National Drug Laws, Policies, and Programs in India: A Narrative Review

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ABSTRACT

Background: Drug use is a major public health issue in India. Significant changes in the approach toward drug use have happened in the last few decades. Despite this, no systematic attempt has been made to document the same in the scientific literature. This narrative review attempts to discuss the major drug laws, policies, and national programs of the Government of India (GoI).

Methods: A thorough search was conducted to look for policies, programs, acts, and notifications related to substance use/drug use on various websites of different ministries of the GoI. Acts, programs, and policies addressing substance use were identified.

Results: Various drug laws, programs, and acts from the GoI provide a multipronged approach to curbing the procurement of drug use along with its prevention and cure. The Ministry of Social Justice and Empowerment (MoSJE) is the nodal ministry for drug demand reduction. The enactment of the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985 and Policy 2012 and the implementation of India's Drug De-Addiction Program (DDAP) are important landmarks in this journey.

Conclusion: The GoI initiatives for reducing the mental health burden in this country in general and substance use disorders (SUDs), in particular, are immense. The acts/statutes/laws/notifications are all interlinked. Stakeholders in mental health, public health, and policy-making need to upgrade themselves with the relevant statutes to curb the menace of drug use.

Keywords: Drug laws, NDPS act, drug de-addiction program of India, NDPS policy

Substance use disorder (SUD) is a significant global public health issue. As per the latest World Drug Report 2022, roughly 209 million people used cannabis, while 61 million people used opioids in 2020.[1] Even in India, the rates of cannabis and opioid use are high. Despite this, the availability of treatment is low, with only one in eight receiving any professional help (with more treatment gaps in poorer countries). In India, the treatment gap for SUDs is around 90%.[2] This is associated with various health hazards and places a heavy public health burden due to the associated health consequences.

The Government of India (GoI) has been taking steps relentlessly since independence to tackle the issue of drug use in India. Many acts have been enacted and amended during these seven decades, while many national programs were launched. Despite this, no systematic attempt has been made to document the same in the scientific literature. Hence, we aimed to conduct a narrative review of the major drug laws, policies, and national programs of the GoI. The various programs discussed in this article are not mutually exclusive. Instead, they work together, involving different stakeholders in the field of health and policy-making, ultimately aiming to improve the overall healthcare system in this country and ease access to care. A critical appraisal of all the existing laws, policies, and programs is beyond the scope of this paper. [For this article, wherever possible, we have replaced the stigmatizing terms related to drug use with terms that are less stigmatizing and more acceptable to the contemporary scientific community. For example, "drug addicts"/"abusers" have been replaced with "people who use drugs (PWUD)".] Also, the article does not cover acts, programs, or policies specific to tobacco or alcohol and focuses only on drug use.

Ministries Involved in Drug Control and Demand Reduction

As with many countries, the GoI also follows a multipronged approach to address the issue of drug use in India (**Table 1**).

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TABLE 1.

An Overview of the Programs/Policies/Laws Commensurate With the Different Strategies to Control Drug Use in India.

Approach	Program/Policy/Law With the Approach*
Supply Reduction	1. NDPS Act 1985# 2. National policy on NDPS 2012#
Demand Reduction	1. Central Sector Scheme for prevention of alcoholism and drug abuse 2. DDAP of India 3. Rights of Persons With Disabilities Act 2016 4. Mental Healthcare Act 2017 5. NAPDDR 2018 6. Ayushman Bharat – Pradhan Mantri Jan Arogya Yojna 2017–2018 7. National Tele Mental Health Program 2022
Harm Reduction	1. NACP 2. National Viral Hepatitis Control Program

*While the approach can be multiple-pronged, the classification is based on the core principles and implementation of the particular program/policy/law.
#Though the NDPS Act and Policy talk about demand and harm reduction, the primary focus is on supply reduction.
NDPS, Narcotic Drugs and Psychotropic Substances; DDAP, Drug De-Addiction Program; NAPDDR, National Action Plan for Drug Demand Reduction; NACP, National AIDS Control Program.

1. "Supply Reduction" aims to reduce the availability of illicit drugs through various laws and policies and is primarily enforced by the various central and state government ministries and agencies. Central departments and agencies such as the Department of Revenue under the Ministry of Finance of the GoI, the Narcotics Control Bureau (NCB), the Central Bureau of Narcotics (CBN), the Central Economic Intelligence Bureau (CEIB), as well as state agencies such as the state police and state excise officers, play their respective roles. The Narcotic Drugs and Psychotropic Substances (NDPS) Act (1985) and Policy (2012) were enacted for this purpose.
2. The "Demand Reduction" sector works for the prevention, early identification, treatment, and rehabilitation of those with drug use-related problems, thus reducing the "demand" for the same. The Ministry of Social Justice and Empowerment (MoSJE) is the nodal ministry in India. In addition, the Ministry of Health and Family Welfare (MoHFW) and state health departments play a crucial role by providing treatment and rehabilitation services to PWUD through their health facilities. Furthermore, the National Institute of Social Defence (NISD), an autonomous body under MoSJE, works as a nodal institute for training and research. Under the NISD, a National Center for Drug Abuse Prevention (NCDAP) is set up to provide technical support to the government on various substance-related policy matters.
3. The third and most recent addition is the "harm reduction" sector in India, which is primarily aimed at HIV prevention in India among people who inject drugs (PWID). Harm reduction strategies are implemented by the National AIDS Control Organization (NACO) under the MoHFW. However, in India, harm reduction, far from being an essential pillar of drug policy, as is the case in many countries worldwide, is restricted to a program in the limited context of HIV and other infectious diseases prevention.

Drug-related Laws in India

History of Drug Laws

The cultivation of opium in India dates back to the 10th century. During the colonial era, the Opium Acts (1867 and 1878) were passed to control the cultivation and manufacture (not consumption) of opium. During the 1920s, due to the pressure of the growing nationalist movements, many provincial governments enacted laws to control the consumption of opium. The Dangerous Drugs Act was passed in 1930. This sought to control drug cultivation, manufacture, sale, possession, trade, and transactions. The act primarily applied to the drugs derived from plants such as poppy, hemp, and coca and had no offenses attached to cannabis/drug consumption. The control was primarily through licensing and penalizing unlicensed activities. In 1940, the Drugs and Cosmetics Act (DCA) was enacted to regulate medicines, including those developed from cannabis and opium.

Narcotic Drugs and Psychotropic Substances Act 1985 (NDPS Act 1985)

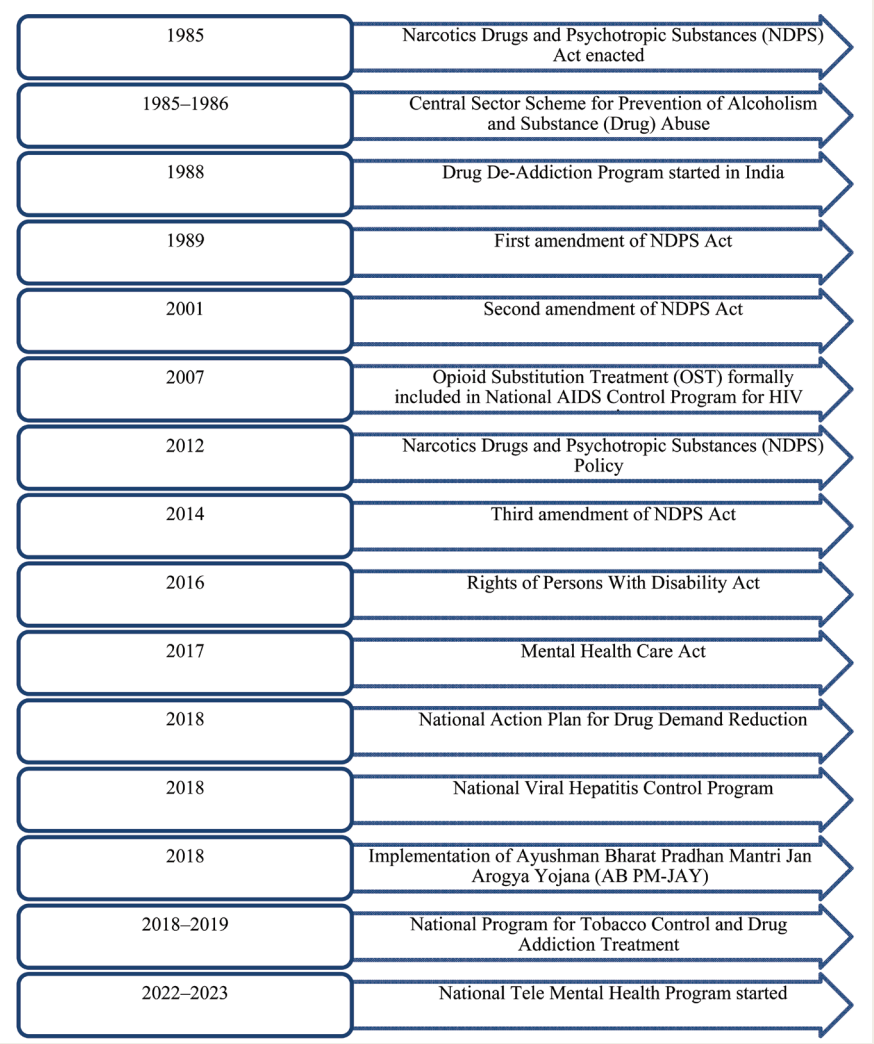
Article 47 of the Indian Constitution states, "The State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and drugs which are injurious to health," thus further entrenching the prohibitionist sentiment even during the post-independence era. Besides this, India is also a party to three United Nations conventions on drug use (the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in NDPS). To give effect to its obligations under these conventions, India passed and implemented the NDPS Act in 1985 (**Figure 1**). It replaced the Opium Acts and the Dangerous Drugs Act of 1930. However, the DCA of 1940 continues to apply.

The act covers three broad categories of drugs and substances: (1) narcotic drugs (as defined in the 1961 Convention), (2) psychotropic substances (as defined in the 1971 Convention or the drugs notified by the government as such), and (3) controlled substances that are used to manufacture these substances, including precursor chemicals such as ephedrine and pseudoephedrine. The cannabis-leaf product known as *bhang* in India is excluded from the act (as per the 1961 Convention) and is primarily regulated through respective state governments' excise laws. The NDPS Act prohibits the cultivation, production, sale, purchase, trade, import, export, use, and consumption of psychotropics and narcotics except for scientific and medical purposes. The Act is primarily punitive. However, it also empowers the government to allow drug-related activities under "medicinal or scientific use."

The NDPS Act has been amended three times to date. (1) The 1989 amendment led to more stringent and harsh provisions, such as the mandatory death penalty for certain repeat offenses, mandatory ten

FIGURE 1.

Flowchart of Landmarks of Indian Drug Laws, Policies, and Programs.



NDPS, Narcotic Drugs and Psychotropic Substances; OST, Opioid Substitution Therapy; DDAP, Drug De-Addiction Program; RPWD, Rights of Persons With Disability; NAPDDR, National Action Plan for Drug Demand Reduction; NPTCDAT, National Program for Tobacco Control and Drug Addiction Treatment; NACP, National AIDS Control Program; AB PM-JAY, Ayushman Bharat Pradhan Mantri Jan Arogya Yojna.

years' imprisonment (minimum) for certain offenses, bail restriction, and trial by special courts. (2) The 2001 amendment provided quantity-based sentencing (i.e., graded punishment based on "small," "intermediate," and "commercial" quantity). (3) Finally, the latest amendment was made in 2014, which included (a) the creation of a new category named "essential narcotics drugs" to regulate certain essential narcotics in a unified manner across the country, (b) widening the objective of the law to promote medicinal and scientific use to balance the control and availability of drugs, (c) the introduction of the terms "management" and "recognition and approval" of treatment centers to allow establishing evidence-based treatment approaches, and (d) making the death penalty discretionary, among many others. Despite these, several aspects of the act need attention. Some major criticisms of the act are criminalizing drug use and consumption, quantity-based sentencing (thus making motives and the role of the offender irrelevant), restricting access to essential medicines, including buprenorphine, uneven coordination among governmental agencies, and the death penalty.

Mental Healthcare Act (MHCA) 2017

MHCA 2017 includes SUDs in the definition of mental illness. The act has been complimented for its rights-based approach. The act protects persons with addiction from cruel, inhumane treatment at mental health establishments. This is achieved through the compulsory registration of mental health establishments and periodic evaluation by state mental health review boards. Furthermore, the inclusion underscores that SUDs are health problems rather than law and order issues alone.[3] Despite these welcoming changes, there are some drawbacks in MHCA related to SUDs. It uses outdated terms such as "abuse," which are not used in the current classification systems. SUDs as a whole are considered a single entity. There is a lack of clarity on which substance categories are included and the severity of SUDs. The MHCA 2017 also lays down various human rights of patients with mental illnesses, such as protection from inhuman and degrading treatment. This is really important considering that inhuman treatment and human rights violations are often reported in the name of SUD treatment.[3]

Rights of Persons With Disability (RPWD) Act 2016

RPWD 2016 replaced the persons with disabilities (PWD) Act 1995 to comply with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified in 2007. The act upholds the dignity of every person with a disability with a rights-based approach. According to the gazette notification, persons diagnosed with "mental illness" are eligible for disability certification irrespective of the diagnosis. In MHCA 2017, SUDs are included in the definition of mental illness. Considering these points, a person with SUD is eligible for disability certification.[4] However, many psychiatrists debate providing disability benefits to persons with SUDs due to stigma and attitudinal barriers, which the current act intends to break.[4,5] It is essential to observe that substance use is a leading risk factor for the global disease burden and causes substantial disability.[6] Therefore, it is essential to understand that disability is important regardless of diagnosis. Furthermore, there are challenges in quantifying disability related to SUDs, certification, and the provision of benefits. MHCA 2017 and RPWD 2016 are rights-based acts that uphold the autonomy and rights of persons with mental illness. Therefore, a non-discriminatory and humane approach

is required from all stakeholders for people with SUD.

Drug Policy in India

For the first time, the GoI introduced a national policy on NDPS in 2012. The objective was to guide various ministries/departments, state governments, international organizations, and non-governmental organizations (NGOs) and re-assert India's commitment to combat the drug menace holistically. The policy, interalia, states the role of the government in the treatment, rehabilitation, and social reintegration of drug "addicts." For drug demand reduction, the policy lists out the functions of various ministries/departments, which include conducting a national survey on drug abuse, training government-hospital doctors in de-addiction, supporting other hospitals in setting up de-addiction and treatment facilities, establishing separate facilities for female patients, developing minimum standards of care to be followed by "de-addiction centers," and the inclusion of rehabilitation and social reintegration programs for those with drug abuse in all government-run treatment centers. The policy also notes that several de-addiction centers have come up in the private sector and states that the GoI shall lay down standards and guidelines for these "de-addiction centers" to follow and shall recognize such centers that meet the standards and guidelines. The policy has taken a conflicting approach from the existing international policies.[7] Some of the problems are as follows:

1. The policy appears heavily skewed toward adopting supply reduction.
2. The policy document fails to mention the type of treatment that would be provided for PWUDs.
3. Despite opioid substitution treatment being evidence-based, the document does not acknowledge it as treatment; instead, as per the policy, it is used to persuade injectable users to abuse it orally.
4. The policy has a non-evidence-based interpretation of harm reduction principles.
5. Mandatory drug testing and categorically disallowing harm reduction in prisons.

National Programs Related to Drug Use

National Mental Health Program (NMHP) 1982

The NMHP was launched in 1982 with the objective of providing accessible and available mental healthcare services, encourage community participation, and translate existing knowledge for social development. The flagship operational component of the program is the District Mental Health Program (DMHP) 1996. The World Health Organization (WHO) recommends scaling up resources for SUDs through the mhGAP action program, and SUDs have been an integral part of NMHP.[8] However, at the level of its implementation, the NMHP has been criticized for neglecting SUDs.[9] For example, in the list of drugs that should be made available at Primary Health Centers (PHC), no medications are available for treating SUDs (except lorazepam).[10] The most recent Health and Wellness Clinics (HWCs) initiative by the GoI in 2018 attempts to integrate the management of SUDs into primary care. The operational guidelines comprehensively cover the basic management of SUDs, including medications like naltrexone, naloxone, and thiamine.[11] However, only time will tell how much of this integration of SUD management in PHCs is actually implementable in both short and long term. In implementing NMHP, rather than approaching the whole spectrum of mental illnesses as a single entity, dividing it into smaller entities like psychotic spectrum disorders and SUDs will ensure equitable distribution of resources and delivery of services.[12]

Central Sector Scheme for Prevention of Alcoholism and Substance (Drug) Abuse 1985

The MoSJE has been implementing a Central Sector Scheme of Assistance for the Prevention of Alcoholism and Substance (Drugs) Abuse since 1985–1986 for identification, counseling, treatment, and rehabilitation of people with addiction through voluntary and other eligible organizations. In 2008, it was merged with the social services scheme into a common umbrella scheme. Under this scheme, financial assistance is given to voluntary organizations and other eligible agencies for inter-alia, running, and maintaining Integrated Rehabilitation Centres for Addicts (IRCA). In addition, the scheme has recently been merged into the umbrella scheme of the National Action Plan for Drug Demand Reduction (NAPDDR) 2018 (**Table 2**).

Drug De-Addiction Program of India 1988

India's Drug De-Addiction Program (DDAP) is another major program constituted by the MoH&FW, GoI, in 1988. It operates in selected government medical institutions by providing a grant for treatments of SUDs. This program envisaged setting up 30-bedded "De-addiction Centres" (DACs) in six premier hospitals/institutions to provide quality inpatient services to patients with SUDs. The program expanded in the next 4–5 years, wherein state medical colleges and district hospitals were also brought under the purview of DDAP.

DDAP works in collaboration with state governments. The central government will do the initial funding (one-time for infrastructure), and the subsequent recurring funding (for workforce and supplies) will be borne by the respective state government (except for the north-eastern Indian states that will receive an additional fund of up to 0.2 million ₹ per year as further recurring assistance). As a result, 122 DACs (up to 2017) were established under DDAP. However, apart from the aid to north-eastern states, only some medical institutions receive full financial support (including the recurring costs). These are the All India Institute of Medical Sciences, New Delhi (designated as the "National Drug Dependence Treatment Centre" (NDDTC) in 2002), the Post Graduate Institute of Medical Education and Research, Chandigarh, the National Institute of Mental Health and Neurosciences, Bengaluru, and the Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry. The NDDTC, New Delhi, is the nodal center under the DDAP, GOI.[7,13]

Priority Areas of Focus for DDAP and Its Limitations

DDAP primarily works to provide quality healthcare and build capacity. This in-

TABLE 2.

Summary of National Action Plan on Drug Demand Reduction (NAPDDR).

Component	Description
Ministry involved	MoSJE
Background for the plan	To maintain the spirit of United Nations conventions, NDPS 1985, NDPS Policy 2012
Duration of the action plan	2018–2023
Objectives	1. Preventive education, awareness generation, identification, counseling, treatment, and rehabilitation of persons dependent on drugs 2. Training and capacity building of the service providers through collaborative efforts of the central and state governments and non-governmental organizations 3. Reduce stigma and discrimination against persons using drugs 4. Facilitate research, including data collection and innovation 5. Provide community-based services to facilitate "WPR" 6. Implementation of drug demand reduction through a multi-agency approach across different drugs 7. Reduce harms related to drug use
Components	The scheme has different components to achieve the set of objectives. Some of the salient features are: 1. Provision of financial support to multiple stakeholders and for different objectives 2. IRCA are the means of treatment provided under this scheme. 3. ATFs being established in government hospitals of the vulnerable districts under the supervision of NDDTC, AIIMS, New Delhi 4. CLPI programs in identified districts for the prevention of drug use among adolescents 5. Establishing ODIC in vulnerable areas, focusing on youth 6. SLCA, earlier called the regional resource and training center, serves the purpose of training and technical support. The guiding document also describes the scope of activities under each activity, eligible organizations, and financial assistance as applicable.
Subscheme	Scheme for Prevention of Alcoholism and Substance (Drug) Abuse: The scheme has been recently merged under the umbrella of NAPDDR

ATF, Addiction Treatment Facility; IRCA, Integrated Rehabilitation Centre for Addicts; DAMS, Drug Abuse Monitoring System; CLPI, Community Lead Peer Intervention; ODIC, Outreach and Drop-In Centers; SLCA, State-Level Coordinating Agency; MoSJE, Ministry of Social Justice and Empowerment; NGOs, non-governmental organizations; NDDTC, National Drug Dependence Treatment Centre; DTC, Drug Treatment Clinics; WPR, whole person recovery.

volves in-service training of non-specialist medical officers and paramedical and paraclinical staff on the various aspects of SUDs and their management. This also consists of developing resource materials in the form of handbooks and manuals for different cadres of health-care workers.[14]

Another function area of DDAP is the Drug Abuse Monitoring System (DAMS). This includes data collection from all DACs on a timely basis to obtain data on drug use patterns and profiles of treatment seekers and assess any change in trends among treatment seekers at the government DACs.[15] DDAP also has enforced a system wherein it monitors the functioning of DACs across India to understand the pitfalls in the system. The pitfalls they detected were regarding the availability of funds, a trained and dedicated workforce, record keeping and community-based activities, and insufficient treatment adherence. On the contrary, the DACs followed a model of primarily inpatient treatment and shared responsibility between the central and state governments. Hence, the model was only partially successful.

Hence, another scheme was approved to strengthen the program, and Drug Treatment Clinics (DTCs) were established. DTCs followed a model for primarily outpatient treatment, with direct support from the central government for staff and medications. As of now, 27 such DTCs are functioning across the country. Another area for improvement of the DDAP is the limited success of the initial funding strategy of one-time infrastructure support from the central government and recurring support from the state governments, which a few experts on SUD in this country have pointed out. They have also pointed out the need to continuously monitor this program and its sustainability.[14]

Recent Developments in DDAP

Recently, the DDAP and the National Program for Tobacco Control (NPTC) were renamed as the "National Program for Tobacco Control and Drug Addiction Treatment (NPTCDAT)." NPTCDAT is one of the eight tertiary care programs for non-communicable diseases (NCDs) and e-health.[16] In addition, the provision of services was extended to three more tertiary care centers, namely, AIIMS, Bhubaneswar; Ram Manohar Lohia Hospital, New Delhi; and the Central Institute of Psychiatry, Ranchi. An average budget of ₹45–51 crores has been allotted to DDAP for the institutes mentioned above during 3 years from 2019 to 2021.

National AIDS Control Program and PWID

Harm reduction is considered a key strategy to reduce the risk of HIV among PWID and their sexual partners. Needle Syringe Exchange Program (NSEP) and Opioid Substitution Therapy (OST) are the primary harm reduction strategies utilized by NACO. National AIDS Control Program (NACP) II focused primarily on NSEP and other activities; NACP III formally included OST as an HIV prevention strategy among injecting drug users (IDUs) in 2007 in an NGO model. Before this integration, OST for the said purpose was provided by some NGOs. Since 2010, government hospitals have been roped in to provide OST services through a collaborative public health model. The psychiatry departments of the government hospitals work as OST centers in close collaboration with the NGOs (GO-NGO model).

Under NACP, OST (primarily buprenorphine) is provided in clinics known as OST centers, as "Directly Observed Treatment." Recently, however, take-home dosing and doorstep delivery were also initiated during the COVID-19 pandemic. As per HIV sentinel surveillance 2017,

the prevalence of HIV among PWID stands at 6.26% nationally (the highest among all the high-risk groups covered under NACP). As per the most recent estimates, 0.168 million PWID are covered under 204 PWID-targeted intervention sites, and 28% (n = 41,215) of PWID are covered through 232 OST centers under the program.[17] However, looking at the current number of PWID in India as per the National Survey 2019, there is an urgent need to scale up the harm reduction arm of drug control.

National Viral Hepatitis Control Program (NVHCP) and PWID

The NVHCP was launched in 2018 to combat hepatitis and achieve country-wide elimination of hepatitis C by 2030, along with a reduction in prevalence, morbidity, and mortality associated with hepatitis B and C. PWID are at a higher risk of hepatitis B and C. They are also at a higher risk of all-cause mortality and morbidity, requiring special attention. Since the transmission mode is similar to HIV/AIDS, NVHCP, using the National Viral Hepatitis Management Unit and the State Viral Hepatitis Management Unit, coordinates with NACP to include prevention and management of hepatitis B and C in the prevention package for key populations (including PWID). PWID is among the specific people listed for initial focused screening of HCV under the program and is offered screening for HCV as an integral component of a comprehensive package of harm reduction services.

National Action Plan for Drug Demand Reduction (NAPDDR) 2018

Section 71 of the NDPS Act, 1985 (the power of the government to establish centers for the identification and treatment of addicts and the supply of NDPS) states that "The Government may establish, recognize or approve as many centers as it thinks fit for identification, treatment, management, education, after-care, rehabilitation, social reintegration of addicts and for supply, subject to such conditions and in such manner as may be prescribed, by the concerned Government of any narcotic drugs and psychotropic substances to the addicts registered with the Government and to others where such supply is a medical necessity." For effective implementation of the objectives of the act and NDPS Policy 2012, NAPDDR has been contrived. It has been recognized that a multipronged approach is the best-suited strategy to reduce the prevalence of drug use in the country. The MoSJE provides financial support to establish "District De-Addiction Centres" in various vulnerable districts.

Nasha Mukt Bharat Abhiyan

This campaign has been launched as a part of NAPDDR under the aegis of MoSJE. The campaign has an active outreach program (**Table 3**). It has a website with access to discussion forums; information, education, and communication material; and a live dashboard. In addition, awareness programs are being conducted across social media platforms and at grass-root levels by key stakeholders like IRCAs. Furthermore, internship programs are being offered to adolescents and young adults to disseminate awareness in the community.

Ayushman Bharat Pradhan Mantri Jan Arogya Yojna 2018

The GoI recently launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojna (AB PM-JAY) in 2018, intending to achieve universal health coverage (UHC).[18] It rests on two pillars: first, strengthening universal, comprehensive primary healthcare and providing health insurance schemes to nearly 500 million Indians to reduce out-of-pocket expenditure on the ever-increasing costs of healthcare, and second, setting up Health and Wellness Centers (HWCs).[19] This is planned to cater to the 1.3 billion Indians with a wide diversity in their socio-demographic profile and health-related needs in a country that spends a meager proportion of its gross domestic product (GDP) on health. The benefits covered under this unique scheme include the creation of 0.15 million HWCs pan-India and cashless treatment up to ₹0.5 million per family each year on a floater basis, which covers around 1,350 medical and surgical procedures.[20]

Until recently, treatment of mental illness was kept outside the purview of health insurance in India. The MHCA 2017 clearly states that "Every person with mental illness shall be treated as equal to persons with physical illness in the provisions of all health care." and "Every insurer

TABLE 3.
Summary of Nasha Mukt Bharat Abhiyan Campaign.

Component	Description
Ministry	MoSJE
Background for the plan	Initiated for the implementation of objectives under NAPDDR
Duration of the action plan	August 2020 onwards
Objectives	Three-pronged approach: 1. Supply-curb by NCB 2. Outreach, awareness, and demand reduction by the MoSJE 3. Establishment of treatment centers like IRCAs and ATFs by AIIMS, New Delhi
Implementation	Implementation from the district level, with state- and central-level monitoring
Funding	Through NAPDDR scheme

NAPDDR, National Action Plan for Drug Demand Reduction; NCB, Narcotics Control Bureau; MoSJE, Ministry of Social Justice and Empowerment; IRCA, Integrated Rehabilitation Center for Addicts; ATF, Addiction Treatment Facility; AIIMS, All India Institute of Medical Sciences.

needs to make provisions for mental illness on the same basis as is available for the treatment of physical illness."[21] A total of 17 mental health conditions, including those due to psychoactive drugs, are included in this scheme. Despite this, the health insurance agencies kept mental illnesses/SUDs off their insured list of diseases and illnesses. Recently, after much advocacy and activism from relevant stakeholders in mental health in this country, mental illnesses have also been included in the purview of insured diseases.[22] Including mental illness and SUDs in the AB PM-JAY scheme puts forward the GoI's commitment to better mental healthcare for its population and has set a stronghold on ending the stigma people with SUDs face.

The implementation of this novel health insurance scheme has been subjected to evaluation recently. Sriee et al. (2021) evaluated the coverage, impact, and utilization of the AB PM-JAY scheme in a rural catchment area of a medical college and hospital in Chennai, Tamil Nadu, and found that, out of 300 households, 77.33% were aware of the insurance scheme. Only 42.33% were covered, and 47.24% of the households had availed of healthcare services under this scheme in the previous year.[23] In another survey, the National Health Authority revealed a wide range of coverage for the Ayushman Bharat scheme across Indian states. While 80% of the population was aware of this scheme in Tamil Nadu, only around 20% were aware in Northern states like Bihar and Haryana.[24] A periodic evaluation over time is needed to assess awareness and implementation of this scheme, which might provide a surrogate indication of its effectiveness in alleviating the healthcare cost burden in India. A separate evaluation of the coverage of mental illness and SUDs by this scheme is also urgently needed.

Non-Communicable Disease (NCD) Control Programs

NCDs account for around 62% of mortality in India, the majority of which is preventable.[25] SUDs fall within the ambit of NCDs and are among the most important contributors to other NCDs (such as cardiovascular diseases, respiratory diseases, diabetes mellitus, and cancer).[26] The NCD-related Sustainable Development Goal target of the GoI is: "by 2030, reduce by one-third premature mortality from NCDs through prevention and treatment and promote mental health and well-being."[27] This calls for understanding the epidemiology, strengthening the infrastructure and workforce, health promotion, and early diagnosis and treatment of NCDs. In addition, the GoI has acknowledged the association of tobacco and alcohol use with various NCDs in its recent launch of the "National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)," which further calls for identifying and managing those at risk of these SUDs. Under this initiative, NCD cells are created to address all the various strategic needs for the effective functioning of the NPCDCS at the state and district levels.[28] Since then, multiple stakeholders have come forward to implement this novel program. There has been a consensus call to establish a research agenda for NCDs to impact policy-making and healthcare delivery across the country.[29] SUDs, especially alcohol and tobacco use disorders, have been given particular focus in this program, primarily as one of the major risk factors for all types of NCDs. The MoHFW and GoI have come up with various educational materials in liaison with premier institutes in this country that address the identification of these risk factors and the management of NCDs.[30] Screening and interventions for alcohol and tobacco use are part of the operational guidelines. Health promotion activities include improving awareness in the community about the harmful effects of tobacco and alcohol. These activities may help reduce the treatment gap for SUDs.

National Telemental Health Program (NTMHP) 2022

The GoI launched the NTMHP in its recent Union Budget (2022–2023). The objective of NTMHP is to ease access to mental health services. NIMHANS, Bengaluru, is the nodal center that will function with 23 Tele-Mental Health Centres of Excellence in various parts of the country, with technical support from the International Institute of Information Technology (IIIT), Bengaluru.[31] After this announcement, NIMHANS initiated the Tele-Mental Health Assistance and Networking Across States (Tele-MANAS) initiative under the MTMHP to provide free tele-counseling services (toll-free number 14416) throughout the country, mainly in underserved and remote areas.[32] Tele-MANAS plans to liaise with locally available mental health services, namely, the medical colleges, mental hospitals, district hospitals, and other mental health services provided by the state or central governments. As per the recent report, Tele-MANAS received over 20,000 calls over 2 months.

The NTMHP plans to link with the health-related services of the government. This includes the Ayushman Bharat Digital Mission, the backbone of the country's digital health infrastructure, and the e-Sanjeevani platform (the national teleconsultation service).[33] Being a recent addition to the mental health policy armamentarium of the GoI, the NTMHP is yet to be implemented to its fullest extent. While services for SUDs will be under the ambit of Tele-MANAS, its implementation is yet to be understood.

"Telemedicine Practice Guidelines" and "Telepsychiatry Operational Guidelines" of India

The GoI recently released the "Telemedicine Practice Guidelines 2020" during the COVID-19 first wave in India, which was soon followed by the release of Telepsychiatry Operational Guidelines.[34] This not only eased access to mental healthcare, but, being an over-inclusive, patient-centric service, it also eased access to SUD treatment.[35] However, there are a few significant loopholes in this guideline. These include the non-inclusion of medications used for SUDs (namely, Baclofen, Acamprosate, Naltrexone, Topiramate, Bupropion, and Varenicline) in List A of drugs as notified in the telepsychiatry guideline. List A includes relatively safe medicines with low abuse potential that can be safely prescribed in the first teleconsultation. Similarly, drugs such as benzodiazepines and opioids are included in Schedule X, that is, fall under the NDPS Act and hence cannot be prescribed through

teleconsultation.[36,37] The latter poses a significant problem, since excluding certain benzodiazepines (e.g., Lorazepam, Diazepam, and Chlordiazepoxide) from teleprescription makes managing patients with alcohol withdrawal syndrome difficult if they present in a teleconsultation seeking help. Along with the fact that anti-craving agents (mentioned before) cannot be prescribed in the first teleconsultation, it might prevent patients with SUDs from a remote area from seeking help (due to the unavailability of proper long term pharmacological maintenance therapy).

These are a few limitations to this novel program. However, it needs to be emphasized that since in India only mental health (and no other medical or surgical specialty) has a separate telemedicine guideline, in years to come, it will remain a matter of speculation whether the guidelines will extend to managing SUDs more holistically. This might decrease the treatment gap of SUD in India.

Conclusion

The GoI has made significant progress in drug control and reduction of demand over the last seven decades. The programs, acts, and statutes that were launched and evolved over time played an important role in reducing the mental health burden in this country in general and SUD in particular. These policies are interlinked, with varying implementation and coverage across the country. Primary care physicians, mental health professionals, and various stakeholders at the state and national levels should be aware of these policies to provide better healthcare services for those with SUDs. These also call for a comparison of India's drug[38] use policies with those of other countries, which will give a bird's-eye view of the strengths and weaknesses of the current Indian approaches and provide necessary inputs for an amendment, if any.

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