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Original Article

Substance Use and Addiction in Kashmir Division: A Review of Prevalence, Determinants, Health Consequences and Community-Based Intervention Strategies

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ABSTRACT: *Substance use and addiction have emerged as important public health and social concerns in Kashmir Division, requiring an integrated response involving healthcare institutions, educational organisations, families, communities and government agencies. The problem extends beyond the consumption of illicit drugs to include alcohol, cannabis, opioids, pharmaceutical preparations and other psychoactive substances. Substance use disorders can affect physical health, psychological well-being, family relationships, educational attainment, employment and social participation. However, the extent and distribution of substance use cannot be understood through treatment-centre statistics alone, because individuals who do not seek formal assistance may remain unrepresented in institutional records. This review examines the available literature on substance use in Kashmir, with particular attention to prevalence estimates, patterns of consumption, psychosocial determinants, mental health associations, treatment accessibility and prevention strategies. It draws on published studies concerning Kashmir, the national survey on substance use in India, World Health Organization guidance and the accompanying policy proposal on addiction prevention and service delivery. The review identifies important concerns relating to underreporting, limited community-level evidence, the integration of mental health services into primary healthcare, the accessibility of treatment and the need for sustained prevention programmes. It proposes a coordinated framework involving early identification, school- and college-based prevention, community outreach, family counselling, evidence-based treatment, rehabilitation and systematic monitoring. The review concludes that substance use in Kashmir Division should be addressed as a multidimensional public health issue rather than exclusively through punitive or awareness-based approaches. Further population-based and longitudinal research is necessary to establish reliable prevalence estimates, identify changing patterns and evaluate the effectiveness of interventions.*

KEYWORDS: *Substance Use, Addiction, Kashmir Division, Opioid Dependence, Mental Health, Public Health, Prevention, Rehabilitation.*

1. INTRODUCTION

Substance use and addiction represent complex public health challenges with consequences extending across individual, familial and community life. Although the consumption of psychoactive substances may begin in different social circumstances, problematic use can progressively affect physical health, psychological functioning, educational participation, employment and interpersonal relationships. Substance use disorders therefore require an approach that combines prevention, clinical assessment, treatment, rehabilitation and social reintegration.

In Kashmir Division, substance use has received increasing attention from researchers, healthcare professionals, families and public institutions. Published research has particularly highlighted concerns regarding opioid use, including heroin consumption and injection-related practices. A study conducted in two districts of Kashmir examined substance dependence through respondent-driven sampling, demonstrating the value of specialised recruitment methods for studying populations that are difficult to reach through conventional household surveys (Rather et al., 2021). A separate review of published research also identified substance use as an important health concern in the Kashmir Valley (Yaqoob & Ashraf, 2022).

Nevertheless, the available evidence must be interpreted carefully. The number of individuals attending a de-addiction centre, the number of reported cases, the estimated number of substance users and the prevalence of clinically significant substance use disorders are different measures. These indicators cannot be treated as interchangeable. Treatment-centre records, for example, describe people who have reached a particular service, whereas population-based surveys are designed to estimate patterns within a defined population.

The national survey conducted by the National Drug Dependence Treatment Centre at the All India Institute of Medical Sciences, commissioned by the Ministry of Social Justice and Empowerment, established a national evidence base for understanding the magnitude and pattern of substance use in India (Ambekar et al., 2019). However, national estimates cannot

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automatically be interpreted as estimates for Kashmir Division. Local geographical, socioeconomic, cultural and service-delivery conditions require examination through appropriately designed regional studies.

The present review consequently adopts a general population perspective. It considers substance use among adolescents, young adults, working-age individuals, women and other population groups without restricting the analysis to any particular community. Its central argument is that effective responses require better regional evidence, accessible treatment, integrated mental healthcare, non-stigmatising community participation and sustained interdepartmental coordination.

2. OBJECTIVES OF THE REVIEW

The review has the following objectives:

- To examine the available literature on the prevalence and patterns of substance use in Kashmir Division.
- To identify the individual, psychological, familial and socioeconomic factors associated with problematic substance use.
- To review the physical, psychological and social consequences of substance use and addiction.
- To examine challenges associated with identification, treatment accessibility, rehabilitation and social reintegration.
- To assess the relevance of community-based prevention, educational interventions and family support.
- To propose an integrated framework for prevention, treatment, rehabilitation and monitoring in Kashmir Division.
- To identify research gaps and recommend priorities for future investigation.

3. REVIEW METHODOLOGY

This paper adopts a narrative review approach. It draws upon peer-reviewed publications concerning substance use in Kashmir, the national survey on substance use in India, relevant World Health Organization guidance and the supplied policy proposal addressing addiction prevention and service-delivery mechanisms.

The literature was considered thematically, with attention to regional patterns of substance use, mental health, social determinants, treatment access, prevention and institutional responses. Particular emphasis was placed on studies that provided information directly relevant to Kashmir rather than assuming that findings from other regions were equally applicable.

The review is not presented as a systematic review or meta-analysis. It does not claim to have conducted an exhaustive database search, a formal study-selection process or a quantitative assessment of publication bias. The findings are therefore a critical synthesis of selected available evidence and policy-relevant material. Conclusions concerning the effectiveness of specific interventions should be understood in light of the evidence limitations discussed in the paper.

4. PREVALENCE AND PATTERNS OF SUBSTANCE USE

4.1. NATIONAL EVIDENCE AND ITS REGIONAL RELEVANCE

Ambekar et al. (2019) documented substantial use of alcohol, cannabis, opioids and other psychoactive substances across India. The national survey estimated that approximately 16 crore people consumed alcohol, 3.1 crore used cannabis products and 2.26 crore used opioids. These estimates illustrate the scale and diversity of substance use in the country, but they should not be presented as figures for Kashmir Division.

The national survey also identified considerable variation between substances and population groups. This finding is important because substance-use prevention cannot rely on a single intervention designed around one substance or one demographic category. Alcohol-related harm, opioid dependence, cannabis use and the non-medical consumption of pharmaceutical preparations may involve different patterns of risk and different treatment requirements.

For Kashmir Division, the available regional evidence supports closer examination of opioid use, particularly heroin and injection-related consumption. However, the precise current prevalence of different substances across the entire division remains difficult to establish from a small number of district-level studies or clinical records.

4.2. EVIDENCE FROM KASHMIR

Rather et al. (2021) investigated substance dependence in two districts of Kashmir using respondent-driven sampling and benchmark-multiplier estimation. The study estimated the prevalence of dependence on any substance at 1.95%, dependence on opioids at 1.80% and current injection drug use at 0.95% within its study framework. Among the recruited respondents, heroin was the most commonly reported opioid.

These findings provide valuable regional evidence, but their interpretation requires methodological caution. The estimates were derived from a specific study covering two districts, rather than a contemporary representative survey of the entire Kashmir Division. They should therefore not be extrapolated uncritically to all districts, age groups or population categories.

Yaqoob and Ashraf (2022) similarly reviewed the literature on substance use in the Kashmiri population and highlighted concerns about opioid consumption and injection-related drug use. Together, these publications establish the relevance of regional research while also demonstrating the need for broader geographical coverage and repeated assessments.

4.3. LIMITATIONS OF EXISTING PREVALENCE ESTIMATES

The available evidence presents several limitations. First, studies conducted among people already experiencing substance-related problems may not represent the wider population. Second, stigma and fear of social consequences can discourage disclosure. Third, institutional records are influenced by the geographical distribution, affordability and availability of treatment services. Fourth, differences in definitions and research methods make comparisons between studies difficult.

A further distinction is necessary between substance use, harmful use and dependence. Any consumption does not automatically indicate a substance use disorder. Clinical assessment must consider the pattern of use, loss of control, impairment, associated harm and other diagnostic criteria.

Consequently, a reliable understanding of substance use in Kashmir Division requires representative population surveys, complementary qualitative research, confidential reporting mechanisms and carefully interpreted service-utilisation data.

5. DETERMINANTS OF SUBSTANCE USE AND ADDICTION

Substance use rarely develops from a single cause. Its emergence and persistence may reflect interactions among individual experiences, psychological distress, family relationships, social environments, substance availability and wider socioeconomic conditions.

5.1. PSYCHOLOGICAL DISTRESS AND EMOTIONAL DIFFICULTIES

Mental health is an important dimension of substance-use research. Some individuals may use substances in an attempt to manage anxiety, depressive symptoms, traumatic experiences, sleep difficulties or persistent emotional distress. Such use may provide temporary subjective relief while creating additional health and psychological problems over time.

However, the relationship is not necessarily unidirectional. Psychological difficulties may precede substance use, emerge as a consequence of prolonged consumption or interact with an existing substance use disorder. Co-occurring conditions therefore require comprehensive assessment rather than assumptions that one problem necessarily causes the other.

In Kashmir, regional studies have examined substance use alongside wider concerns about psychological distress and the social environment. Nevertheless, the contribution of specific psychological factors to initiation, progression and relapse must be established through appropriately designed local research rather than inferred solely from the regional context.

5.2. FAMILY ENVIRONMENT AND SOCIAL SUPPORT

Family relationships can influence prevention, treatment-seeking and recovery. Supportive communication, early recognition of behavioural changes and assistance with accessing professional care may facilitate recovery. Conversely, persistent conflict, neglect, social isolation or the normalisation of harmful substance use may complicate prevention and rehabilitation.

Family involvement should nevertheless remain supportive rather than coercive. Excessive blame, humiliation, threats and the public disclosure of an individual's condition may discourage treatment-seeking. Family counselling should therefore promote informed support, appropriate boundaries, recognition of warning signs and constructive participation in recovery.

5.3. EDUCATION, EMPLOYMENT AND SOCIAL PARTICIPATION

Educational disengagement, unemployment, financial insecurity and limited opportunities for constructive recreation are frequently discussed as possible correlates of substance use. These conditions should not be interpreted as direct or inevitable causes of addiction. Most individuals facing socioeconomic hardship do not necessarily develop a substance use disorder, and people from economically secure backgrounds may also experience addiction.

Their relevance lies in the way social circumstances may interact with distress, peer networks, substance availability and access to support. Research in Kashmir should investigate these relationships empirically and distinguish risk factors from assumptions based on age, occupation or economic status.

5.4. PEER INFLUENCE AND THE SOCIAL ENVIRONMENT

Peer networks can influence attitudes towards substance use, perceptions of risk and decisions to seek assistance. Adolescents and young adults may encounter social pressure, curiosity or misinformation about psychoactive substances. Prevention initiatives should address these influences without portraying young people as inherently vulnerable or treating all peer relationships as harmful.

Peer education, mentoring, supervised recreation and youth participation in prevention activities may create opportunities for informed discussion. Such programs are more likely to be meaningful when they provide accurate information, encourage help-seeking and avoid moral condemnation.

5.5. AVAILABILITY AND PATTERNS OF CONSUMPTION

The availability of substances, including illicit drugs and pharmaceutical products used outside appropriate medical supervision, is relevant to prevention and public health. The supplied proposal identifies concerns regarding opioids, tramadol and codeine-containing preparations. These concerns warrant local verification through clinical data, pharmaceutical monitoring and lawfully obtained information from relevant authorities.

The extent to which availability, prescribing practices, informal supply networks and other market conditions contribute to substance use in different districts of Kashmir remains an empirical question. Effective policy should combine appropriate enforcement with treatment access, public education and measures to reduce harmful consumption.

6. HEALTH AND SOCIAL CONSEQUENCES

6.1. PHYSICAL HEALTH

Substance-related harm varies according to the substance consumed, the frequency and duration of use, the route of administration, individual health conditions and the presence of other risk factors. Opioid-related problems may include dependence, overdose and other serious complications. Injection drug use can additionally increase the risk of blood-borne infections when equipment is shared, or unsafe practices occur.

Other substances may contribute to cardiovascular, respiratory, neurological, hepatic or gastrointestinal complications. Pharmaceutical preparations can also produce serious adverse effects when used improperly or in unsafe combinations. These consequences support the need for comprehensive health assessment, early intervention and appropriate referral rather than relying exclusively on visible behavioural signs or police records.

6.2. MENTAL HEALTH AND PSYCHOLOGICAL WELL-BEING

Substance use disorders may coexist with depression, anxiety, trauma-related symptoms and other mental health conditions. They can also affect concentration, motivation, sleep, emotional regulation and interpersonal functioning. These effects may interfere with educational participation, occupational performance and relationships.

The relationship between substance use and mental health requires integrated care. The World Health Organization's Mental Health Gap Action Programme provides evidence-based guidance for the assessment and management of mental, neurological and substance-use conditions by trained professionals in non-specialist healthcare settings (World Health Organization [WHO], 2023).

6.3. FAMILY AND COMMUNITY CONSEQUENCES

Problematic substance use may place financial and emotional pressure on families, disrupt caregiving responsibilities and contribute to conflict or social withdrawal. Families may also experience uncertainty regarding treatment options, relapse and long-term recovery. At the community level, stigma can intensify these difficulties by discouraging disclosure and reducing willingness to seek professional assistance. Treating addiction exclusively as a moral failure may obscure its clinical dimensions and undermine opportunities for early intervention.

A public health approach should recognise individual responsibility while acknowledging the importance of evidence-based treatment, family support and social reintegration.

6.4. EDUCATION AND EMPLOYMENT

Substance-related difficulties may affect attendance, concentration, academic performance, workplace safety and employment continuity. These consequences can, in turn, contribute to financial strain and social isolation.

Educational institutions and employers can support prevention by providing accurate information, confidential referral pathways and appropriate assistance. Responses should be proportionate to the circumstances and should avoid automatic exclusion where supportive intervention and safe participation are possible.

7. TREATMENT ACCESSIBILITY AND SERVICE-DELIVERY CHALLENGES

7.1. GEOGRAPHIC AND INSTITUTIONAL ACCESSIBILITY

The supplied proposal identifies distance, transport difficulties, limited awareness and the concentration of specialised services in urban locations as possible barriers to treatment. These are relevant service-planning concerns, but their distribution and magnitude across Kashmir Division require verification through district-level facility mapping and patient-experience research.

Accessibility includes more than physical distance. It also involves affordability, appointment availability, confidentiality, the perceived quality of services, the availability of trained professionals and the ability to obtain follow-up care. A person may be geographically close to a healthcare facility yet remain unable or unwilling to seek treatment because of stigma, cost, family pressure or concerns about confidentiality.

7.2. INTEGRATION WITH PRIMARY HEALTHCARE

Primary healthcare can contribute to early identification, basic assessment, counselling, treatment where appropriately supported and referral to specialist services. Integration is particularly important for individuals who do not initially approach a dedicated de-addiction facility.

The WHO mhGAP guidelines support the development of appropriate assessment and management capacity among trained non-specialist health workers, subject to the availability of suitable supervision, referral systems and clinical resources (WHO, 2023). For Kashmir Division, this approach could be adapted through selected primary health centres, community health facilities and district hospitals. Implementation would require trained staff, clear referral protocols, clinical supervision, confidentiality safeguards and reliable access to specialist support.

7.3. CONTINUITY OF TREATMENT AND REHABILITATION

Recovery is not necessarily a single event completed after detoxification or a short period of treatment. Some individuals require continuing clinical management, psychosocial support, relapse-prevention planning and assistance with returning to education, work or family responsibilities. A comprehensive service pathway should connect initial identification with assessment, evidence-based treatment, follow-up, rehabilitation and social reintegration. The intensity and duration of support should be determined by clinical need rather than a uniform timetable.

Rehabilitation should also address practical barriers, including disrupted education, employment difficulties, family conflict and limited social support. Without such continuity, individuals may face difficulties maintaining recovery even after initially engaging with services.

8. PREVENTION AND INTERVENTION STRATEGIES FOR KASHMIR DIVISION

8.1. COMMUNITY-BASED AWARENESS AND EARLY IDENTIFICATION

Community awareness should communicate accurate information about the risks of substance use, warning signs, available treatment and routes to professional assistance. Activities can be organised through primary healthcare facilities, local community organisations, village-level institutions and other established public platforms.

Communication should be culturally appropriate, available in locally understood languages and designed for different age groups. The objective should be to encourage early help-seeking rather than to identify, shame or publicly label individuals. Awareness campaigns should be evaluated through measurable outcomes, including changes in knowledge, knowledge of referral pathways, willingness to seek assistance and participation in appropriate services.

8.2. SCHOOL- AND COLLEGE-BASED PREVENTION

Educational institutions provide opportunities to address misinformation before harmful patterns become established. Programmes may include age-appropriate educational sessions, peer-led discussions under professional supervision, counselling access and referral arrangements for students requiring assistance.

Prevention should not be reduced to frightening messages or unsupported claims about particular substances. Students need reliable information, opportunities to discuss peer pressure, practical refusal and help-seeking skills, and assurance that seeking assistance will not automatically lead to humiliation or exclusion. Teachers should not be expected to diagnose substance use disorders. Their role should focus on education, supportive engagement and referral to qualified professionals when concerns arise.

8.3. YOUTH ENGAGEMENT AND CONSTRUCTIVE ACTIVITIES

Sports, recreation, volunteering, cultural activities and skill-development programmes can create opportunities for social participation and positive peer relationships. Such activities may complement prevention efforts by strengthening engagement and providing constructive alternatives for leisure.

However, participation in sports or recreation should not be presented as a proven stand-alone treatment for addiction. These programmes should form part of a broader approach that includes clinical assessment, psychological support and access to treatment when required.

8.4. FAMILY COUNSELLING AND SUPPORT

Family-based interventions may assist relatives in understanding substance use disorders, communicating more effectively and supporting treatment adherence. Counselling can also help families recognise the limits of their role and respond appropriately to relapse or crisis situations.

Services should protect the confidentiality and autonomy of the person receiving treatment while involving family members when clinically appropriate and consistent with the individual's consent and applicable requirements.

8.5. MOBILE OUTREACH AND COMMUNITY-LINKED SERVICES

Where geographic distance or mobility limits access to care, outreach services may help connect underserved populations with screening, counselling, health education and referral. Mobile medical teams, scheduled community clinics and coordinated follow-up may be considered according to local needs and available resources.

Such services should be linked to established health facilities rather than functioning as isolated awareness activities. Screening must be followed by appropriate assessment and access to treatment; otherwise, identifying potential problems may not translate into meaningful health benefits.

8.6. DIGITAL COMMUNICATION AND TELE-SUPPORT

Digital communication may extend the reach of health information through verified public messages, educational videos, appointment information and confidential guidance on accessing services. Telephone-based support and teleconsultation may also be useful where suitable infrastructure and trained professionals are available.

Digital interventions should complement, not replace, in-person clinical care. Privacy, informed consent, secure handling of personal information and reliable referral arrangements are essential, particularly when communicating with adolescents and people experiencing significant psychological distress.

8.7. EVIDENCE-BASED CLINICAL TREATMENT

Individuals experiencing substance use disorders should receive assessment and treatment appropriate to the substance involved, the severity of the condition, physical health, psychological needs and personal circumstances. Treatment may involve medically supervised withdrawal management, psychological interventions, medicines where clinically indicated and continuing rehabilitation.

The availability of particular treatment options should be verified at the district level. Clinical decisions must be made by qualified healthcare professionals, and abrupt discontinuation of substances associated with medically significant withdrawal should not be encouraged without appropriate assessment.

8.8. REDUCING STIGMA AND STRENGTHENING SOCIAL REINTEGRATION

Anti-stigma initiatives should emphasise that substance use disorders are health conditions that can require professional treatment and sustained support. Public communication should avoid dehumanising labels and distinguish between a person's health condition and their wider identity.

Confidentiality, respectful treatment and opportunities to resume education, employment and family responsibilities are important components of reintegration. Public institutions should seek to ensure that people who request help can access appropriate services without unnecessary exposure or discrimination.

9. INSTITUTIONAL COORDINATION AND MONITORING

An effective regional response requires coordination between healthcare services, educational institutions, social welfare agencies, district administrations, youth organisations and civil society. The precise responsibilities of participating departments should be established through formal administrative arrangements.

The Health Department could lead the clinical and public health response, including assessment, treatment, referral and health surveillance. Education authorities could coordinate prevention activities in schools and colleges. District administrations could support interdepartmental planning, while social welfare agencies and community organisations could facilitate rehabilitation and social support within their respective mandates.

A proposed monitoring framework should include the following components:

TABLE 1 Key Monitoring Indicators for Mental Health Services and Programme Evaluation

Monitoring Area	Suggested Indicators
Prevention	Number of prevention sessions, participation and changes in knowledge
Early identification	Number of people assessed and appropriately referred

Treatment access	Waiting times, service availability and treatment uptake
Continuity of care	Follow-up attendance and continuity of treatment
Rehabilitation	Participation in psychosocial support, education and employment programmes
Equity of access	Differences in service utilisation by district, age and gender
Data quality	Completeness, consistency and confidentiality of records

These indicators are proposed for future implementation and are not findings from an existing evaluation. Baseline measurements, operational definitions, data-protection procedures and reporting responsibilities would need to be established before the framework is used to assess performance.

District-level reviews could identify gaps in service coverage, while periodic regional assessments could examine broader patterns and outcomes. Monitoring should prioritise service improvement and public health learning rather than relying solely on the number of arrests, reported cases or awareness events.

10. MAJOR RESEARCH GAPS

The literature reviewed in this paper indicates several priorities for future research. First, representative prevalence data are required. Existing district-level and treatment-based evidence cannot provide a complete contemporary estimate for the entire Kashmir Division. Larger studies using appropriate sampling methods are necessary to estimate the distribution of different substances and levels of associated harm.

Second, longitudinal research is needed. Repeated observations of individuals and communities could help clarify patterns of initiation, progression, treatment engagement, relapse and recovery. Cross-sectional findings alone cannot establish the sequence of these processes.

Third, research should examine gender-related differences. The experiences of women and men may differ in disclosure, stigma, treatment access and social consequences. Studies should examine these differences without assuming that one group's experiences can be inferred from the other.

Fourth, adolescents and young adults require careful investigation. Research should examine the role of educational experiences, peer networks, psychological well-being, family support and employment expectations. Appropriate ethical protections are necessary when conducting research involving minors.

Fifth, the relationship between mental health and substance use needs further regional examination. Studies should assess co-occurring conditions using appropriate clinical or validated research measures and distinguish association from causation.

Sixth, treatment accessibility requires systematic evaluation. Facility mapping, patient interviews and district-level service audits could identify geographical, financial, institutional and social barriers.

Seventh, intervention effectiveness should be evaluated. Community awareness, peer education, family counselling, outreach services and digital communication should be assessed against defined outcomes rather than assumed to be effective because activities have been conducted.

Finally, future studies should establish common definitions, transparent reporting standards and mechanisms for protecting confidentiality. Better coordination between research institutions and health authorities could improve the quality and comparability of regional evidence.

11. DISCUSSION

The available evidence suggests that substance use in Kashmir Division warrants a coordinated public health response, particularly in view of regional research identifying opioid dependence and injection-related drug use as significant concerns. However, the evidence does not justify treating all districts, age groups or population categories as having identical patterns of risk.

An important implication is the need to move beyond a narrow distinction between prevention and treatment. Awareness activities may improve knowledge, but knowledge alone does not guarantee behavioural change or recovery. Individuals may understand the risks associated with substance use while continuing to experience dependence, psychological distress, social pressure or barriers to professional assistance.

Similarly, expanding treatment capacity without improving early identification, continuity of care and rehabilitation may leave important needs unmet. The response should therefore connect public education with confidential assessment, clinically appropriate treatment, family support and opportunities for social reintegration.

The integration of mental health and substance-use services is another important consideration. WHO guidance supports strengthening appropriate care within non-specialist settings, provided that staff receive suitable training and can access supervision and referral pathways. For Kashmir Division, a locally adapted model could improve the connection between community-level identification and specialist services.

The regional evidence also highlights the importance of research design. Findings from selected districts, clinical populations or recruited groups should be interpreted within their methodological limits. Policymaking based on unqualified extrapolation may misrepresent the scale or distribution of the problem. Regular, representative and ethically conducted research is consequently essential for setting priorities and evaluating progress.

A sustainable response should combine clinical services with public health prevention and social support. This does not mean replacing law enforcement where it is legally necessary; rather, it means ensuring that enforcement is complemented by treatment, prevention and protection of public health. The overall objective should be to reduce substance-related harm, improve access to care and strengthen the capacity of individuals, families and institutions to support recovery.

12. POLICY RECOMMENDATIONS

Based on the literature and the identified evidence gaps, the following recommendations are proposed for consideration by relevant authorities in Kashmir Division:

- Develop a regional evidence base: Conduct periodic population-based surveys and establish standardised, confidential mechanisms for collecting and analysing substance-use data.
- Strengthen district-level treatment services: Map existing facilities, identify service gaps and improve access to qualified clinical assessment, counselling, treatment and referral.
- Integrate mental healthcare: Build appropriate capacity in primary healthcare facilities, supported by clinical supervision and specialist referral arrangements.
- Establish sustained educational prevention: Introduce age-appropriate programmes in schools and colleges that emphasise accurate information, help-seeking and early support.
- Improve family and community engagement: Provide counselling, information and referral guidance while protecting confidentiality and avoiding stigmatising practices.
- Expand outreach where justified by local needs: Consider mobile services, community clinics and tele-support in areas where service audits identify access barriers.
- Link treatment with rehabilitation: Strengthen continuity of care and facilitate appropriate social, educational and occupational reintegration.
- Evaluate interventions: Use defined indicators, baseline data and periodic assessments to determine whether programmes improve access, treatment continuity and health outcomes.
- Promote interdepartmental coordination: Establish clear responsibilities and reporting arrangements across healthcare, education, social welfare and district administration.
- Protect dignity and confidentiality: Ensure that prevention and treatment services are non-discriminatory, evidence-based and designed to encourage timely professional assistance.

These recommendations constitute a proposed policy framework. Their implementation should be guided by local needs assessments, available resources, professional standards and evaluation findings.

13. LIMITATIONS OF THE REVIEW

This review is based on selected published literature, national evidence, international guidance and the supplied policy proposal. It does not constitute a systematic review, and no pooled prevalence estimate has been calculated. The regional studies discussed have different geographical coverage, sampling approaches and research objectives, limiting direct comparison.

Furthermore, the review does not establish current prevalence across every district of Kashmir Division or independently verify all service-delivery concerns described in the accompanying proposal. The proposed interventions have not been evaluated within this paper, and their anticipated benefits should not be interpreted as demonstrated local outcomes.

Future systematic reviews and primary studies should use transparent search strategies, predefined eligibility criteria and critical appraisal procedures to develop a more comprehensive assessment of the evidence.

14. CONCLUSION

Substance use and addiction in Kashmir Division require sustained attention as interconnected public health, mental health and social concerns. Published regional research provides evidence of opioid-related problems, while national estimates demonstrate the wider scale and diversity of substance use in India. Nevertheless, the available regional literature remains

insufficient to establish a comprehensive contemporary picture of prevalence, geographical distribution and treatment needs across the entire division.

The review identifies the importance of representative research, early identification, accessible clinical services, integration of mental healthcare, educational prevention, family support and continuing rehabilitation. It also emphasizes that awareness programs and recreational activities should complement, not replace, evidence-based clinical care.

A coordinated approach involving healthcare institutions, educational organisations, district administrations, families and communities offers a practical direction for strengthening prevention and treatment. Its success will depend on adequate resources, trained professionals, confidentiality safeguards, reliable data and systematic evaluation. Ultimately, the response to substance use in Kashmir Division should be guided by scientific evidence, public health priorities and respect for the dignity of individuals seeking assistance.

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