associations (PTAs) should be involved in planning, implementing and reviewing school-based prevention activities.

3.3 Capacity Building of Teachers and Counsellors

The Education Department/School Management should ensure mandatory, periodic capacity building of teachers, school counsellors, heads/principals and other relevant school personnel (including hostel wardens and activity instructors) on prevention, early identification and referral. At minimum, the nodal teacher and school counsellor of every school should undergo prescribed training within one year of issuance of this SOP, refresher training at least once every two years thereafter, and newly appointed teachers/counsellors should be oriented within six months of joining. Training should use standardised material developed or approved by the Education Department, Health Department, NISD, NDDTC (AIIMS) or other designated institutions, covering, at minimum:

- early warning signs and behavioural, physical and academic indicators of possible substance use, and identification of children at risk owing to neglect, abuse, peer influence, familial substance use or exposure to trafficking;
- appropriate, non-stigmatising and confidential communication with a suspected child and with parents/guardians, including basic psychological first response following disclosure;
- do's and don'ts while dealing with a child suspected of substance use, including the imperative of avoiding punitive action, public disclosure, expulsion or humiliation; and
- referral and reporting mechanisms including the roles of RBSK, health facilities, DCPUs, CWCs and, where required, SJPUs, and maintenance of confidentiality of referral records.

Teachers, counsellors and other school personnel should not attempt, to diagnose substance-use disorders, administer any testing, or provide clinical treatment or counselling; their function is limited to prevention, observation, first-level supportive response, and timely referral. The District Education Officer should maintain the district-wide record of teachers and counsellors trained.

3.4 Strengthening of the Health-System Response

The Health Department should strengthen the capacity of Rashtriya Bal SwasthyaKaryakram (RBSK) teams including Mobile Health Teams and District Early Intervention Centres to undertake early identification, screening and referral of children at risk of, or affected by, substance use as part of their existing child health screening mandate. RBSK personnel, medical officers and other relevant health functionaries should be trained, using modules developed by the NDDTC, AIIMS and/or delivered through NISD Master Trainers, in screening tools, referral protocols and age-appropriate management of children with substance-use concerns, and should incorporate substance-use risk screening into routine child health screening, particularly for children identified as vulnerable through schools, Anganwadi Centres, CCIs or child protection authorities.

Where a child is identified as being at risk of, or affected by, substance use, the concerned health functionary should facilitate referral to the nearest designated de-addiction centre, District Hospital with de-addiction facility, or other equipped specialised service, and should simultaneously inform the DCPU/ parents or guardian of the child. All health and de-addiction services extended to children should be child-friendly, age-appropriate and non-stigmatising, provided in settings physically and procedurally distinct from adult treatment settings wherever feasible, with due regard to privacy and dignity.

NDDTC, AIIMS may develop and disseminate standardised, child-specific screening, assessment and treatment protocols and facilitate their adoption by treatment and de-addiction facilities providing services to children. Clear coordination and referral mechanisms should be established among RBSK, health facilities, de-addiction centres and relevant child protection authorities to ensure timely and seamless referral and access to appropriate services. Every child referred for treatment should be covered under a defined follow-up and tracking mechanism, with the treating facility, in coordination with the DCPU, facilitating continuity of care following discharge. Such follow-up should include psychosocial support, family counselling, aftercare and reintegration services, as appropriate, for the minimum period specified in the individual treatment and discharge plan.

3.5 Standardised Referral Pathway

A standardised, child-centric referral pathway is established to ensure seamless coordination between schools, teachers and counsellors, parents/guardians, RBSK and other health facilities, the DEO/DCPU, CWCs, SJPUs (wherever required), de-addiction and rehabilitation centres, and other relevant government or authorised service providers. The stakeholders should follow the sequence below, subject to modification as warranted by the facts and safety needs of the individual case:

- Identification: a child at risk of, or suspected of, substance use may be identified by a teacher, counsellor, Prahari Club member, parent, RBSK Screening, police personnel or through self-disclosure. The identifying person should, without delay and while maintaining confidentiality, inform the school nodal teacher/counsellor (in a school setting) or the nearest health facility/DCPU (in other settings).
- Initial Response and Safety Assessment: the nodal teacher/counsellor or first responding functionary will conduct a preliminary, non-judgmental conversation to assess immediate safety, including any indication of acute intoxication, withdrawal, self-harm risk or exposure to abuse/trafficking. Where medical risk is apparent, the child should be taken to the nearest health facility without delay, and the parent/guardian informed simultaneously, save where doing so would endanger the child.
- Referral to Health/Mental-Health Services: where indicated, the child should be referred to the nearest Primary Health Centre, District Hospital or designated de-addiction facility, with a prescribed referral form completed and the parent/guardian accompanying the child wherever possible.

- Referral to Child Protection Authorities: simultaneously, or immediately thereafter, the case should be reported to the DCPU. Where the child is a victim of trafficking, coercion or abuse, or otherwise a child in need of care and protection, the matter should be reported to the CWC, and, where an NDPS Act or other offence is disclosed, the SJPU should be involved in accordance with law.
- Assessment and Treatment: the receiving facility should conduct a comprehensive assessment and formulate an individualised, age-appropriate treatment plan in a child-friendly setting, with informed consent/assent and due regard to confidentiality.
- Rehabilitation and Psychosocial Support: following or alongside treatment, the child should receive individual and family counselling, life-skills reinforcement and, where required, linkage to educational/vocational support, coordinated between the treatment facility, DCPU and school.
- Follow-up and Monitoring: the DCPU should maintain a follow-up record for every referred child and coordinate periodic follow-up, at intervals specified in the ICP, with the treatment facility, school and family.
- Reintegration: on completion of treatment, the child should be supported towards reintegration into family, school and community, with the School Management facilitating continued education without stigma, and the DCPU coordinating any continuing support required.

Stage	Primary Responsible Stakeholder(s)
Identification	Teachers, Counsellors, Prahari Club, Parents, Health Functionaries, Police
Initial Response & Safety Assessment	School Nodal Teacher/Counsellor; first responding functionary
Referral to Health/Mental-Health Services	RBSK, Primary Health Centre, District Hospital, De-addiction Centre
Referral to Child Protection Authorities	DCPU; CWC; SJPU (where required)
Assessment and Treatment	De-addiction/Treatment Facility
Rehabilitation and Psychosocial Support	Treatment Facility, DCPU, School
Follow-up and Monitoring	DCPU, in coordination with facility, school and family
Reintegration	School Management, DCPU, Family

3.6 Documentation, Referral Records and Confidentiality

Every referral made under Section 3.5 should be recorded on a standardised referral form — date of identification, nature of concern, action taken, receiving authority/facility — maintained by the referring school or functionary and shared with the DCPU/DEO, which would help in maintaining a consolidated, confidential case record for every child referred, updated at each stage. All such records will be confidential, accessible only to functionaries directly involved in the child's case.

3.7 Inter-Departmental Coordination

The Education Department (through the DEO), Health Department, Department of Women and Child Development/Social Justice, and Police, at the District level, should establish a coordination mechanism meeting at least once every quarter, to review implementation of prevention measures under this Chapter, address referral bottlenecks, and share aggregated, de-identified data for planning. The DCPU should serve as the central coordinating point at the district level for tracking referrals across the education, health and police systems, without prejudice to the statutory functions of the CWC and SJPU under the JJ Act, 2015.

3.8 Response Protocol for Children in Street Situations (CISS)

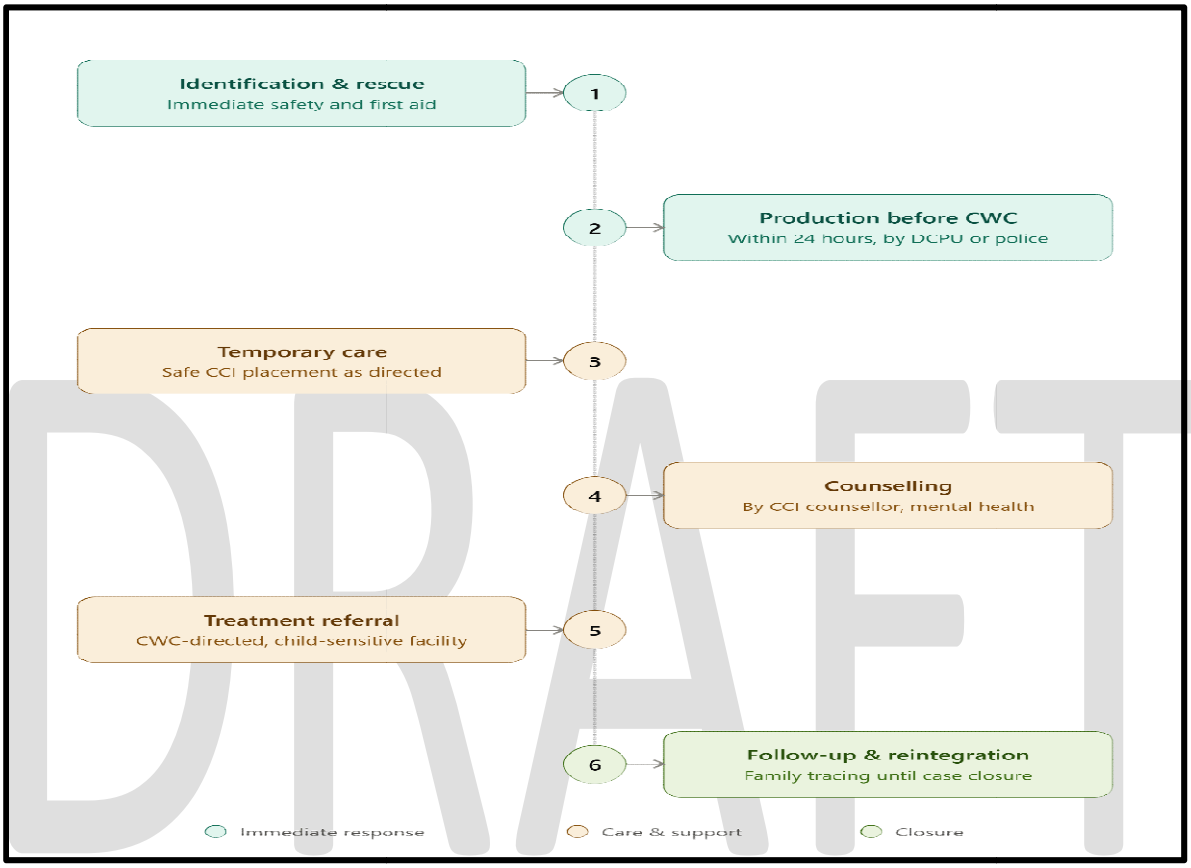
This Section sets out the standardised referral pathway and response mechanism for a Child in Street Situation (CISS) who is identified as using, possessing, being supplied with, or otherwise exposed to drugs or other substances. It should be read in conjunction with the existing Standard Operating Procedure 2.0 on CISS developed by NCPCR and implemented in accordance with the Juvenile Justice (Care and Protection of Children) Act, 2015, and the Rules and Guidelines issued thereunder.

3.8.1 Identification and Initial Response

A CISS affected by drug or substance use may be identified by frontline workers, NGOs and outreach workers, the Child Helpline, the DCPU, Police/SJPU, or other authorised child-protection functionaries. On identification, the concerned functionary should ensure the child's immediate safety; assess and, if necessary, facilitate urgent medical attention; ensure the child is not subjected to stigma, intimidation, public shaming or unnecessary detention; record the basic circumstances of identification; and initiate the appropriate referral pathway without delay. The identifying functionary should make a preliminary assessment of whether the child requires care and protection or whether the circumstances additionally attract action under the JJ Act, 2015.

3.8.2 Track 1 — Child in Need of Care and Protection (CNCP)

A CISS found using, possessing or exposed to substances is, as a general rule, a CNCP under Section 2(14) of the JJ Act, 2015, and should be dealt with accordingly, unless the circumstances warrant classification under Section 3.8.3. The sequence is:



3.8.3 Track 2 — Cases Additionally Requiring Action under the JJ Act, 2015

Sections 77 and 78 of the JJ Act, 2015 *"penalise an adult who gives an intoxicant to a child, or who uses a child to vend, peddle, carry, supply or smuggle any intoxicant."*These are offences against the child; liability under both sections falls on the offending adult, and the child remains a CNCP, with a case additionally registered against the adult.

A child should not be treated as a Child in Conflict with Law (CCL) merely on account of using or possessing a substance; such classification requires a case-specific assessment by the DCPU/Police, in consultation with the CWC where necessary, and should not be presumed from the mere fact of substance use or street situation.

Where a child is, upon such assessment, appropriately classified as a CCL, the sequence is: (a) registration of the case and appropriate legal/police protocol, ensuring child-friendly procedure throughout;

(b) production before the Juvenile Justice Board (JJB) within the prescribed time;

(c) placement in an Observation Home or other appropriate facility as ordered by the JJB;

(d) preparation of the Social Investigation Report (SIR) by the DCPU/Probation Officer;

(e) screening and assessment under Section 3.8.4;

(f) individualised counselling by the institution counsellor;

(g) referral to an authorised de-addiction/treatment facility where clinically indicated, on JJB direction; and

(h) follow-up, rehabilitation and reintegration per JJB orders, coordinated by the DCPU.

3.8.4 Screening and Psychosocial Assessment

Every CISS referred should undergo a standard psychosocial assessment covering the type, pattern, age of initiation, frequency and duration of substance use; signs of intoxication/withdrawal; physical and mental-health concerns; history of trauma or exploitation; family and social circumstances; education status; homelessness/livelihood vulnerabilities; risk of re-exposure; and need for medical, psychological, psychiatric or rehabilitation services. Such screening should be conducted by a qualified counsellor or health professional and is not equivalent to clinical diagnosis, which should be undertaken only by appropriately qualified medical or mental-health professionals. This should be included as part of the ICP/ SIR of the child.

3.8.5 Referral to De-Addiction and Rehabilitation Services

Referral should be made on the basis of the required clinical intervention, by the CWC/ JJB, acting on the recommendation of the CCI/Institution Counsellor or Medical Officer, with the child's informed consent/assent sought and communication conducted in a child-friendly, age-appropriate manner. Emergency referral should be made without awaiting routine procedure where urgent medical or psychiatric intervention is required. The referring authority should maintain documentation and coordinate with the receiving facility for a smooth transition of care; the DCPU/Superintendent of CCI should conduct periodic follow-up, coordinate a discharge plan, and, on completion of treatment, facilitate family or community reintegration with continued monitoring for relapse or re-exposure. All referrals should be made only to facilities that are duly authorised, child-sensitive and equipped for children's needs.

3.8.6 Children Already in CCIs/Observation Homes

Every child admitted to a CCI or Observation Home should be screened for substance use by the institution's Medical Officer/Counsellor at admission, using the standard assessment framework under this SOP, and thereafter re-screened at least quarterly, to enable early identification of relapse or new-onset use during institutional stay. Where relapse or new-onset use is identified, the Institution Counsellor should immediately initiate individualised

counselling and record the finding in the child's case file; where the assessment indicates a clinical need, the child should be referred, with CWC/JJB approval as applicable, to an authorised de-addiction/treatment facility, with documentation and coordination maintained per the referral provisions of this SOP. The Institution Superintendent should report any substance-related incident to the DCPU and CWC immediately, and to the Police/SJPU without delay where a cognisable offence arises. Follow-up should be continuous through the child's stay, with each case reviewed at least monthly, extending to rehabilitation planning — including relapse-prevention support, continued education/vocational engagement, and preparation for family or community reintegration — in accordance with the Individual Care Plan (ICP).

Throughout the referral process, the best interests of the child should remain the paramount consideration, the child should be treated with dignity and without discrimination, and should not be criminalised merely on account of substance use or street situation; confidentiality and privacy should be maintained by all functionaries; the child should be protected from exploitation, trafficking, abuse and further exposure to substances at every stage; family tracing and restoration should be undertaken wherever feasible and in the child's best interests; and the child should receive continued care, counselling, treatment and rehabilitation, coordinated between the DCPU, CCI/institution and treatment facility, until case closure.

3.9 Illicit Trafficking of Drugs and Substance Abuse: Coordinated Stakeholder Response

Recognising that children are particularly vulnerable to recruitment, coercion and exploitation by organised drug trafficking networks, all concerned authorities should adopt a coordinated child protection approach to prevent children's involvement in the illicit cultivation, production, transportation, distribution and sale of narcotic drugs and psychotropic substances. District Administrations, in coordination with the NCB, State Police, SJPUs, Child Welfare Police Officers (CWPOs), DCPUs, and the Education, Health, Excise and Drug Control Authorities, should strengthen preventive interventions, early identification of vulnerable children, timely rescue, referral and rehabilitation, while ensuring strict enforcement against those who exploit children. In border, coastal and other high-risk districts, the District Administration should establish enhanced coordination with the Border Security Force (BSF), Sashastra Seema Bal (SSB), Assam Rifles, Indian Coast Guard or other competent agencies, as applicable, for timely identification and safe referral of children intercepted or rescued from trafficking-related situations.

Children are increasingly vulnerable to exploitation by evolving trafficking networks operating through cross-border routes, digital platforms and local distribution channels. Understanding

these trends and the roles of key stakeholder agencies is essential to strengthening prevention, early intervention and coordinated child protection responses under this SOP.

Trend/Route	Brief Description	Primary Coordinating Agencies
Source and transit exposure	Myanmar has overtaken Afghanistan as the principal source of illicit opium reaching India (NCB Annual Report 2025).	NCB (intelligence-led operations, Zonal/Regional Offices)
North-eastern border corridors	Manipur and Mizoram corridors are active staging grounds for heroin and methamphetamine entering the Indian heartland.	State Police, Assam Rifles, SJPU, NCB Regional Offices
Western border smuggling	Drone-based smuggling across the Punjab border has risen sharply in recent years.	Punjab Police, Border Security Force (BSF), NCB
Digital and darknet trafficking	Traffickers increasingly use encrypted platforms (Telegram, WhatsApp, Signal) and darknet marketplaces.	NCB, State Cyber Cells, MANAS Helpline (1933)
Synthetic drugs and precursors	Rising use of methamphetamine, mephedrone and other synthetic drugs, with precursor chemical diversion.	CDSCO, State Drugs Control Authorities, NCB
Use of children in trafficking	Children used for vending, peddling, carrying or smuggling substances, or exposed to sale near schools.	SJPU/CWPO, Local Police, District Administration

Sources: Ministry of Home Affairs, Government of India, Press Release, Release (24 June 2026); Narcotics Control Bureau, Annual Report 2025; Ministry of Home Affairs, Press Release, Release (18 July 2024).

Traffickers increasingly route consignments through private couriers and postal services, at times using "dead-drop" delivery to avoid direct contact with buyers, while orders placed on darknet marketplaces are settled through cryptocurrencies to evade detection. Encrypted messaging applications are used for solicitation and coordination, exposing children to online recruitment and exploitation as couriers or intermediaries; enforcement agencies have accordingly shifted focus from apprehending individual carriers to dismantling entire networks, supported by enhanced cyber-surveillance and inter-agency intelligence sharing (NCB Annual Report 2025). Schools should organise periodic, age-appropriate awareness programmes — conducted by the School Counsellor/nodal teacher in coordination with the Police Cyber Cell,

at least once every academic year — to help children recognise and resist recruitment attempts involving couriers, dark-web marketplaces and encrypted platforms.

CHAPTER 4: GENERAL OPERATING PROCEDURES COMMON TO ALL SETTINGS

4.1 Identification and Screening

Functionaries across schools, CCIs, health facilities and community settings will be oriented to recognise general categories of indicators that may warrant a supportive conversation and, where appropriate, referral for professional assessment. Identification will never be undertaken through search, interrogation or confrontation of the child by non-clinical staff; it will be limited to observation and referral to the designated counsellor, medical officer or DCPU for formal assessment.

Category	Illustrative Indicators
Behavioural / Emotional	Sudden withdrawal from family or peers, marked changes in mood or temperament, secrecy, loss of interest in previously enjoyed activities, unexplained aggression or anxiety.
Academic / Attendance	Declining academic performance, frequent unexplained absence, disengagement from school or vocational activities.
Physical / Health	Unexplained changes in appearance, sleep or appetite patterns, repeated minor injuries, or health complaints without clear cause.
Social / Environmental	Association with a new peer group involved in known risk behaviour, presence in or near locations associated with substance availability, or reports from family/community members.

4.2 Health-System Entry and De-addiction Services

4.2.1 Entry Points for Health Assessment

A child suspected of substance use will first be linked to an appropriate health entry point for clinical assessment: the nearest public health facility, or an Adolescent Friendly Health Clinic (AFHC) operating under the RKSK in accordance with the M-AFHC Guidelines. The treating medical officer at any entry point will determine the need for counselling, outpatient management, specialist consultation or referral to de-addiction services.

4.2.2 De-addiction Services

Based on the clinical assessment, the child shall be referred to the appropriate de-addiction facility or service available in the district for children, considering the child's age, clinical needs and level of care required. District authorities shall maintain an updated directory of de-addiction facilities and services providing care to children, along with their contact details,

services available and referral requirements, and ensure its accessibility to relevant stakeholders for timely referral. Referral shall ensure access to age-appropriate assessment, counselling, treatment, rehabilitation, family support and follow-up, as clinically indicated, while maintaining child protection, confidentiality and other safeguards.

4.2.3 Need for Exclusive Child-Specific Facilities

De-addiction Centres functioning under the NAPDDR currently provide services largely on an age-mixed basis. Given children's distinct developmental, protection and confidentiality needs, State Governments should progressively reserve exclusive child-friendly wards, beds or dedicated hours within existing De-addiction Centres, where district caseloads justify it, establish stand-alone child-exclusive facilities staffed by personnel trained in child-friendly, trauma-informed care. Until such facilities are established, children referred to age-mixed De-addiction Centres will be kept segregated from adult residents/patients and accompanied by a parent, guardian or authorised functionary throughout treatment, consistent with child protection safeguards under the JJ Act, 2015.

It has also been observed that children identified as using or dependent on drugs or other substances may not be suitable for placement in the same facilities as other children in CCIs, given their specific treatment, protection and psychosocial needs. There is, therefore, a need to make appropriate provisions for dedicated and child-friendly de-addiction facilities.

4.3 Do's and Don'ts for Functionaries

Do	Don't
Listen to the child without judgement and reassure them of support.	Do not interrogate, search or confront the child independently.
Maintain confidentiality of the child's identity and case details.	Do not discuss the case in public forums, staff rooms or with uninvolved persons.
Refer the child to the designated counsellor, medical officer or DCPU.	Do not attempt to independently diagnose, counsel beyond one's competence, or administer any treatment.
Continue to provide the child access to education and normal activities.	Do not suspend, expel or publicly label a child on account of suspected or confirmed substance use.

Do	Don't
Involve parents/guardians and the child in a supportive manner.	Do not shame the family or attribute blame in front of the child.
Document observations factually and report through the designated channel.	Do not record personal opinions, assumptions or unverified information in the case file.

CHAPTER 5: MONITORING, REPORTING AND EVALUATION

5.1 District-Level Monitoring

Implementation of this SOP should be monitored by the District Nodal Officer (Additional District Magistrate) through quarterly review meetings of the District-Level Coordination Committee, covering implementation by all concerned stakeholders — including the Child Protection, Education, Health, Police, Excise and Drug Control Departments — with particular emphasis on:

- implementation of preventive measures in schools and communities;
- identification, referral, treatment and rehabilitation of children;
- functioning of Child Care Institutions and District De-addiction Centres;
- enforcement of applicable legal provisions relating to sale and supply of intoxicating substances to children;
- conduct of sensitisation and awareness programmes; and
- submission of quarterly monitoring data as prescribed at Annexure III.

5.2 State-Level Monitoring

The State Commission for Protection of Child Rights (SCPCR) should serve as the State-level monitoring authority and should: monitor overall implementation of this SOP across all districts within the State/UT; review district-wise progress through quarterly meetings with District Nodal Officers; monitor implementation of key indicators under the Joint Action Plan, including prevention activities, identification, treatment, rehabilitation, enforcement actions and institutional compliance; identify implementation gaps and issue recommendations for corrective action; escalate persistent non-compliance or systemic issues to the NCPCR; and undertake an annual State-level evaluation, submitting a consolidated report to the NCPCR.

5.3 National-Level Monitoring

The National Commission for Protection of Child Rights (NCPCR), in coordination with the NCB and concerned Ministries, should: review State-wise implementation of the SOP and Joint Action Plan; analyse monitoring data received from States; identify national trends, implementation gaps and best practices; recommend policy measures and corrective actions; and facilitate inter-ministerial coordination for strengthening prevention, treatment, rehabilitation and enforcement mechanisms.

CHAPTER 6: GRIEVANCE REDRESSAL AND CHILD PROTECTION SAFEGUARDS

6.1 Grievance Redressal

Any child, parent, guardian or functionary may report non-compliance with this SOP, denial of services, or violation of a child's rights to the DCPU, the CWC, the District Nodal Officer (Additional District Magistrate), the SCPCR, or the NCPCR through its online Complaint Management System ('eBaalnidan', accessible at ncpcr.gov.in). Complaints concerning sexual offences against a child may additionally be filed through the NCPCR's POCSO e-Box. A child in immediate distress may access the Child Helpline (1098), integrated with the Emergency Response Support System (112) under the Mission Vatsalya scheme.

6.2 Accountability

Failure by any institution or functionary to comply with the non-punitive, confidentiality and referral requirements of this SOP will be reported to the concerned administrative authority and, where applicable, to the SCPCR/NCPCR, for appropriate action.

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ANNEXURE I: KEY STAKEHOLDERS AT STATE AND DISTRICT LEVEL

Effective prevention and response depend on close coordination between administrative, law enforcement, health, education and child protection functionaries at every level. The functionaries listed below carry distinct but interdependent responsibilities — spanning enforcement, treatment, education, welfare and overall monitoring. Their coordinated action determines whether a child at risk is identified early, protected, treated and successfully reintegrated.

Stakeholders at the District Level	Stakeholders at the State Level
1. District Magistrate (DM) / Deputy Commissioner (DC)	1. State Commission for Protection of Child Rights (SCPCR)
2. Superintendent of Police (SP)	2. Department of Women & Child Development / Social Welfare
3. District Excise Officer	3. State Department of Education
4. District Education Officer (DEO)	4. State Department of Health & Family Welfare
5. Chief Medical Officer (CMO) / District Health Officer	5. State Pharmacy Council
6. District Child Protection Unit (DCPU) — Member-Secretary and nodal unit	6. State AIDS Control Society
7. District Social Welfare Officer	7. State Excise Department
8. District Drugs Control Authority	8. State Drugs Controller Authority
9. Special Juvenile Police Unit (SJPU)	
10. Child Welfare Committee (CWC)	
11. Child Welfare Police Officer (CWPO)	
12. State/Regional Officer of the Narcotics Control Bureau (NCB)	
13. Chief Executive Officer, Zila Panchayat	

Note: The functionaries listed above are illustrative of the core institutional set-up envisaged under this SOP. State Governments and Union Territory Administrations may notify additional

members or co-opt other departments/agencies as considered necessary, consistent with the objectives of the Joint Action Plan.

Detailed Roles and Responsibilities — School-Level Stakeholders

Stakeholder	Roles and Responsibilities
Principal / Head of School	• Overall responsibility for implementation of preventive measures in the school • Constitutes the School Health and Safety Committee and nominates a nodal teacher • Ensures COTPA compliance and Nasha Mukt Vidyalaya renewal • Maintains confidential case records of identified children • Coordinates with the DEO/DCPU, Health Department and Police as required • Reviews implementation of this SOP during periodic school inspection
District Education Officer (DEO)	• Monitors SOP compliance by every Government, Government-aided and coordinate with the appropriate regulatory authorities for private schools, as applicable under the relevant State/UT framework. • Ensures every school constitutes a Prahari Club, designates a nodal teacher, and completes prescribed staff training within stipulated timelines • Consolidates quarterly school-level compliance and activity reports for submission to the State Education Department • Coordinates with the DCPU, Health Department and Police on referral cases involving children enrolled in schools • Addresses school-level non-compliance and escalates persistent or systemic gaps to the State Education Department/District Nodal Officer

Stakeholder	Roles and Responsibilities
Teachers	• Remain vigilant for behavioural, physical or academic changes in students • Complete NAVCHETNA sensitisation and signs/symptoms training • Report concerns confidentially to the School Counsellor without confronting or interrogating the child • Support continued academic engagement of children undergoing counselling or treatment
School Counsellor / Wellness Teacher	• Serves as the focal point for psycho-social assessment and support • Conducts confidential interaction with the identified child and, where appropriate, the family • Prepares an Individual Support Plan (ISP) and coordinates referral to RBSK/de-addiction services • Monitors progress through periodic follow-up and supports reintegration into school life
Prahari Club (Teacher-in-Charge and Student Members)	• Conducts at least two awareness activities each year • Undertakes peer vigilance and reports suspected drug-related activity to the Teacher-in-Charge • Supports observance of designated awareness days
School Management Committee (SMC) / Parents	• Support awareness activities and participate in the dedicated PTA session • Maintain regular communication with teachers/counsellor regarding the child's well-being • Support adherence to counselling/treatment plans at home
Police / Special Juvenile Police Unit (SJPU)	• Prevents sale or supply of narcotic drugs in the vicinity of educational institutions • Investigates cases of drug peddling, trafficking or exploitation of children • Coordinates with DCPU and CWC while ensuring child-friendly, non-criminalising procedures • Participates in dark web/cyber-trafficking sensitisation workshops for schools

Detailed Roles and Responsibilities — District-Level Stakeholders (Child Protection Officers)

Stakeholder	Roles and Responsibilities
District Child Protection Unit (DCPU)	• Serves as the central coordinating authority for referral, case tracking and follow-up • Conducts outreach in collaboration with NGOs and local authorities • Prepares and maintains the Individual Care Plan (ICP) and Social Investigation Report (SIR) • Coordinates production of children before the CWC/JJB • Monitors restoration, follow-up and closure of every case • Coordinates DCPU and stakeholder sensitisation under Section 3.1
Child Welfare Committee (CWC)	• Assesses the child's need for care and protection under Section 77 cases • Passes orders for shifting to a CCI, counselling, rehabilitation, restoration, foster care or institutional care • Approves restoration only after assessing the safety and readiness of the home environment
Juvenile Justice Board (JJB)	• Adjudicates cases of children in conflict with law under Section 78 • Considers the Social Investigation Report before passing orders • Directs SIR-based rehabilitation measures, including counselling and de-addiction referral
Special Juvenile Police Unit (SJPU)	• Registers the FIR and ensures child-friendly procedure at every stage • Produces the child before the CWC/JJB within the prescribed timeline • Coordinates with DCPU for case follow-up

Stakeholder	Roles and Responsibilities
District Nodal Officer (Additional District Magistrate)	• Provides district-level coordination among all stakeholders • Conducts quarterly review of prevention, identification and rehabilitation data • Reports progress to the SCPCR • Directs escalation action where a case is not resolved within the stated timeline
Chief Medical Officer / District Health Officer	• Oversees RBSK/RKSK screening and referral linkages to de-addiction services • Ensures availability of trained medical officers/counsellors at CCIs and Observation Homes • Coordinates treatment protocols with DDAC/IRCA/ATF centres

ANNEXURE II: DIRECTORY OF KEY NATIONAL HELPLINES AND PORTALS

Service	Contact / Portal
Child Helpline (integrated with Emergency Response Support System)	1098
National Toll-Free Drug De-addiction Helpline (Ministry of Social Justice and Empowerment)	14446
MANAS — NCB Portal & Helpline	1933 / ncbmanas.gov.in
National Tobacco Quit Line	1800-11-2356
Tele MANAS, Ministry of Health and Family Welfare	14416
NCPCR SAMVEDNA Tele-Counselling Service	1800-121-2830
NIMHANS Helpline	080-4611-0007
NCPCR Online Complaint Management System	eBaalnidan, via ncpcr.gov.in
NCPCR POCSO e-Box (for sexual offences against children)	via ncpcr.gov.in/pocso
Nasha Mukt Bharat Abhiyaan Portal	nmba.dosje.gov.in
Nasha Mukt Vidyalaya (NMV) Portal (Ministry of Education)	tofei.education.gov.in

Note: District Administration should additionally maintain an updated local directory of District De-Addiction Centres, IRCAs, ODICs and CPLI projects operating in their district.

ANNEXURE III: FORMAT FOR QUARTERLY DISTRICT MONITORING REPORT

S. No.	Monitoring Parameter	Response
A. District Details		
1	Name of Nodal Officer	
2	Designation	
3	Email ID	
4	Mobile Number	
5	State	
6	District	
B. Institutional Mechanism		
7	Whether the District has implemented the Joint Action Plan (JAP). (Yes/No)	
8	Number of review meetings conducted under the Joint Action Plan	
9	Whether sensitization and training programmes for schools on treatment, de-addiction counselling and rehabilitation of children with drug and substance abuse have been conducted. (Yes/No)	
C. School-Based Prevention Measures		
10	Total number of Government Schools	
11	Number of Prahari Clubs constituted in Government Schools	
12	Total number of Private Schools	
13	Number of Prahari Clubs constituted in Private Schools	
14	Number of awareness programmes conducted by members of Prahari Clubs in school premises	
D. Regulation of Scheduled Drugs & Medical Stores		
15	Whether the District Magistrate has issued an order under Section 152 of the BNSS for installation of CCTV cameras at medical stores. (Yes/No)	

S. No.	Monitoring Parameter	Response
16	Total number of shops selling Schedule H, H1 and X drugs in the district	
17	Number of medical stores where CCTV cameras have been installed	
18	Number of shops where digitization of registers for Schedule H, H1 and X drugs has been completed	
E. Tobacco & Alcohol Control Measures		
19	Whether liquor shops have been relocated away from schools as per State norms. (Yes/No)	
20	Number of tobacco/cigarette selling shops relocated away from schools in compliance with Section 6 of the COTPA Act	
21	Whether fines have been imposed on shops violating Section 6 of the COTPA Act. (Yes/No)	
22	Whether hoardings/display material regarding prohibition of sale of tobacco/alcohol to children below 18 years have been installed at appropriate places in the district. (Yes/No)	
F. Treatment & Rehabilitation		
23	Number of de-addiction centres in the district	
24	Whether a separate child-friendly partitioned area is available within existing de-addiction centres. (Yes/No)	
25	Number of exclusive de-addiction centres for children in the district	
G. Awareness & Capacity Building		
26	Number of awareness programmes organized by district officials on prevention of drug and substance abuse among children	
27	Number of trainings conducted on the NCPCR Safety and Security Manual for Children	
H. Child Protection Measures		

S. No.	Monitoring Parameter	Response
28	Whether mapping of children in street situations using drugs/substances has been conducted and identified children produced before the CWC for counselling, treatment and rehabilitation. (Yes/No)	
29	Number of children in street situations identified/rescued using drugs/substances	
I. Enforcement Measures		
30	Whether the District Magistrate has conducted a meeting with Traders'/Shop Owners' Associations regarding the sale of inhalants. (Yes/No)	
31	Number of cases registered under Section 77 of the JJ Act, 2015	
32	Number of cases registered under Section 78 of the JJ Act, 2015	
33	Number of training programmes conducted for Child Welfare Police Officers (CWPOs) on Sections 77 and 78 of the JJ Act, 2015	

ANNEXURE IV: QUICK REFERENCE — COORDINATION COMMITTEES

Level	Nodal Authority
National	NCPCR & NCB (jointly)
State	Monitoring by SCPCR
District	Additional District Magistrate

ANNEXURE V: PRAHARI CLUB ACTIVITIES

Quarter	Activity	Action Points
Quarter I (April–June)	School Safety Survey	Conduct a survey of the area surrounding the school to identify shops selling tobacco products within 100 metres of the institution in violation of the COTPA Act, 2003; report violations to the School Head; ensure the mandatory "No Sale of Tobacco Products within 100 Metres of Educational Institutions" board is displayed.
	Poster Making Competition	Organise a poster competition on the harmful effects of tobacco, drugs and substance abuse; display selected posters in the school.
	Expert Awareness Session	Invite health professionals, counsellors, police officials or other experts to interact with students on prevention and child safety.
	Prahari Club Meeting	Review activities undertaken, discuss observations and prepare the quarterly action plan.
Quarter II (July–September)	Awareness Campaign	Conduct awareness activities through assemblies, posters, exhibitions and digital platforms promoting a drug-free and tobacco-free environment.
	Slogan Writing Competition	Organise a slogan-writing competition on healthy lifestyles and prevention of substance abuse; display winning entries on notice boards.
Quarter III (October–December)	Classroom Discussions	Conduct interactive sessions on peer pressure, refusal skills, harmful effects of drugs and available support services.
	Awareness Workshop	Organise workshops for students, teachers and parents on prevention, early identification and referral.

Quarter	Activity	Action Points
	Community Outreach	Undertake neighbourhood awareness activities and encourage community participation in protecting children.
Quarter IV (January–March)	Annual Review	Review Prahari Club activities undertaken during the year, identify good practices and prepare recommendations for the following year.
	Role Play/Street Play	Organise role plays or street plays on prevention, healthy decision-making and help-seeking behaviour.

Role	Responsibility
Club Members	Maintain confidentiality of information regarding a specific child's suspected substance use, share it only with the Teacher-in-Charge, and never confront or publicly identify the child concerned.
Teacher-in-Charge	Mentor the club, coordinate its quarterly activities, receive and escalate confidential reports, and consolidate the club's activity report each quarter.
Principal / School Management Committee	Provide institutional oversight, ensure the club's activities are integrated with the school's broader health and wellness programme, and forward consolidated reports to the DEO.

Source: NCPCR and NCB, Joint Action Plan on Prevention of Drugs and Substance Abuse among Children and Illicit Trafficking (2021), Section 6 and Annexure-3; NCPCR Prahari Club Portal.

ANNEXURE VI: CHECKLIST FOR IDENTIFYING POSSIBLE SIGNS AND SYMPTOMS OF SUBSTANCE USE IN CHILDREN

S. No.	Possible Signs and Symptoms	Observed
1	Sudden changes in behaviour or mood	☐
2	Decline in school attendance or academic performance	☐
3	Loss of interest in studies, sports or other activities	☐
4	Red or watery eyes	☐
5	Slurred speech or poor coordination	☐
6	Unusual smell of tobacco, alcohol or chemicals	☐
7	Excessive sleepiness or unusual hyperactivity	☐
8	Irritability, anxiety, aggression or mood swings	☐
9	Withdrawal from family, friends or social activities	☐
10	Secretive behaviour or frequent lying	☐
11	Unexplained need for money or missing valuables	☐
12	Possession of tobacco products, vaping devices, alcohol, pills, powders or other suspicious substances/items	☐
13	Poor personal hygiene or sudden weight loss	☐
14	Frequent complaints of headache, nausea or dizziness	☐

DSM-5-TR: Substance Use Disorder (For Clinical Assessment Only)

A diagnosis of Substance Use Disorder (SUD) should be made only by a qualified mental health professional in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). The diagnosis is based on the presence of at least two specified clinical criteria occurring within a 12-month period, with severity classified as Mild (2–3 criteria), Moderate (4–5 criteria) or Severe (6 or more criteria).

During street-level outreach, frontline workers may look for **injection marks on the arms, unusual or inappropriate clothing/appearance, disorganised or unclear speech, unusual**

alertness or drowsiness, and sudden changes in behaviour or mood. These signs do not confirm substance use but may indicate the need for further screening and referral.

Note: Teachers, caregivers and frontline workers are not expected to diagnose substance use disorders. Their role is limited to identifying warning signs and facilitating timely referral for professional assessment and appropriate care.

ANNEXURE VII: ILLUSTRATIVE CASE EXAMPLE AND SUGGESTED PROMPTS FOR COUNSELLORS

This illustrative, fictional case example is provided to help school and CCI counsellors approach a conversation with a child suspected of substance use in a manner that is warm, non-judgmental and focused on the child's safety and wellbeing, consistent with the Guiding Principles at Section 4.1. It is a training aid, not a script to be followed word for word; every conversation should be adapted to the individual child.

Illustrative Scenario

A Class 9 student (referred to here as 'R', aged 14) has been referred to the school counsellor after a teacher noticed a decline in attendance, a change in friend group, and the smell of a chemical substance on R's clothing. The counsellor meets R individually, in a private, confidential setting.

Sample Conversation

- Counsellor: Hi R, thanks for coming by. This isn't about getting you into trouble - I just wanted to check in, because I care about how you're doing. Is now an okay time to talk?
- R: I guess so. Am I in trouble?
- Counsellor: No, you're not in trouble. Whatever we talk about stays between us, unless I'm worried about your safety - and if that ever happens, I'll tell you first before I speak to anyone else. How have things been for you lately, at school and at home?
- R: It's been okay. School's just been a lot.
- Counsellor: That sounds tough. I noticed you've missed a few days recently, and your teacher mentioned some things have felt different this term. What's been the hardest part?
- R: (pause) Some of my friends have been through a lot this year. We've been hanging out more, trying to feel better, I guess.
- Counsellor: It makes sense to want to feel better when things are hard. Sometimes, when friends are going through a lot together, people try things to cope - like smoking, vaping, or other substances. Has anything like that come up for you or your friends?
- R: (hesitates) Some of us have tried things. I don't do it a lot.
- Counsellor: Thank you for trusting me with that - I know that wasn't easy to say. I'm not here to judge you. I'd like to understand a bit more, just so I can support you properly. When you say you've tried things, can you tell me a bit about what's happened?
- R: Just a couple of times with friends. I don't want my parents to find out.
- Counsellor: I hear that you're worried about your parents finding out, and we can talk through how and when that happens. Right now, my main concern is you - how you're

feeling, and making sure you're safe. Have you ever felt very unwell, or unsafe, when this has happened?

- R: No, nothing like that.
- Counsellor: That's good to know. Here's what I'd like to do next: I'd like us to make a plan together, so you have some support - that might include check-ins with me, and connecting with your parents in a way that feels less scary. Would that be okay with you?
- R: Yeah, I think so.

Suggested Prompts for Counsellors

The following open-ended, non-judgmental prompts may help counsellors initiate and sustain such conversations. They should be adapted to the child's age and comfort, and are best used to open dialogue rather than to interrogate.

- "How have things been for you lately - at home, at school, with friends?"
- "I noticed [specific, non-accusatory observation]. Can you help me understand what's been going on?"
- "Sometimes when things are hard, people try things to cope or feel different. Has that ever come up for you?"
- "You're not in trouble for talking to me. What would help you feel safe telling me more?"
- "What do your friends think or do about this? How do you feel about that?"
- "Is there anything that worries you about your own health or safety right now?"
- "What would you like to happen next? Let's figure out a plan together."
- "How would you like your parent/guardian to be involved, and when would feel right to you?"

Points for the Counsellor to Keep in Mind

- Maintain a calm, warm, non-judgmental tone throughout; avoid expressions of shock, disapproval or lecturing.
- Use open-ended questions and reflective listening rather than direct accusations.
- Be explicit and honest about the limits of confidentiality (i.e., where the child's safety is at risk) before the child discloses sensitive information.
- Assess for immediate safety concerns (acute intoxication, withdrawal, self-harm risk, coercion or exploitation) and escalate urgently where needed.
- Involve the parent/guardian and prepare an Individual Care Plan/Individual Support Plan.
- Document the conversation factually and confidentially, avoiding personal opinions or assumptions.

ANNEXURE VIII: MINIMUM STANDARDS FOR CHILD-FRIENDLY DE-ADDICTION CENTRES

All District De-addiction Centres (DDACs), Integrated Rehabilitation Centres for Addicts (IRCAs), Addiction Treatment Facilities (ATFs) and any other treatment facility admitting children should ensure the following minimum standards:

Component	Minimum Requirements
Child-Friendly Infrastructure	Separate treatment facilities for children, distinct from adult patients; safe, clean and age-appropriate environment with adequate sanitation, ventilation and recreational space.
Separate Wards	Dedicated inpatient and outpatient facilities for children, with separate accommodation for boys and girls, wherever residential care is provided.
Medical Services	Medical assessment, detoxification (where clinically indicated), treatment of withdrawal symptoms, emergency medical care and management of co-occurring physical illnesses by qualified medical professionals.
Mental Health Services	Comprehensive psychological assessment, psychiatric consultation, individual counselling, group therapy, behavioural interventions and relapse prevention planning by trained mental health professionals.
Multidisciplinary Team	Availability of a psychiatrist/addiction medicine specialist, medical officer, clinical psychologist/counsellor, psychiatric nurse, social worker and other trained personnel as required.
Individual Care Plan (ICP)	Preparation and periodic review of an Individual Care Plan for every child, covering treatment goals, education, psychosocial support, rehabilitation and restoration.
Family-Based Interventions	Family counselling, caregiver education and active involvement of parents/guardians in treatment, rehabilitation and relapse prevention, wherever appropriate.
Education & Recreation	Continuation of education through linkage with schools or alternative education, along with structured recreational, sports, art and life-skills activities during treatment.

Component	Minimum Requirements
Protection & Safeguarding	Compliance with the JJ Act, 2015; protection from abuse, neglect, discrimination and corporal punishment; maintenance of confidentiality and privacy.
Referral & Rehabilitation	Linkages with the DCPU, CWC, schools, District Mental Health Programme (DMHP), IRCAs/DDACs and community-based rehabilitation services for continuity of care.
Follow-up & Reintegration	Regular follow-up after discharge, relapse prevention, school reintegration, vocational support (where age-appropriate) and community-based rehabilitation.
Capacity Building	Periodic training of medical, counselling and support staff on child rights, child protection, adolescent mental health, trauma-informed care and management of substance use disorders in children.
Record Keeping	Maintain confidential case records, treatment plans, follow-up reports and referral records, while ensuring compliance with applicable laws relating to privacy and child protection.