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The Official Newsletter of Addiction Psychiatry Society of India (APSI)

Theme- Rethinking Substance Use: From Disorder to Disability - or Just Disabling?

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Obituary: Professor Rajat Ray



10 September 1948 – 10 July 2026

Ex-Head of Department, Psychiatry, and Chief, NDDTC, AIIMS, New Delhi

Ex-Member, International Narcotics Control Board (INCB)

The Addiction Psychiatry Society of India (APSI) expresses its profound grief on the occasion of the sad demise of Professor Rajat Ray.

Professor Ray was the Founder President of APSI and served the nascent Society with enthusiasm, leadership and wisdom. But more than that, he was truly a doyen of addiction psychiatry, in India and abroad. During an era when there were very few mental health professionals pursuing addiction psychiatry, even when addiction psychiatry was yet to be christened in India as a super specialty subject and at times much marginalized and stigmatized, Professor Ray stood tall in his conviction for decades, and with herculean efforts helped to bring it to the public and political attention that it deserved. Professor Ray admirably combined in himself a number of distinct characters: an avid scientific researcher (especially during his early years at NIMHANS Bangalore), a dedicated clinician, a passionate teacher, an expert administrator, a top-notch negotiator especially with the Government agencies to push public health policies and programs related to addiction psychiatry, and, last but not the least, a wonderful human being who spoke with conviction (in his characteristic high-pitched tone), care and confidence.

Professor Rajat Ray left a void that will be hard to fill, but thankfully, he has also left a rich legacy by virtue of his countless generations of students who themselves are eminent addiction psychiatrists now. That legacy will carry on the torch that this torchbearer had lit and carried all these years.

APSI extends its deepest condolences to his family, associates and students.

Editorial

Rethinking Substance Use: From Disorder to Disability - or Just Disabling?

Vinit Patel, Ravindra Rao

We begin this issue on a deeply sombre note as we mourn the departure of our esteemed past president, Prof. Rajat Ray to heavenly abode. The addiction psychiatry community in India has lost one of its guiding lights. For many stalwarts of addiction psychiatry, he was a teacher and mentor, guiding them in their professional journey. Many of those he mentored have since gone on to lead the field, further strengthening and expanding addiction psychiatry across the country. His association with the National Drug Dependence Treatment Centre (NDDTC), his contribution to national epidemiological work on substance use, his service as a member of the International Narcotics Control Board (INCB), and his pioneering work in opioid agonist treatment, including buprenorphine-based treatment, have left an enduring mark on addiction psychiatry in India. His influence extends beyond these achievements - to the many clinicians, researchers, teachers, and, more importantly, the people whose lives have been touched by his work. To reflect the somber mood, the current issue is presented in grey. It is with profound respect for his legacy of advancing evidence-based and compassionate care that we introduce the theme of this issue: Rethinking Substance Use: From Disorder to Disability - or Just Disabling? As the field he helped build continues to evolve, we must also continue to ask difficult questions about how people with substance use disorders (SUD) are understood, treated, and supported. This issue takes up one such question: Can SUD be considered a disability? At first glance, the question may appear straightforward. But what exactly do we mean by disability?

Traditionally, disability has often been understood through a medical lens – as a problem arising from an impairment or health condition within an individual. Contemporary disability frameworks, however, offer a broader understanding. The International Classification of Functioning, Disability and Health (ICF) distinguishes between impairment, activity, and participation, drawing attention to how health conditions interact with environmental and social factors to influence functioning (1,2). The social model of disability goes further, emphasizing that disadvantage may arise not only from the impairment itself but also from physical, institutional and attitudinal barriers in society (2,3). This distinction becomes particularly relevant to substance use disorders. A person may have a diagnosis of SUD, but that diagnosis alone does not tell us how well the person functions. For some, substance use may coexist with relatively preserved occupational, interpersonal and social functioning. For others, SUD may be accompanied by profound difficulties in employment, relationships, self-care, cognition, financial independence or participation in community life (1,4).

This brings us to an important distinction: A disorder may be disabling without necessarily being a disability. Perhaps this is the space captured by the word “disabling.” Between having a disorder and being recognized as a person with a disability lies the question of what that

disorder actually does to a person's life. When does impairment become sufficiently consequential to restrict activity or participation? And when should such disabling effects translate into formal recognition, rights and social protection? These questions are particularly complicated in SUD because it is not a binary condition. Substance use disorders exist across a spectrum of severity, and their effects on functioning can vary considerably. A person may experience substantial impairment during one period and regain much of their functioning during another. SUD can also follow a chronic, relapsing and remitting course. This raises difficult questions for any disability framework: Should disability recognition depend on diagnosis, severity, functional impairment, duration, or participation restriction? Where should the threshold be drawn? What happens during remission? And should support to the individual change as functioning changes?

There is another important dimension to this discussion. If disability is understood only as an attribute of the individual, we may overlook the ways in which society itself can induce and perpetuate disabling. Stigma, discrimination, exclusion from employment, housing insecurity, inadequate access to healthcare, and restrictive institutional practices can amplify the consequences of SUD. The social model reminds us that the disadvantage experienced by a person may arise partly from the interaction between impairment and the environment rather than from the impairment alone (2,3,5).

For people with SUD, this distinction is particularly important. Someone may struggle to maintain employment not only because of the effects of their disorder, but also because of discrimination. A person may remain outside the healthcare system not only because of their illness, but because of stigma or institutional barriers. In this sense, the question is not simply whether SUD is disabling, but also what makes it disabling. If SUD were to be considered within a disability framework, therefore, the potential benefits need not be limited to financial assistance or employment-related concessions. Recognition could potentially support access to healthcare and insurance, housing, vocational rehabilitation, occupational training, workplace accommodation, social protection and protection from discrimination. In the Indian context, such recognition could also contribute to a more humane, health-oriented, response to people with substance use problems.

At the same time, recognition carries its own complexities. Will a universal classification of SUD as a disability be appropriate when the condition varies so widely in severity and functional impact? Can a disability label inadvertently reinforce perceptions of incapacity or undermine agency and autonomy? Will existing disability assessment instruments adequately capture the fluctuating and multidimensional nature of addiction? And can a framework designed around relatively stable impairments adequately account for recovery and relapse? These are not merely academic questions. They determine who qualifies, on what basis, for how long, and for what kind of support.

This issue of APSI Newsbuzz therefore approaches the question from three complementary perspectives. The first thematic article, “Substance Use Disorders as Disability: The Case for Recognition,” examines the arguments for bringing SUD within a disability framework. The second, “Substance Use Disorders as Disability: Arguments Against Universal Classification,” explores the limitations and potential unintended consequences of such an approach. The third, “Substance Use Disorders as Disability: Global Perspectives and the Way Forward for India,” looks at how different countries have approached this question and considers what India might learn from these experiences.

Ultimately, the purpose of recognizing disability should not be the creation of another label. It should be to ensure that people whose health conditions substantially limit their functioning or participation are not excluded from the opportunities, protections and dignity available to others. The challenge for addiction psychiatry is to find a framework that recognizes genuine impairment without equating diagnosis with incapacity, supports people without undermining agency, and promotes recovery without making support conditional on being permanently unwell.

Beyond the thematic section, this issue brings together several developments from across addiction psychiatry. In Basic Sciences, “MicroRNA Regulation of DAT Expression in Opioid Reward: Insights from Translational Research” explores emerging translational evidence on the molecular regulation of opioid reward. In Alcohol and Tobacco, “Rewiring Recovery: Optimizing Brain Networks with Continuous Theta Burst Stimulation (cTBS) to Reduce Relapse in Alcohol Use Disorder” examines an innovative neuromodulation approach to relapse prevention. In Special Populations, “Revolving Doors: Substance Use and Reincarceration in Women in Correctional Settings” explores the intersection of substance use, incarceration, and the challenges of sustained recovery among women. As always, we also have a crossword to test your knowledge and a creative artwork to provide a different perspective on the themes explored in this issue.

We hope this issue encourages reflection and discussion, not necessarily consensus. Some questions are valuable precisely because they force us to examine the assumptions behind our existing systems of care, law and social protection.

We look forward to your feedback and suggestions.



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THEMATIC ARTICLES

Substance Use Disorders as Disability: The Case for Recognition

Shreya Shukla

Disability constitutes an integral dimension of the human experience. Early conceptualizations were dominated by the medical model, which construed disability as a direct consequence of disease, manifesting in impairment, functional limitation, and social disadvantage. Over time, this perspective has undergone significant transformation. The World Health Organization's International Classification of Functioning, Disability and Health (ICF), 2001, marked a fundamental shift by reframing disability from a "consequence of disease" to a "component of health."⁽¹⁾ This reconceptualization emphasized that disability is not merely an individual deficit but emerges through the interaction between impairment and environmental barriers, thereby restricting participation of the individual. This was further consolidated by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), 2006. The Convention advanced a rights-based framework, affirming equality, dignity, and justice for persons with disabilities. In India, these global developments found legislative expression in the Rights of Persons with Disabilities Act (RPWD Act), 2016. The Act defines persons with disabilities as those with long-term physical, mental, intellectual, or sensory impairments which, in interaction with barriers, hinder full and effective participation in society on an equal basis with others ⁽²⁾. Against this backdrop, the classification of substance use disorder (SUD) as a disability warrants critical examination.

Substance use disorders under the disability umbrella: conceptual and clinical arguments

The widely accepted brain disease model of addiction situates it within the domain of medical illness, thereby laying the groundwork for its recognition as a disability. SUDs produce persistent impairments in functioning, restrict societal participation and significantly reduce quality of life. Evidence from the Australian National Study of Mental Health and Wellbeing (2020–2022) demonstrates that the individuals with SUD experience substantially greater functional impairment, losing an average of 3.89 productive days in the preceding month compared with only 0.79 days among individuals without mental illness ⁽³⁾. Similarly, community-based studies have reported that alcohol and drug dependence are associated with moderate-to-severe disability across various domains such as occupational functioning, social relationships, cognition, and independent living ⁽⁶⁾.

Indian research further supports these observations. WHODAS 2.0 assessments have shown that alcohol use disorder is associated with the greatest disability in societal participation, household responsibilities, work-related activities, and cognitive functioning. Among

individuals with opioid use disorder, disability is particularly pronounced in employment and interpersonal functioning, with nearly half experiencing moderate disability (6,7).

People with SUD face substantially more social stigma than those with conventional disabilities. Society evaluates groups through the dual lens of political power and social standing. Schneider and Ingram's social construction framework suggests that individuals with SUD occupy the lowest place such that they are perceived as politically powerless and socially undeserving. They are assigned to the "deviant" category thereby excluding them from most social welfare policies (8).

The classification of SUD as a disability holds the potential to shift this dynamic by moving this population into the "dependent" category. The public attitude that the society bears no obligation towards them could change into one deserving of care and support cultivating greater public empathy. Stigma reduction is, in itself, a central argument for disability classification. Evidence supports that the perception of SUD as a medical illness is associated with reduced stigma and stronger public support for harm reduction and overdose prevention services. Similarly, formal disability classification could expand access to treatment and assistance, thereby lowering barriers to care (8).

Empirical data suggests that individuals with SUD who receive disability benefits are far more likely to access treatment services than those who do not (9). This aligns with broader global data indicating that direct cash transfers significantly lower financial hurdles, thereby improving access to medical and rehabilitative care across diverse disability classifications (10). Broadly, the social security system plays a critical role in fostering economic stability by narrowing the income inequality gap and reducing household financial uncertainty. Conversely, restricting access to disability benefits can induce counterproductive fiscal outcomes. Rescinding disability benefits for people with SUD can lead to an increase in employment rates. However, research suggests that only one-fourths of those employed had income above which individuals could be considered non-disabled. Majority of this population remains economically marginalized with no access to health insurance. Decline in treatment participation and a subsequent increase in acquisitive crime offsets any fiscal benefits of rescinding disability benefits to people with SUDs. Therefore, the designation of SUD as a disability is not merely a semantic shift. It is a structural intervention with the potential to reduce stigma, expand access to care, stabilise households, protect children, and ultimately lower the broader social costs that arise from exclusion and neglect.

Addressing the counterarguments

Individual nations maintain distinct legislative frameworks concerning disability recognition and the allocation of associated welfare benefits. In the United States, the Americans with Disabilities Act (ADA) primarily governs the legal protections and state welfare provided to persons with disabilities. However, following the enactment of the Contract with America

Advancement Act in 1996, individuals diagnosed with drug addiction and alcohol dependence were explicitly rendered ineligible for disability benefits. A comparable legislative approach is evident in the United Kingdom under the Equality Act 2010, which established that substance use disorder does not constitute a qualifying impairment by itself. These legislative amendments were largely catalyzed by political lobbying and underlying concerns among policymakers that financial benefits promote substance use, deter labor participation, and generate significant fiscal costs for the state. Despite these concerns, further literature suggests that such arguments do not have much evidentiary support and were primarily rooted in stigma.

- **The “Check Effect”:** One of the chief concerns raised against the argument of extending disability benefits to people with SUD is the “Check effect”. The assumption that the recipients of cash benefits for disability are more likely to spend the money on continuing substance use which is more rooted in stigma than empirical evidence. Schwartz et al. (2003) in their longitudinal study found no significant increase in opiate use in the initial ten days of the month following receipt of government benefits (11).
- **Employment disincentive:** A further challenge to the disability paradigm arises from the rationale that disability income disincentivizes participation in labour force. One study utilized administrative data to assess the effect of disability benefits on employment following removal of the drug and alcohol addiction as a stand-alone criterion for disability benefits. The study demonstrated that the employment effect was highest for those participants who had received benefits for approximately 2.7 years prior to termination. The study suggested that a period of temporary financial support can serve a dual purpose by supporting individuals in their acute phase of poor health while ultimately facilitating their return to the labour force (12).
- **Fiscal savings or compounding costs?:** The exclusion of people with SUD from the social security benefit system was justified on fiscal grounds. However, the declining participation in treatment programs, loss of medical insurance and rising cost of incarceration undermines this rationale. Evidence suggests that over the following 24 months after discontinuation of disability benefits, there was a substantial increase in the rates of criminal activity among those who no longer qualified for disability benefits (13).

Benefit Models for substance use disorder as disability

Welfare systems treat disability through three broad benefit models namely form (insurance-based versus means-tested assistance), duration (temporary versus permanent), and extent (partial versus full). Social insurance-based programs (such as disability income) provide financial support to individuals with documented history of participation in workforce and can now no longer maintain gainful employment due to their disability. Means-tested

income assistance programs (such as supplemental security income) is a need-based programme that includes health insurance as well as cash benefits to people with disability irrespective of their work history, such as those with visual impairment or aged individuals. Eligibility for disability benefits is based on functional impairment rather than diagnosis alone. Countries have also incorporated treatment resistance or the concept of maximum correction such that disability benefits are contingent on failed treatment attempts. In practice, this means higher assessed impairment yields greater benefits: partial impairments attract proportionally smaller payments or accommodations, while severe, work-precluding impairments justify full, long-term support. Benefits are not necessarily permanent, many jurisdictions offer time-limited or conditional payments based on prognosis, vocational rehabilitation, or demonstrated recovery, with pathways to return to work and to transition off these benefits (14). In addition, certain states mandate treatment participation through existing government treatment programs for receiving disability benefits. Determining which SUD warrant classification as recognised disability is a subject of debate. A number of jurisdictions extend economic and social support benefits to individuals with alcohol and drug dependence. For instance, Australia has established a structured framework to evaluate and grant assistance for SUD while explicitly excluding nicotine dependence (15).

Disability entitlements extend beyond cash and they commonly include legal protections and workplace accommodations. For instance, anti-discrimination and 'duty-to-accommodate up to the point of undue hardship' frameworks are recognised by bodies such as the Ontario Human Rights Commission (16). Finally, policy should also recognise the value of acute-phase, non-monetary supports such as temporary access to free treatment, housing, personal care, and case management as essential complements to income replacement, consistent with public-health indicators promoted by international agencies. Together, these principles frame a rights-based, recovery-oriented, approach that balances support, rehabilitation, and accountability.

The Indian Landscape: Legal interfaces and bridging the gap

India's disability rights framework is well-equipped to include substance use disorders as a recognized disability. The RPWD Act of 2016 was created to follow the social model of disability outlined in the 2007 UNCRPD. However, substance use disorder is noticeably absent from the RPWD Act's list of recognized disabilities (17).

A deeper structural issue is that laws concerning drug use conflict with other legal systems in India such as the Narcotic Drugs and Psychotropic Substances (NDPS) Act (1985) and the Mental Health Care Act (MHCA), 2017. The NDPS Act makes drug possession and use a crime, at the same time offering limited legal protection to those who voluntarily seek treatment. Although the MHCA takes a more progressive, rights-based approach and includes people

with SUD, it has not supplanted the NDPS Act on ground (18). Certain Indian states maintain medical reimbursement policies that cover both outpatient (OPD) and inpatient (IPD) treatment expenses for a designated registry of chronic diseases, typically valid for a duration of three to five years. Although severe mental illnesses are incorporated into this registry, SUDs are categorically excluded from eligibility. Non-representation of SUD treatment in majority of health insurance programs is also a cause of concern. Furthermore, in Indian employment law, issues related to addiction are still widely treated as moral or behavioural failures. They are not managed with the supportive, "accommodation-first" approach that is now standard for other mental health conditions. This contradiction creates a confusing legal status for individuals with SUD.

The RPWD Act can be modified vide an executive order to incorporate SUD. Steps should also be taken to harmonise the various laws pertaining to people with SUD with an emphasis on non-discrimination, pro-treatment and rights-based perspective adopted by the MHCA 2017. Finally, the operationalization of these rights necessitates the formulation of a clear, standardized disability certification pathway for individuals with substance use disorders, strategically modelled upon the successful administrative frameworks implemented under RPWD 2016 for other recognized psychosocial disabilities.

Conclusion: The case for recognition and the way forward

Recognizing substance use disorder as a disability does not diminish personal responsibility; rather, it acknowledges the genuine functional impairments experienced by affected individuals. Notwithstanding their sustained advocacy on the public health dimensions of substance use disorders, UNODC and WHO have yet to articulate a formal position on the classification of SUD as a disability. This omission has drawn concern from within the disability rights community and stalled meaningful progress in its recognition. Effective integration of SUD into the current legal framework is pertinent. Such recognition can improve access to healthcare, rehabilitation, workplace accommodations, social protection, and anti-discrimination measures, ultimately promoting recovery, social inclusion, and equitable participation in society.



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Substance Use Disorders as Disability: Arguments Against Universal Classification

Manmeet Kaur Brar, Asmita Vashisht

Substance Use Disorders (SUD) is a group of chronic relapsing disorder characterised by compulsive drug seeking and use of substances despite negative consequences. The International Classification of Functioning, Disability and Health conceptualises disability as a dynamic interaction between an individual's health condition, impairments in body functions or structures, limitations in activities, restrictions in participation, and the facilitating or disabling effects of environmental factors. The current model tries to move away from the medical model as well as the social model of disability and rather focusses on the biopsychosocial underpinnings of the resulting decreased activity or participation in the functioning of a person (1). At a superficial glance, this model seems to parallel the etiological concepts of the substance use disorder, but a more nuanced exploration shows that bringing SUD under the caveat of disability policy frameworks is not the optimal way of helping people with SUD. The multiple reasons for the same are discussed in this article.

Free Will, Agency, and Autonomy

The proposed classification impinges of the ethical concepts of free will which is the ability to act at one's own discretion, autonomy defined as the inherent right and capacity to make choices that shape one's life, free from external interference, and agency or the ability to act on those choices, set goals, and influence outcomes (2). Such a framing imposes a uniform identity of deviance against a prescribed norm, regardless of whether people who use substances themselves identify as disabled. This neglect of the lived experience of people with SUD has been challenged by user-led organisations. The Australian Injecting and Illicit Drug Users League (AIVL) has argued that many people do not experience their drug use as physically or emotionally problematic, and therefore reject disability or illness labels (3). Eliot Ross Albers, then Executive Director of the International Network of People Who Use Drugs (INPUD), further sharpened this critique by stating that under prohibition, drug users have been understood only as criminals or deviants, and a disability framing does not dismantle this logic, rather it merely relocates this deviance under a medical concept (4).

Understanding addiction as a concept

Classifying SUD as a disability commits to the brain disease model of addiction which frames drug use as compulsive and involuntary, but the model itself has its shortcomings. Literature shows that there are multiple models that conceptualise addiction differently as no model completely describes all facets of addiction. One such model is the choice model which argues that drug use reflects reinforcement dynamics: substances carry higher immediate value than

available alternatives at the moment of choice (5,6). Earlier animal studies showed that rats given unlimited access to cocaine would continue to self-administer until death, a result long taken as proof that drugs override voluntary control. However, Venniro et. al. (2018) challenged this assumption by designing a model that introduced a meaningful alternative to the drug in the form of social interaction. Instead of choosing only between drug intake and abstinence, rats could choose between self-administering methamphetamine or heroin and engaging in social interaction with another rat. The outcome was consistent across sex, drug type, dose, training conditions, and abstinence periods. Rats consistently preferred the social reward over the drug even after dependence was established. When a valued alternative was available, they did not persist in drug use (7). This undermines the idea of drug-induced compulsion and shows that behaviour is sensitive to context.

Support for the alternative choice account also comes from well-established behavioural principles that explain why immediate rewards often dominate decision-making. The matching law shows that behaviour tends to distribute in proportion to the reinforcement available. Therefore, as drugs provide stronger reinforcement than alternatives, their use persists. Melioration captures the tendency to select the option with the highest short-term payoff, even when it undermines longer-term outcomes. Added to this is the principal of hyperbolic discounting which explains steep devaluation of delayed rewards compared to immediate ones which makes drug use especially compelling in the moment (5).

These principles highlight how ordinary choice dynamics can lock behaviour into stable but self-defeating patterns. Crucially, they also show that most choice situations contain more than one optimal choice. A local optimum reflects the best choice in immediate circumstances whereas a global optimum reflects the best choice when wider time horizons and social values are considered such as health, family and long-term consequences. Addiction reflects the dominance of local optima, while recovery reflects the ability to act on global bookkeeping (8,9). Behavioural economics has extended these insights into the idea of reinforcer pathology where the drugs are persistently valued highly and preferred for immediate consumption despite long-term costs. Importantly, this does not mean that voluntary control disappears; rather, it shows how reinforcement dynamics shape choice (8). The contextual choice models summate diverse choice models and emphasise the core principle that the broader context and the relative costs and benefits of drug use shape behaviour in ways that may resemble compulsion but remain fundamentally choice-driven. Many treatment approaches such as contingency management, motivational interviewing, and harm reduction are designed to shift reinforcement patterns and broaden the frame of reference and work by engaging choice rather than bypassing it (8). Instead of assuming compulsion, they create environments where non-drug alternatives become more valuable, immediate rewards are balanced against longer-term goals, and agency is actively supported (6). Even though disability benefits aim to optimise the environmental factors to decrease the functional impairment, the contexts in case

of addiction are broad and diverse, and a singular policy benefit are less likely to optimally benefit all people with SUD.

Stigma, Prejudice and Discrimination in addiction and the legal aspects

Stigma occurs when a person is tagged to an undesirable stereotype, causing others to see them not as a whole, normal individual but as someone “tainted”. Researchers hoped that explaining substance use in biological terms, i.e. as a brain disease rather than a moral failing, would reduce this stigma. The evidence on this is, however, mixed. For people with SUDs, being told that their condition is “biogenetic” can reduce their sense of control over recovery and increase feelings of hopelessness. It does not protect them from feeling ashamed or internalizing stigma (10). Meta-analytic evidence also confirms that biogenetic explanations do make people with SUD less likely to blame self, but they simultaneously make the public see the person as more dangerous and less likely to recover. They also do not reduce the public’s desire to keep their distance from the individual (11). This is emphasised in the Mixed Blessings Model which states that the framing addiction as biological or as a disability removes blame, but it also triggers “psychological essentialism”, which increases pessimism, fear, and the desire to stay away from people with SUDs (12). Population-level data also reinforce this point: how much the public accepts the “brain disease model” of addiction doesn’t reliably predict how much stigma they hold. Stigma is shaped more by demographic factors such as age, sex, education and familiarity with addiction (13). Therefore, simply relabelling addiction as a medical condition or disability does not, by itself, reduce discrimination.

Real-World Examples: When “Disability” status backfires

Looking at how different countries have treated SUD as a disability shows why labelling alone is not only not enough but can even cause harm.

- **Canada (Insite, Vancouver):** Insite project is a supervised injection site located in Vancouver’s Downtown Eastside. It has successfully reduced overdose deaths and connected people to health services. It operates under a legal exemption from the Controlled Drugs and Substances Act (2003), which a court granted based on the constitutional Right to Life, Liberty, and Security of the person. Despite these benefits, the site still faces heavy stigma and discrimination from the general public.
- **Australia (the Wayne Marsden case):** Mr. Marsden was on methadone maintenance treatment for opioid dependence. When a bar refused to serve him alcohol, he sued for disability discrimination and won. But the judgement attracted immediate public backlash. This led to legislative reform in the form of the Anti-Discrimination Amendment (Drug Addiction) Act 2002 (NSW), and the Disability Discrimination Amendment Bill of 2003, both of which specifically excluded addiction to illicit drugs from disability protection. This case reveals a legal paradox: the law protects people from discrimination based on

disability, yet simultaneously criminalises the substances tied to that very disability. Simply placing substance use under a “disability” framework triggered public backlash, and ultimately led to narrower legal protections, not broader ones (14).

- **United States (1997 Supplemental Security Income (SSI) policy change):** For years, drug addiction and alcoholism qualified as disabilities under SSI. But public and political stigma persisted, and in 1997, these conditions were removed as qualifying impairments. The results were mixed: people’s substance use severity (measured by the Addiction Severity Index) improved, but many also became more dependent on other forms of public assistance, since they struggled to find employment and support themselves without SSI (15).

Indian scenario and practical constraints

In India, disability benefits are provided for twenty-one disorders including four mental health conditions. The commonality in these is the fixed prognosis and the impact on functioning of the affected individual which is assessed using Indian Disability Evaluation and Assessment Scale (IDEAS) consisting of four domains namely self-care, interpersonal activities, communications and understanding, and work. For SUD, there is no clear instrument to measure the impact on functioning over time as the illness has a chronic and relapsing course determined by various personal and environmental contexts. The period of re-evaluation and the apprehension of spending the disability pension on substance itself further offsets the objective of such a classification. The illegality of substances and the differential impact of each substance on the functioning of the individual also makes this assessing the impairment difficult. In low resource settings, it may potentially lead to higher costs and limited or no benefits to the affected population.

Conclusions

Substance use disorder is a complex challenge. However, placing it under the disability umbrella is not the optimal strategy to help people affected by it. It strips people with SUD of agency and autonomy, reinforces stigma rather than dismantling it, and burdens an already underfunded and underutilised disability system. International experiences show that such classification often provokes backlash and narrows protections. In India, the reality of stagnant pensions and unspent budgets makes the system ill-equipped to absorb SUD. A better approach would be a parallel targeted, rights-based policies, vocational opportunities, and harm-reduction strategies that respect their dignity and address their unique realities.



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Substance Use Disorders and Disability: Global Approaches and Implications for India

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Substance use disorders (SUD) are important contributors to years lived with disability (YLDs) and disability-adjusted life years (DALYs) (1). YLDs and DALYs quantify population health loss associated with morbidity, premature mortality, and disability; the use of “disability” in these measures does not itself confer legal disability status. According to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (2). This article examines how SUD-related impairment is treated in disability frameworks internationally and considers a function-based, context-sensitive approach for India.

Medical Diagnosis and Legal Recognition of Disability

A medical diagnosis does not automatically confer legal recognition of disability. Legal recognition depends on statutes, assessment tools, institutional practices, and prevailing social values. UNCRPD uses a broad concept of disability and does not function as a diagnostic catalogue. It does not specifically name SUD, leaving countries to decide whether and under what circumstances it should be brought within a disability framework. SUD have been described as “contested” or “second-class” disability as they are medically recognised, socially disabling, and yet strongly moralised (3).

Legal Position in India

The Rights of Persons with Disabilities (RPwD) Act, 2016, and the Mental Healthcare Act, 2017, use closely related definitions of mental illness (4,5). The MHCA definition expressly includes ‘mental conditions associated with the abuse of alcohol and drugs’. The RPwD Act does not reproduce that additional phrase in its definition of mental illness. The implications of this textual difference for the disability certification of primary SUD are unclear; nevertheless, it creates uncertainty for assessment, certification, rehabilitation, and access to disability-related rights and entitlements.

The Indian Disability Evaluation and Assessment Scale (IDEAS) is the prescribed assessment instrument used for evaluating disability due to mental illness under the applicable disability-certification framework (6). A person certified as having benchmark disability ($\geq 40\%$ disability) may be eligible for specified rights and entitlements under the RPwD Act and other schemes, subject to the relevant eligibility criteria.

A distinction should be made between uncomplicated intoxication, withdrawal, episodic harmful use, or recently diagnosed SUD, on the one hand, and severe, persistent, or recurrent SUD associated with substantial and enduring impairment, on the other. Such impairment may involve cognition, self-care, occupational functioning, interpersonal relationships, decision-making, or community participation.

International approach from high-income countries

Across high-income countries, the legal recognition of SUDs as a ‘disability’ varies widely. Most systems now distinguish between civil-rights protection, disability certification, and eligibility for income support (7).

The Americans with Disabilities Act (ADA) protects persons with SUDs who are engaged in treatment or supervised rehabilitation. Current illegal drug use is generally excluded from protection. ADA status does not determine eligibility for Social Security disability benefits. For Social Security disability benefits, the relevant agency applies a separate “materiality” standard. If the person does not remain disabled after stopping substance use, benefits are denied. (8,9)

Australia uses a functional, impairment-based model. For ‘Disability Support Pension’, a person with alcohol, drug, or other substance use disorder must have a diagnosed condition that is reasonably treated and stabilised, produce at least 20 impairment points, be likely to persist for more than two years, and satisfy the applicable work-capacity requirements; rehabilitation or Program of Support requirements may also apply. The emphasis is on enduring functional limitations in areas such as self-management, social functioning, cognition, behavioural regulation, and work-related functioning, not on substance use alone (10).

The United Kingdom similarly relies on function rather than diagnosis. For ‘Personal Independence Payment’, claimants must show long-term difficulty with daily living or mobility tasks such as preparing food, managing treatment, communicating, budgeting, or planning journeys (11).

Assessment considers whether activities can be performed safely, repeatedly, to an acceptable standard, and within a reasonable time.

High-income countries differ in how they translate SUD-related impairment into rights and benefits, but the common trend is away from diagnosis alone and toward functional limitation and rehabilitation-oriented assessment.

Why should India adapt rather than transplant?

Some high-income countries provide more developed combinations of income support, treatment continuity, housing assistance, and psychosocial services than are commonly available in India. However, coverage, eligibility, and continuity vary considerably within and between countries. Disability-related pension support in India is often limited in amount and

varies across states.

Families seeking treatment at government-run tertiary-care facilities may incur substantial out-of-pocket costs, including treatment-related expenses, transport costs, lost productivity, and debts associated with substance use. Besides, the onus of ensuring continuity of SUD treatment and of providing housing, food, and clothing may also fall substantially on the family.

India should understand the historical context of substance use, existing social welfare systems, the evolution of thought processes, and the budgetary allocations of high-income countries. In India, disability inclusion depends on affordability, accessibility, local delivery systems, and social context. While India can aspire to global standards in the long run, we should be guided by local realities and resource constraints in the short run.

Fragmentation across Ministries and Systems

Legal substances (alcohol and tobacco) are regulated by the state and generate substantial revenue. Illegal substances are governed by the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 (12). SUD can be viewed through a 'public health' or 'law-and-order' lens, depending on the legal status of the substance used. India's response to SUD is distributed across multiple ministries, departments, and levels of government. Depending on the substance involved and the circumstances, a person with SUD may be encountered within different policy frameworks: criminal law enforcement, health care treatment, and social rehabilitation. This fragmentation can affect access to treatment, social support, legal protection, housing, employment, and long-term recovery.

A function-based approach to SUD and disability

The legal status of primary SUD as a disability requires clarification because the RPwD Act does not reproduce the MHCA's express reference to mental conditions associated with alcohol and drug abuse. In this context, the pragmatic approach would be to influence public opinion for a nuanced recognition of SUD as a disability.

SUD should not be automatically included nor categorically excluded as a disability. There should be a substantial and enduring functional limitation. Uncomplicated intoxication, withdrawal, episodic use, or a recently diagnosed SUD should not, by themselves, ordinarily justify disability certification. Policymakers should adopt the position that disability assessment is warranted only for severe, persistent, or recurrent SUD associated with substantial and enduring impairment in cognition, self-care, occupational functioning, interpersonal relationships, decision-making, or community participation.

Implications for clinical training and rehabilitation

The expansion of DM Addiction Psychiatry seats and addiction treatment services offers an opportunity to incorporate a rehabilitation approach that goes beyond diagnosis, pharmacological management, and relapse prevention. A skilled professional combines evidence-based interventions with supervised clinical experience and an understanding of how treatment and rehabilitation can be adapted to the person's family, community, and socioeconomic context. Pharmacological and other clinical interventions are often supported by formal evidence and delivered through structured services. Rehabilitation interventions also require an evidence-informed approach, but they must be adapted to the person's family, community, work opportunities, resources, and changing functional needs. Professionals who build trust with stakeholders-including people with SUD, families, employers, community organisations- are better positioned to select pragmatic interventions, review their effects, and modify the intervention over time.

Policy priorities

1. **Influence public conversation on SUDs:** If SUDs are viewed mainly as a moral failure, any attempt to discuss treatment, rehabilitation, disability, or insurance parity will be misunderstood as excuse-making. A more mature discourse would acknowledge personal agency and accountability, while also recognising that severe and chronic SUDs can become a source of long-term impairment that requires structured support if meaningful participation is to be restored.
2. **Harmonise legislation:** The legal relationship between the NDPS Act, the RPwD Act, and the MHCA needs closer harmonisation. Clinicians, legislators, and rehabilitation professionals should work toward a framework that distinguishes trafficking from criminal conduct to chronic disorder, to help protect persons with SUDs who need help without diluting the legal response to illicit supply.
3. **Advocate for a function-based legal and administrative framework:** Policymakers should clarify the operational definition of mental illness in the RPwD Act 2016, avoid both automatic inclusion and categorical exclusion of SUDs and should clarify how persistence, remission, comorbidity, relapse, treatment response, and functional impairment should be assessed.

Conclusions

Reframing SUD as a potential source of legally recognised disability is not a matter of semantics. It has consequences for how clinicians think, how families cope, how legal systems classify impairment, and how social and financial support is organised.

International experience suggests that SUD should not be treated either as an automatically disabling diagnosis or as a condition categorically excluded from disability frameworks due to

its persistence, treatment response, and functional consequences. For India, this would require harmonisation between the NDPS Act, the RPwD Act, and the MHCA, together with operational guidance on remission, relapse, comorbidity, reassessment, and work-related functioning.

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SECTION UPDATES

Opioid use disorders contribute to about 70% morbidity and mortality attributable to drug use disorders across the globe (1). However, several aspects of the neurobiological basis of opioid-related reward remain to be discovered. Research has highlighted the key roles played by dopamine and dopamine transporter (DAT) in the neurobiological effects of opioids. DAT, a Na⁺/Cl⁻ dependent membrane transporter located on dopaminergic nerve terminals, regulates dopamine reuptake and neurotransmission and plays an important role in reward-related processes. Opioid exposure also increases DAT expression within the mesolimbic reward pathway, including the ventral tegmental area (VTA), nucleus accumbens (NAc), and hippocampus, thereby influencing dopamine signalling and reinforcing drug-related behaviours (2).

A recent study published in *Translational Psychiatry* explored the putative role of microRNAs in modulating the rewarding effect of opioids through DAT (3). MicroRNAs are small non-coding RNAs, usually 19 – 25 nucleotides long, which regulate gene expression through post-transcriptional modifications by binding to the target mRNA transcripts. Two such microRNAs, miR-132 and miR-212, which arise from a shared non-coding transcript, have been found to have links with various psychiatric disorders, including addictive disorders such as cocaine use disorder (4,5).

In this study, the authors found that the miR-132/212 modulates morphine-induced reward by fine tuning dopamine transporter (DAT) expression at the post-transcriptional level. The researchers used rat models of morphine conditioned place preference (CPP), a technique for studying the rewarding properties of psychoactive substances and discovered that chronic morphine exposure significantly reduced miR-132 and miR-212 expression in the ventral tegmental area (VTA), while increasing DAT mRNA and protein expression. Repeated morphine administration independent of CPP conditioning also yielded similar results, which suggested that morphine itself alters miR-132/212 and DAT signaling.

The researchers further tried to find the binding site of miR-132/212 and discovered a binding site for miR-132/212 on the 3' untranslated region (UTR) of the SLC6A3 gene which encodes DAT, and with the help of luciferase assays confirmed that miR132/212 directly bind this site and suppress DAT expression. When this binding region was mutated, this regulatory effect was abolished, and this established DAT as a direct target of miR-132/212.

Through functional studies, they observed that miR-132/212 was inversely related to dopamine uptake. The modulating effect of miR-132/212 on dopamine uptake through DAT was observed through the finding that when DAT was overexpressed, dopamine uptake rose markedly, but

miR-132/212 reduced this effect. Conversely, DAT knockdown abolished the ability of miR-132/212 to regulate dopamine uptake. They also demonstrated that miR-132 overexpression in the VTA increased the levels of extracellular dopamine in both the VTA and nucleus accumbens (NAc), further confirming that the mechanism of miR-132/212 regulation of dopamine transmission occurs via DAT modulation.

Through behavioural experiments, they examined how these molecular changes influenced morphine reward through the use of viral sponges to inhibit miR-132 or miR-212 specifically in the VTA. While knockdown of either miRNA led to an increase in DAT expression and enhanced morphine CPP which was indicative of stronger morphine reward, overexpression of miR-132 in the VTA was associated with a diminished DAT expression and lowered morphine CPP. The researchers noted that this effect occurred across male, female, and adolescent rats, which suggested broad generalizability. Importantly, miR-132 overexpression did not impair locomotor activity or natural reward responses like sucrose preference which suggest specificity for opioid reward pathway rather than a generalised behavioural suppression. To confirm the role of DAT in the pathway mediating opioid reward, selective DAT inhibitor GBR 12909 was infused into the VTA during conditioned place preference conditioning. DAT inhibition was found to reduce morphine preference significantly, further supporting the inference that DAT activity contributes to opioid reward.

Previously studies have shown that miR-132/212 regulate cocaine reward and synaptic plasticity through CREB, BDNF and MeCP2 signalling pathways (4,5). The current study identifies DAT as a direct target of miR-132/212 and proposes that reduced miR-132/212 signalling contributes to morphine reward by enhancing DAT-mediated dopamine regulation. Overexpression of miR-132/212 reduces DAT expression and weakens morphine reward, which suggests that miRNA based interventions targeting this pathway could be a novel therapeutic strategy.



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The prevalence of Alcohol Use Disorder (AUD) in India is close to 5% with treatment gap of nearly 85% (1). AUD has high relapse rate which reflects not only on high treatment gap but also intricate pathology involving neural networks. Hence from the perspective of dual process model of addiction, AUD reflect dysfunction across large scale brain networks, particularly an imbalance between the top-down Fronto-parietal network (FPN), which governs cognitive control and bottom-up systems related to stimulus salience and reward processing, including ventral attention network (VAN) & the subcortical network (SUB). Further studies have also reflected that AUD has impaired prefrontal cortical function, with the right dorsolateral prefrontal cortex (rDLPFC) playing a central role in craving, attentional bias, alcohol-cue processing, and relapse vulnerability. Structural and functional imaging studies have demonstrated widespread network abnormalities in AUD, largely driven by white matter microstructural damage, suggesting that relapse arises from disturbances in large-scale brain networks rather than isolated regional dysfunction.

Neuromodulation has emerged as promising tool for AUD (2). Most interventions have used conventional repetitive transcranial magnetic stimulation (rTMS) which has shown promising results. However conventional rTMS requires daily sessions over several weeks, whereas continuous theta burst stimulation (cTBS) delivers an effective protocol in approximately 40 seconds, making it more suitable for accelerated clinical applications. Beyond its efficiency, cTBS induces sustained neuroplastic changes, enabling modulation of dysfunctional cortical circuits implicated in addictive behaviours. Wu ZK et al. (2026) employed inhibitory cTBS targeting the rDLPFC, with the aim of reducing maladaptive craving-related network activity and restoring frontoparietal network (FPN) function (3).

To comprehensively characterize relapse mechanisms, this study adopted a multiscale framework integrating functional neuroimaging, network control theory, molecular architecture, and cross-species circuit mapping. Amplitude of low-frequency fluctuations (ALFF), combined with non-negative matrix factorization (NMF) and TabPFN-based machine learning, is used to identify data-driven neural oscillatory patterns associated with relapse risk. While ALFF quantifies spontaneous neural activity, network control theory evaluates the energetic cost of transitions between brain states, with higher control energy reflecting less efficient and more pathological network dynamics.

The authors hypothesised that Inhibitory cTBS targeting the rDLPFC modulates neural oscillatory patterns would be associated with relapse risk in AUD, reduce the control energy required by the frontoparietal network, thereby improving global network efficiency, and that changes in network control dynamics would be associated with improvements in clinical

severity and prospective relapse outcomes. Finally, they also hypothesised that the effects of cTBS are influenced by regional gene expression patterns, and the identified human network-control targets correspond to homologous rodent circuits involved in top-down executive control.

The study was a single-centre, randomized, double-blind, sham-controlled clinical trial conducted at the First Special Hospital of Harbin in China. Participants aged 18–60 years who met DSM-5 criteria for Alcohol Use Disorder (AUD) were recruited. 50 participants were recruited among which 29 participants were recruited in the active intervention group and 21 participants in the sham group. The intervention was administered over 10 days, with two cTBS sessions per day, spaced 6 hours apart. Randomization was computer-generated with appropriate allocation concealment, and both participants and investigators were blinded to treatment allocation. Continuous theta burst stimulation (cTBS) was delivered using a figure-of-eight coil connected to a CCY-I stimulator. The right dorsolateral prefrontal cortex (rDLPFC) was targeted at the F4 location using the Yiruide TMS positioning cap. Each session consisted of 50 Hz triplets repeated at 5 Hz, delivered at 100% of the resting motor threshold (RMT). Clinical assessments included the Alcohol Use Disorders Identification Test (AUDIT) and a Visual Analogue Scale (VAS) for craving, administered at baseline and immediately after the intervention. Participants were subsequently followed up by telephone for one year at predefined intervals to assess relapse outcomes.

To identify neural oscillatory patterns predictive of relapse, the study developed a TabPFN-based classification model. Spatial component matrices derived from non-negative matrix factorization (NMF) of neuroimaging data were used as input features, while relapse status at follow-up served as the classification outcome. Following the identification of global functional brain changes, Network Control Theory (NCT) was applied to quantify the theoretical control energy required for transitions between brain states. To ensure comparability across participants, brain states were defined using the standardized group-level spatial patterns (H matrix) derived from the non-negative matrix factorization (NMF) component of interest. The frontoparietal network (FPN) was identified as the principal network associated with the right dorsolateral prefrontal cortex (rDLPFC) stimulation target, enabling the assessment of network-level effects centered on this FPN-dominant region. To further elucidate the molecular basis of these network alterations, spatial associations between the neuroimaging findings and brain-wide gene expression profiles from the AHBA were examined. To investigate further evolutionary conservation of these network-control targets, cross species phenotype mapping using TransBrain framework were performed.

The results showed that repeated-measures ANOVA demonstrated a significant time $\times$ group interaction for the Perceived Stress Scale (PSS-10), indicating a greater reduction in perceived stress following active cTBS. Participants receiving active cTBS also exhibited a significantly

lower risk of relapse than those in the sham group, a finding that was consistent with cross-sectional analyses showing reduced relapse rates. However, no significant between-group differences were observed in AUDIT scores or craving ratings.

The study also showed that non-negative matrix factorization (NMF) of ALFF data identified five distinct brain network components (C1–C5), each demonstrating bilateral symmetry and spatial heterogeneity. Among these, Component 1 (C1), predominantly involving the subcortical (SUB) and ventral attention network (VAN), emerged as the strongest predictor of relapse, with higher C1 expression associated with a lower relapse risk. Active cTBS produced a significant time $\times$ group interaction for C1 expression, with increased C1 activity observed only in the active treatment group. These findings suggest that cTBS selectively modulates neural oscillatory patterns linked to sustained abstinence. Network Control Theory analysis demonstrated that cTBS selectively altered control energy for transitions from the frontoparietal network (FPN) to the ventral attention network (VAN) and from the FPN to the subcortical network (SUB). Significant time $\times$ group interactions were observed for both transition pathways, whereas no comparable changes occurred in the sham group.

This study provides preliminary evidence that inhibitory cTBS targeting the right dorsolateral prefrontal cortex (rDLPFC) may reduce long-term relapse risk and perceived stress (PSS-10) in individuals with AUD. However, active cTBS did not produce clinically meaningful improvements in alcohol use severity or craving. The study also demonstrated that cTBS modulated an abstinence-associated neural oscillatory pattern identified through non-negative matrix factorization. The findings also suggest that cTBS may promote adaptive functional changes within brain networks implicated in addiction. These findings are consistent with the dual-process model of addiction and indicate that cTBS may improve the efficiency of brain network dynamics involved in cognitive control and relapse prevention.

However, the results should be interpreted with caution. The study was limited by a moderate sample size, which may restrict the generalizability of the findings. In addition, the Network Control Theory framework employed a linear model of brain dynamics, which may not fully capture the complex non-linear nature of neural state transitions. Furthermore, the molecular analyses were based on baseline spatial gene expression data from healthy donors in the Allen Human Brain Atlas (AHBA) and therefore may not accurately reflect disease-specific or dynamic transcriptional changes associated with AUD.

Overall, while these findings provide promising mechanistic evidence supporting the use of cTBS in AUD, larger, multicentre studies with longer follow-up and more comprehensive neurobiological assessments are needed to confirm whether rDLPFC-targeted cTBS can meaningfully reduce relapse risk and improve long-term clinical outcomes.



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The global population of incarcerated women and girls is rapidly increasing. Despite this trend, research on the physical and mental healthcare needs of incarcerated women remains significantly underrepresented in published literature. The health challenges faced by incarcerated women are distinct from those of the general female population or even incarcerated men. Incarcerated women often have extensive histories of trauma and abuse, higher prevalence of mental and physical health conditions, substance use, and worse health outcomes, including elevated post-release mortality rates. Furthermore, they encounter unique social and structural barriers to care such as family responsibilities, limited economic resources, and pervasive stigma, unlike incarcerated men. The overall well-being and health of incarcerated women rarely receive the spotlight, and mental health, particularly substance use disorder (SUD), in this population has been studied even less. Across most correctional systems worldwide, provisions for the treatment and rehabilitation of both SUD and Mental Illness (MI) are severely lacking, particularly for women. This deficiency is compounded by a scarcity of good-quality research and established guidelines. In some instances, this lack of evidence has even been used to justify the neglect of tailored mental health and addiction treatment services for incarcerated women. To further understand the complexities of SUD and reincarceration among women, we examine three research papers that shed light on various aspects of this critical issue.

Association between severe mental illness, substance use disorder, and the risk of reoffending in women prisoners

In a retrospective cohort study, Svendsen et al. (2025) investigated the risk of reoffending among 4,573 women released from Norwegian prisons between 2011 and 2019. They followed the women participants for two years after their release, with additional focus on coexisting severe mental illness (SMI) and substance use disorders (SUD). This study was part of a larger national cohort named the Norwegian Prison Release Study (nPRIS). Despite having relatively small prison populations, Scandinavian countries report increasing prevalence of psychiatric disorders among incarcerated women.

The cohort was categorised into four groups based on ICD-10 codes: SUD-SMI (SUD and severe mental illness), SMI (severe mental illness only), SUD-OMI (SUD and other mental illness), and POLY-SUD (multiple SUDs). These groups were compared to a reference population with no such disorders. The researchers used logistic regression to estimate the risk of violent (VR), drug-related (DR), or other reoffending (ORE), adjusting for various socioeconomic and clinical risk factors.

The findings indicate that the SUD-SMI, SUD-OMI, or POLY-SUD groups were at a significantly greater risk of violent and drug-related reoffending compared to the reference. Specifically, SUD-SMI had an adjusted odds ratio (OR) of 2.27 (95% CI 1.37–3.76) for violent and 2.10 (95% CI 1.49–2.95) for drug-related reoffending. POLY-SUD was associated with an OR of 1.87 (95% CI 1.04–3.31) for violent and 2.51 (95% CI 1.80–3.49) for drug-related reoffending. Only SMI showed a significantly higher risk (OR 2.64, 95% CI 1.21–5.30) of other reoffending (ORE). Notably, though the SUD-SMI and POLY-SUD groups constituted a minority (25%) of the population, they accounted for nearly half of the violent and drug-related reoffences. SMI was primarily associated with non-violent and non-drug-related reoffences, suggesting different risk profiles. This emphasises the importance of addressing mental health needs, including SUD treatment, among incarcerated women.

While this study attempted to quantify the risk of reoffending post-release associated with SMI and SUD, the trajectories of psychiatric symptoms, suicidality, and SUD following release from prison warrant further longitudinal investigation.

Longitudinal trajectory after release from prison

Bórquez et al. (2025) studied the longitudinal trajectories of psychiatric symptoms, suicidality, and SUD, alongside service utilisation, in a prospective cohort of 200 women released from prison in Santiago, Chile, over 12 months. This study acknowledges the high prevalence of mental disorders and SUDs in this population, particularly among women with histories of trauma and neglect.

They assessed psychiatric symptoms using the Symptom Checklist 90-Revised (SCL-90-R), self-reported suicide attempts, and SUD using the Mini Neuropsychiatric Interview (MINI). Latent class growth analysis identified three trajectory groups for mental health symptom severity. The majority (85.8%) showed 'low' mental health symptom severity over the 12 months. However, a significant minority reported 'increasing' (6.8%) or consistently 'high' (7.4%) symptom severity. A staggering 19.3% reported attempting suicide during follow-up, and 18.9% met criteria for persistent SUD. Women in the 'Increasing' and 'High severity' groups, those who attempted suicide, and those with persistent SUD had more previous sentences, higher rates of recidivism, and greater experiences of victimisation (both pre-incarceration and post-release). However, only 10% or less received mental health services at any time point, and continuity of care was scarce for all three groups.

While the association between untreated SUD, SMI, and reoffending in incarcerated women have recently gained attention, effective post-release community management protocols are grossly lacking. Some recent evidence is worth noting in this regard.

Role of extensive community engagement in reducing reincarceration

Mejia et al. (2024) report findings from the Female Offender Re-Entry Movement (FOR-Me) programme, a transitional community treatment designed to provide specialised SUD and trauma treatment, recovery, and re-entry services to 113 released female offenders in Houston, USA. Re-entry refers to the process by which individuals released from prison transition back into society, involving preparation before release and support afterwards to reduce recidivism and promote successful reintegration. The FOR-Me programme utilised a client-centred approach, including pretreatment interventions such as pre-screening, motivational interviewing, and support-building, delivered by trained professionals. Thereafter, participants were linked to community SUD treatment and recovery services upon release, where evidence-based practices such as the Seeking Safety model for trauma and addiction were initiated. The programme provided services at various stages, beginning in the jail and courtroom and extending through halfway homes into the community. Weekly psychotherapy sessions and individual/group recovery support were also provided.

A significant 44.5% reduction in self-reported psychiatric symptoms (anxiety and depression) and significant improvements in trauma-related symptoms were observed at the six-month follow-up. Abstinence rates reached 93.8%, and the proportion of participants with substance-related consequences decreased by 73%. Furthermore, marked improvements in functioning, including increased employment (from 2% to 38%) and housing stability (from 0% to 68%) were reported. Reincarceration was significantly reduced from 96.5% at intake to 3.7% at follow-up. This emphasises the effectiveness of gender-responsive, client-centred approaches and continued care in the community for improving outcomes and reducing recidivism.

Implication for India

The situation in India is even worse. Government data on mental health in prisons is scarce. The India Justice Report 2025 highlights a critical shortage of mental health professionals (MHPs) in Indian prisons, with only 25 MHPs serving 1,330 prisons nationwide. This translates to one professional for every 22,929 inmates, a stark contrast to the Model Prison Manual 2016 recommendation of one MHP per 500 inmates. This severe understaffing underscores a profound systemic failure to address the mental health and SUD needs of incarcerated individuals, especially women, in India.

Conclusions

Incarcerated women often have coexisting SUD and SMI, associated with systemic stigma, exclusion, and high risk of post-release suicide and reoffending. Hence, comprehensive assessment and management of comorbid SMI and SUD in incarcerated women, both during imprisonment and after release, is the need of the hour in most countries of the world, including India.



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CREATIVE SECTION



DRUGGED ME said, "I was high, seeing the world with dilated pupils blurred; nothing was clear. Clenching my teeth. Sweating with perspiration. With a weird smile. Like no one was seeing me. The cunning, baffling, and powerful DOC (Drug of Choice) ruled my life. It was trying to pull me towards it and making me fall in the life I had constructed all the clean years and reach my rock bottom. I was hopeless. I thought my life was no more without drugs. Luckily, I was God-chosen, got into rehabilitation, and got introduced to NA.

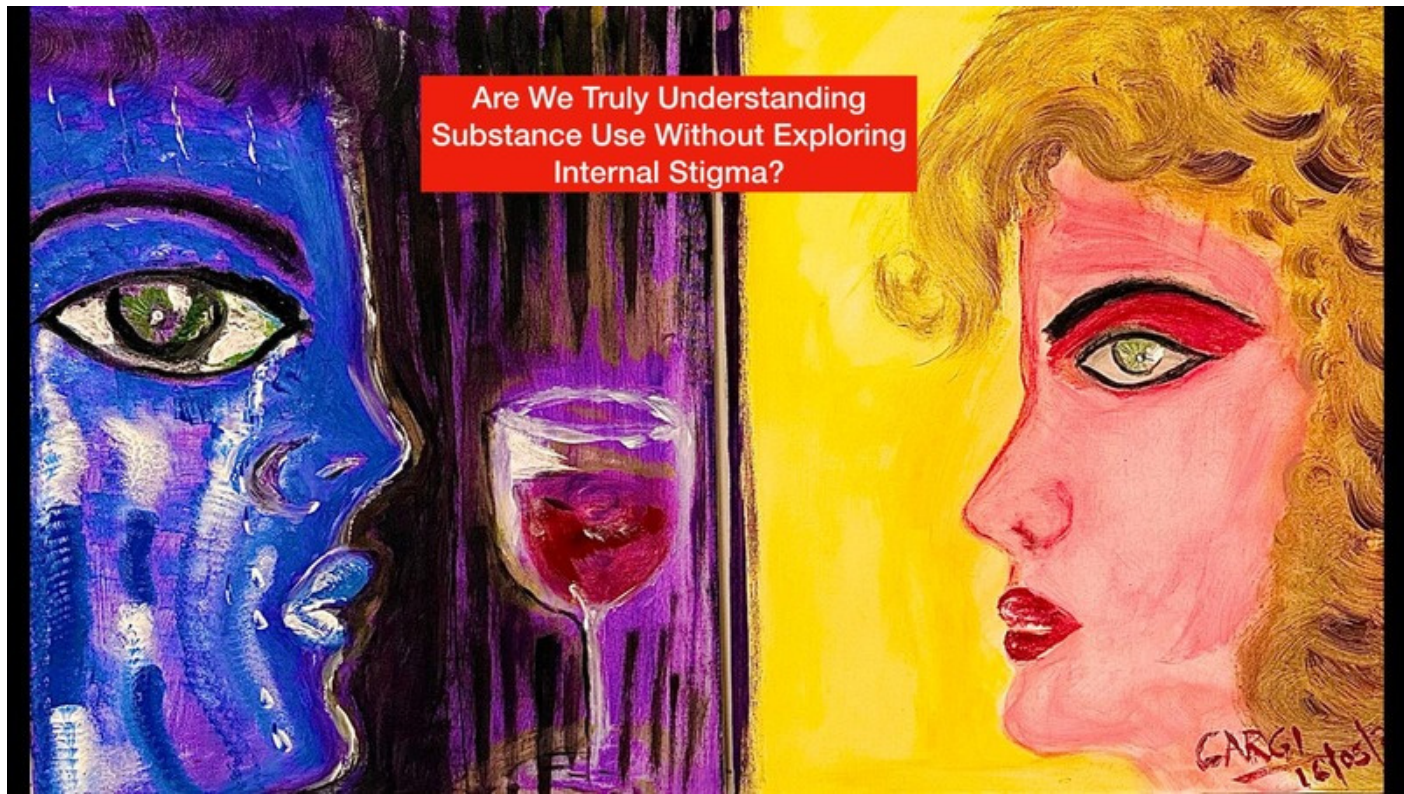
SOBER ME said, "I am clean, seeing the world with normal pupils, making it clearer. I got a smile, living a happy life with my family. Through NA, I got my new peer group where I shared my thoughts. Got solution to a lot of problems in life which lead to addiction. It gave me a better perspective on life and helped me find a new way of life. 'Sharing is caring' turned out to be true in my case. They pulled me back from falling into the trap the DRUG entangled me in. It made me stand straight and proud. It made me understand I have a disease called addiction. It convinced me that VERBAL THERAPY is the last resort to get out of addiction. It made me rise and build a life, getting back all the happiness I lost".

" I WAS JUST A MIRACLE "

Art Work

Are We Truly Understanding Substance Use Without Exploring Internal Stigma?

Gargi Sinha

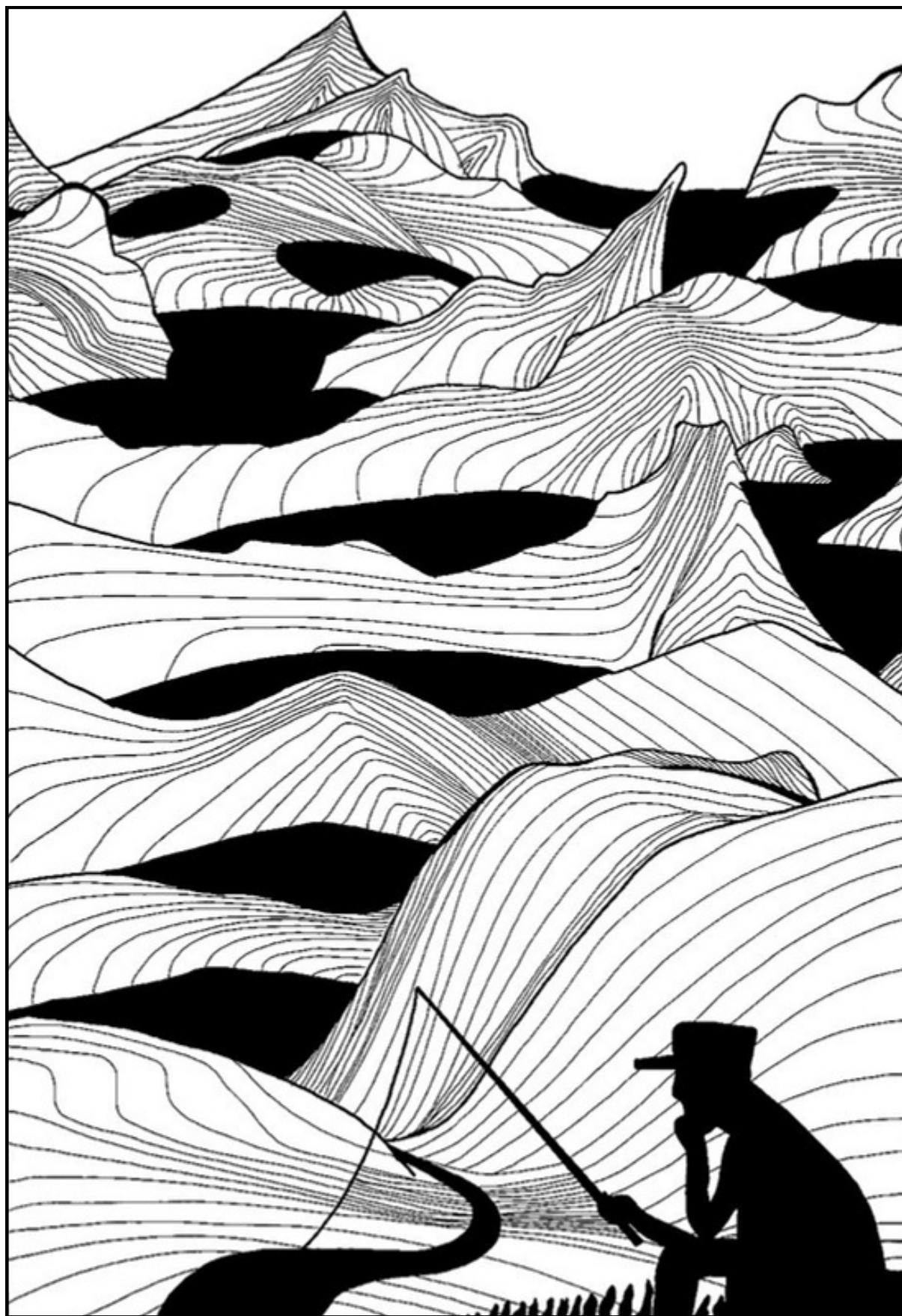


This portrait examines the role of internal stigma in shaping addictive behaviour. Although stigma may broadly be understood as public, structural, or internal, its most profound impact is often experienced within the individual. A person may appear entirely normal externally, while internally struggling with shame, hopelessness, low self-worth, and emotional isolation.

The darker colour tones symbolise the feeling of being trapped within an emotional cage and the silent suffering concealed beneath a brighter, socially acceptable exterior. This fragmented sense of self can contribute to maladaptive coping strategies, including continued substance use, further reinforcing the cycle of addiction. The portrait also reflects a biopsychosocial understanding of addiction, illustrating how internal psychological distress and the social experience of stigma can influence behaviour and treatment seeking.

Art Work Hooked

P. Anuprabha



This monochromatic art piece portrays a vast landscape of mountains, valleys, and a dark winding river, with a lone fisherman seated quietly at its edge. The flowing lines of the mountains create a sense of constant movement, yet the scene itself feels still, empty, and lifeless. The fisherman sits with his head resting on his palm, holding onto his fishing rod as he waits beside the dark river. The black and white palette strips the world of its warmth, reflecting the dark, all-consuming nature of addiction and substance use, where life slowly loses its colour.

The mountains rise and collapse into one another, their crests and valleys mirroring the long, winding, and unpredictable journey of addiction. At the center of *Hooked* sits the lone fisherman, a metaphor for the addicted mind. His fishing line disappears into the black river, symbolizing emptiness, hopelessness, and the lifeless pull of addiction. Though no fish ever arrives, he cannot bring himself to leave. Each time he tries to walk away, the slightest ripple in the water draws him back, convincing him to wait just a little longer. Days and nights pass, yet his pursuit continues relentlessly. Catching the fish has become both the bane of his existence and the object of all his desire.

This cycle of craving, disappointment, return, and obsession reflects the psychological reality of addiction. Over time, substance use begins to preoccupy every aspect of a person's life, leading to emotional, cognitive, behavioural, and social impairment. The individual slowly becomes consumed by the procurement and use of the desired substance and the constant chase for the next high. Like the fisherman in *Hooked*, the addicted individual remains trapped in a cycle of longing and suffering that feels impossible to leave behind.

Euphoria: An Introduction to the Series

Euphoria is an American coming-of-age teen drama series created by Sam Levinson. It follows a group of teenagers as they navigate adolescence, exploring themes of love, friendship, identity, addiction, and the challenges of growing up (1).

The series centres primarily on Rue Bennett, while also exploring the interconnected lives and relationships of the other teenagers around her. The story begins with Rue returning home from rehabilitation and meeting Jules Vaughn, whose presence becomes an important part of her journey (1). Through its characters, Euphoria examines vulnerability, relationships, substance use, identity, and the difficulties young people may face while trying to understand themselves and their place in the world.

Rue Bennett

Rue Bennett, portrayed by Zendaya, is the protagonist and narrator of Euphoria. She is a teenager struggling with drug addiction and sobriety, and her substance use significantly affects her relationships and everyday life (1).

Rue's journey involves a recurring conflict between her desire to remain sober and her tendency to return to substance use. Her intense relationship with Jules Vaughn becomes particularly significant, with Rue at times becoming emotionally dependent on Jules while attempting to maintain her sobriety (2).

Rather than being portrayed as simply "good" or "bad," Rue is presented as a complex and flawed character whose experiences reflect the struggles associated with addiction, relationships, emotional vulnerability, and recovery. Her journey forms much of the emotional core of Euphoria (1).

Introduction to the Write-Up

This letter is a message to Rue Bennett, whose character in HBO's Euphoria was led to drug use as a result of her loneliness and longing for her deceased parent. I want to elaborate on the film's representation of the issue concerning drug use, especially in the context of addiction treatment. People start using drugs not just to experience pleasure; however, doctors accept the hard truth that knowing the reasons behind addiction does not lessen the damage it causes. A goal of this letter is to demonstrate the complexity of drug addiction and show that it can be addressed better with love and sympathy.

Dear Rue,

I often remember the time your mother saw the bathroom door locked. She did not get angry or scream. She just remained there waiting. It seemed as if, in some way, she already knew what she would discover. It was her few seconds' delay that allowed her to collect her thoughts. This silence seemed to tell me a lot about addiction. I have seen addiction at its quiet times, when a person is still on the verge of deciding whether to continue the cycle of pretending or not.

At the beginning, I really thought that you were seeking pleasure and trying to get high. You were using drugs, and I couldn't understand why. It was sad to see what drugs were doing to you and the fact that you did not want to stop. You seemed to be unable to stop using drugs. I was wondering why you were doing this since you were losing your friends and relatives.

Then I understood that I was asking myself the wrong question.

It could be that you were not looking for a good feeling. Probably, you wanted to stop feeling bad. But although both things might seem the same from the outside, they do not actually mean the same thing. You lived with your father's death as if something was constantly happening to you. It stopped being just a memory and became a burden, a space that never got closed. Drugs appeared to be a key to dealing with your thoughts. For some time, you were not supposed to feel anything, and that was what frightened me the most, Rue. At some point, the drugs started to look not like a poison but rather a friend that made you feel better long before destroying you.

You did not seem to be someone who wanted to stop. That was one of the things that troubled me. Wanting to stop and being able to do so are two different things, and you were crossing a line that was not real in the same way. Most films do not understand the concept correctly.

They show the situation when a person relapses and think of it as a moral weakness. A fault in a person's character. However, your work with your story did not depict such things at all. Instead, it simply illustrated a human body performing its functions, faster than anyone can think of any arguments against that.

At times I found myself upset with you. I observed your mother struggling to keep things in check, your sister being put under pressure that no little girl should experience, and people around you being hurt and getting drained and mad at the same time. Your suffering was yours, but it did not remain only yours. It also affected everyone close to you. A reason behind your actions does not mean it is justified. Perhaps that is the message that the series was trying to deliver all the time: one can be in pain but still hurt someone else. One can be empathetic and angry with one person, and the same person, and both feelings can co-exist.

Write-Up

Not Euphoria, But Escape: A Letter to Rue Bennett

Lakshita Verma

I also think about Jules. Not because she could have moved heaven and earth to save you, but due to the fact that she couldn't, and the series made it possible without making it more difficult for both of you.

There were instances when you were fully aware of the effects of drugs. You were well aware of who cared for you and whom you were harming. Even though you were cognizant of the fact, you still turned towards the drugs. This was the moment I realized that addiction is not about seeking pleasure in consuming drugs. Addiction is simply escaping pain. This realization brings us down because we are forced to understand that the item we resort to in our troubled times can bring more trouble too.

For this reason, I do not like the title of Euphoria. The word 'euphoria' suggests joy and happiness, which contradicts your story. You are not moving toward something uplifting. You are escaping from something unbearable. The question that stays with me is this one: once you get trapped by your drugs, what happens next?

It might be the reason why it's so tough to get better. It's not really about not using drugs. It is more about being able to face what you were trying to escape from. Sadness, fear, loneliness, and life itself do not go away. Getting better is simply a matter of learning to live with these feelings.

I see your personality in other people: the charm, the intimacy of the night, and the sincerity that separates by morning. So, I can say that fiction just gave it a name. I do not write this just because I know what to say. I write it because I see a person, not drugs anymore. I do not want to excuse anything; I just want to understand.

So, Rue, it is not about making you feel good. It's about making you feel bad. You were seeking some peace of mind, and I will say that the process begins when you can find peace without running away from your reality.

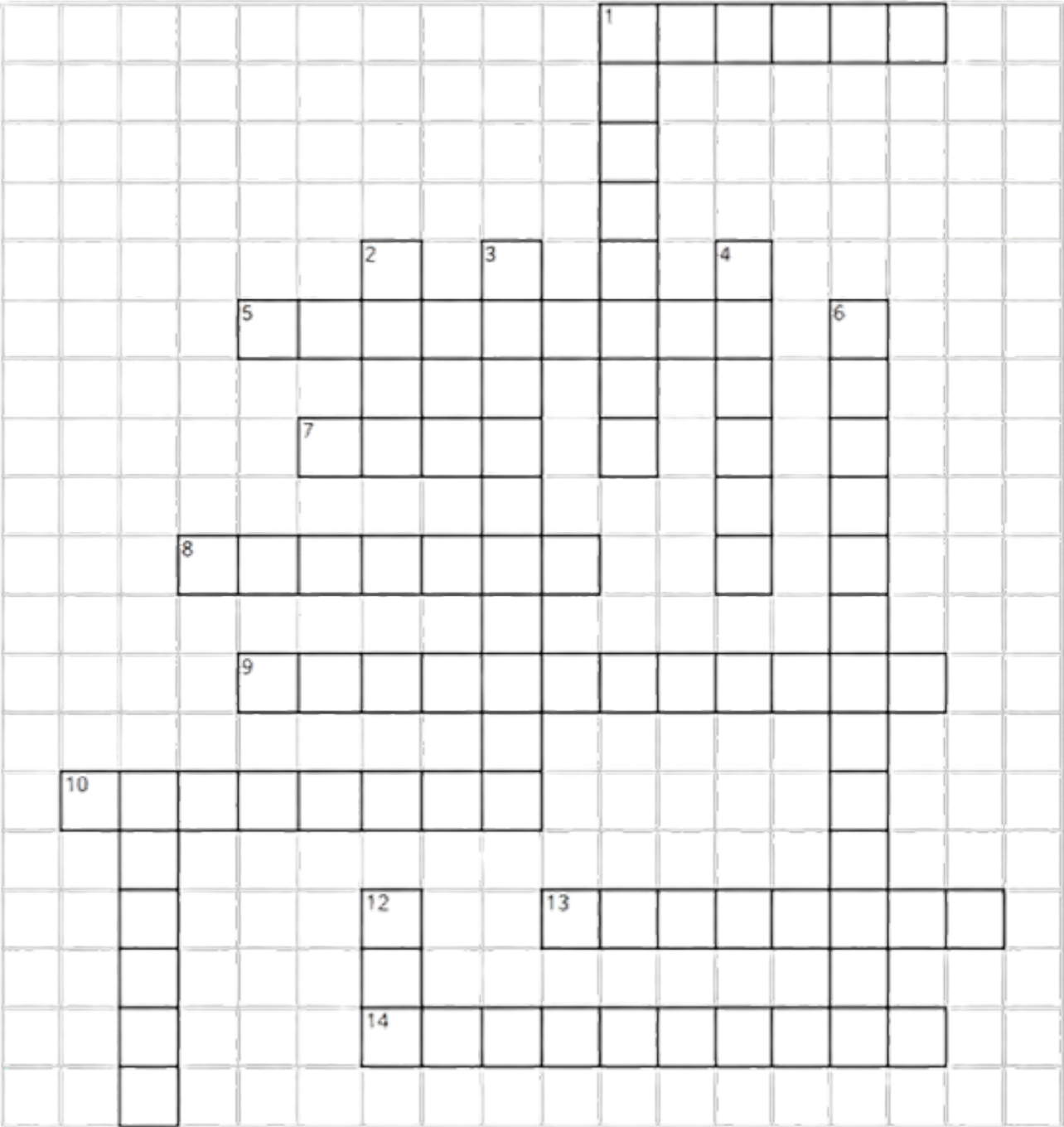
I hoped for you the whole way through, better with your mother, your sister, Jules, and yourself. Wherever the story leaves you, I hope it's closer to a morning than a relapse. Not fixed. Just breathing. One day, not the last one.

Yours,
Someone who finally stopped asking why you wouldn't just stop.



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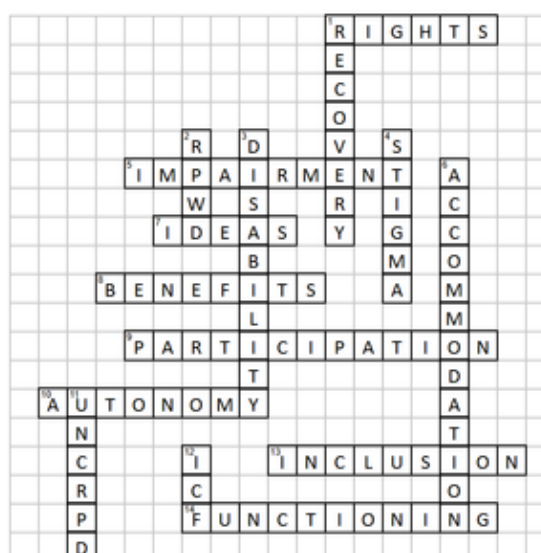
Down

1. The process of regaining health, functioning and participation following substance use disorder
2. Abbreviation of the Indian legislation providing the legal framework for the rights of persons with disabilities
3. A condition that limits a person's ability to carry out certain daily tasks or interact with the world around
4. Negative stereotyping and social devaluation associated with illnesses such as SUD
6. Modification of work conditions to support a person with disability
11. Abbreviation of the UN convention establishing a rights-based framework for persons with disabilities
12. Abbreviation of the WHO framework that conceptualizes disability through functioning, activity and participation

Across

1. Principles emphasizing dignity, equality and protection from discrimination
5. Abnormality or loss of a body function or structure in the ICF framework
7. Abbreviation of the Indian scale used to assess disability across self-care, interpersonal activities, communication/understanding and work
8. Financial support that can improve treatment access and economic stability
9. Involvement of an individual in a life situation
10. The capacity and right to make one's own choices
13. The process of enabling people with disabilities to participate fully in society
14. Overall ability of an individual to perform tasks and participate in life

Solutions Mindbender



Upcoming Events

ADDICON, 2026



Organised by: All India Institute of Medical Sciences

When: December 4-6, 2026

Where: AIIMS Nagpur

Link: <https://addictionpsychiatry.in/>

Annual Global ISAM Congress, 2026

Organised by: International Society of Addiction Medicine (ISAM)

When: October 1-3, 2026

Where: Rotterdam, the Netherlands

Link: <https://congresscare.eventsair.com/isam-2026-rotterdam/attendee-registration-2/Site/Register>



AddictionZ Conference, 2027



Organised by: Sofitel Brisbane Central

When: May 10 and 11, 2027

Where: Sofitel Brisbane Central, Brisbane, Australia

Link: <https://www.addz.au/event/2027/home>



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