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Law against substance abuse in India

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Abstract
Indian public health, social harmony, and economic growth are all greatly affected by drug abuse. This essay gives a thorough synopsis of the background history, statistics, policy answers, and suggestions related to drug abuse in India. The paper looks at how views, practices, and laws about drugs have changed over time from ancient times through the present day. It does this by using different fields of study, such as history, sociology, public health, or policy studies. It looks at the rates, trends, and links between substance abuse and different groups of people and places, focusing on the societal and financial factors and mental health problems that happen at the same time as substance abuse. The paper also looks at current laws, public health programs, and community-based efforts that are meant to stop drug abuse. It also finds problems and holes in how these policies are being put into action. Based on these findings, the paper suggests ways to improve enforcement, boost efforts to stop drug abuse, increase access to treatment and rehabilitation services, deal with socioeconomic factors, encourage collaboration and partnerships, support research and data collection, fight discrimination and stigma, make policy implementation stronger, give community-based approaches more power, and support a more complete approach to drug abuse.

Keywords: Substance abuse, India, historical context, epidemiology, policy responses, prevention, treatment

Introduction

Legal frameworks and principles of substance abuse in India

An enormous problem in public health across the world is substance use disorder (SUD). Nearly 209 million individuals used cannabis in 2020, with 61 million using opioids, according to the most recent World Drug Report 2022. The use of cannabis and opioids is prevalent even in India. Regardless, therapy is scarce; only one for eight people get any kind of professional assistance (the treatment gap is worse in nations with lower per capita income). Nearly 90% of substance use disorders in India go untreated. This poses a significant threat to public health because of the wide range of health problems it may cause.

Since India's independence, the government has been working tirelessly to address the country's drug problem. Over the course of those seven decades, several national initiatives were established, and numerous legislation were passed and revised. Regardless, documenting the same is the scientific literature has not been attempted in a systematic manner. As a result, we set out to provide a narrative overview of the most important drug laws, regulations, and government initiatives in India. None of the programs mentioned in this article were incompatible with one another. On the contrary, they collaborate with many health and policy-making partners to enhance the nation's healthcare system and make treatment more accessible. The purpose of this study does not permit an exhaustive analysis of all current regulations, policies, and initiatives. In this piece, we have tried to avoid using terminology that are associated with drug use that are considered stigmatizing as much as possible. Instead, we have tried to use terms that are more accepted in today's scientific community. The terms "drug addicts" and "abusers" have been superseded by "people who use drugs (PWUD)". Furthermore, the article only addresses drug usage and does not address any laws, initiatives, or activities pertaining to alcohol or tobacco.

One of the most pressing problems in public health across the world is substance use disorder (SUD).

According to the most recent World Drug Report (2022), around 61 million individuals used opioids in 2020, while 209,000,000 people used cannabis.

The use of cannabis and opioids is prevalent even in India. Regardless, there is a severe lack of treatment options; only 20% of those affected get any kind of professional assistance, and that number rises in economically disadvantaged nations. Nearly 90% of those with SUDs in India do not get therapy.

Because of the serious health risks involved, this is a major concern in the field of public health.

Since gaining independence, the Government of India (GOI) is actively working to address drug usage in the country. During these seven decades, several national initiatives have been initiated and numerous legislations have been changed. But this has not led to any concerted efforts to prove it in the academic journals.

As a result, we set out to provide a narrative overview of the key drug laws, regulations, and government initiatives in India. There is no incompatibility between the applications covered in this article. Instead, they collaborate with various health and policy-making stakeholders to enhance the nation's healthcare system and make it more accessible to everyone. It is beyond the purpose of this study to provide an analysis of every legislation, policy, and program that is now in place. Wherever feasible, we have used more modern, scientifically accepted terminology to describe drug usage in this page, avoiding any phrases that perpetuate stigma. The article only addresses drug usage and does not include behaviors, programs, or policies related to tobacco or alcohol. For instance, "people who use drugs (PWUD)" has substituted "drug addicts" or "abusers."

Ministries involved in drug control and demand reduction

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.

- Authorities at the federal and state levels are mostly responsible for enforcing the many laws and regulations that make up "Supply Reduction," the overarching goal of which is to decrease the accessibility of illegal narcotics. A variety of federal and state agencies, including the Department of Revenue within the Ministry in Finance of the GoI, the Narcotics Control Bureau (NCB), the Central Bureau for Narcotics (CBN), and the Central Economic Intelligence Bureau (CEIB), carry out their responsibilities. That is why this goal was pursued by the NDPS Act (1985) & Policy (2012).
- Reducing the "demand" for drugs is the goal of the "Demand Reduction" sector's efforts in the areas of prevention, early detection, treatment, and rehabilitation. One Indian ministry that serves as a hub is the Ministry of Social Justice & Empowerment, or MOSJE. Treatment and rehabilitation services for PWUD are provided by state health departments and the Ministry of Health and Family Welfare (MOHFW), which is an important component of their responsibilities. In addition, the National Institute for Social Defence (NISD) serves as a hub for training and research; it is an independent agency within the MOSJE. In order to provide the government with technical assistance on a range of substance-related policy issues, the National Institute for Substance Abuse Prevention (NCDAP) was established under the NISD.
- Thirdly, the "harm reduction" industry in India is very new; it mainly aims to limit the spread of HIV among the country's injecting drug population (PWID). The National AIDS Control Organization (NACO) executes harm reduction programs on behalf of the Ministry of Health and Family Welfare (MOHFW). Nevertheless, unlike in many other nations throughout the globe, India has confined harm reduction initiatives to the prevention of HIV along with other infectious illnesses.

Drug-related laws in India

Opium has been grown in India since the 10th century. The cultivation and manufacturing, rather than use, of opium were regulated by the Opium Acts (1867 & 1878) during the colonial period. In response to rising nationalist sentiment in the 1920s, some province governments passed legislation restricting opium use. In 1930, the Dangerous Drugs Act came into being. The goal was to regulate the many stages of the drug trade, including production, distribution, sale, possession, and trading itself. There were no penalties for using cannabis or other plant-based drugs under the legislation, which mainly dealt with narcotics made from hemp, coca, and poppy. Primarily, the regulation was enforced by means of licenses and penalties for those who did not possess them. To control pharmaceuticals, particularly those made from opium and cannabis, the Drugs and Cosmetics Act (DCA) was enacted in 1940.

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

"The State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and drugs which are injurious to health," reads Article 47 of the Indian Constitution, hence the prohibitionist sentiment remained strong even after independence. In addition to this, India has been a signatory to three UN treaties dealing with drug use: the Single Convention of Narcotic Drugs of 1961, the Convention of Psychotropic Substances of 1971, and the Convention on Illicit Traffic in NDPS of 1988. In 1985, India enacted and executed the NDPS Act (Figure 1) to fulfil its responsibilities under these accords. The Dangerous Drugs Act in 1930 and the Opium Acts were superseded by it. On the other hand, the DCA from 1940 is still in effect.

First, narcotic drugs (as defined by the 1961 Convention), second, psychotropic substances (as of the defined within the 1971 Convention and the drugs that the government has designated as such), and third, controlled substances which are utilized in their production, including precursor chemicals like pseudoephedrine and ephedrine, are all encompassed by the act. The 1961 Convention exempts the cannabis-leaf product bhang from the act, and the excise laws of the individual states are the primary means of regulation for this substance in India. All activities related to psychotropics and narcotics are strictly forbidden under the NDPS Act, with the exception of certain medical and scientific research. Primarily, the Act is a punitive measure. Still, it gives the government the authority to legalize drug-related activities for "medicinal or scientific use."

Up to now, the NDPS Act has undergone three revisions. (1) The amendment of 1989 brought about stricter and harsher regulations, including the need for special courts for trials, a minimum of 10 years in jail for certain crimes, bail restrictions, and the death sentence for specific repeat offenses. (2) Penalties were graded according to "small," "intermediate," and "commercial" quantities as a result of the 2001 amendment's provision of quantity-based sentencing. (3) In 2014, the most recent amendment introduced a number of changes, including: (a) making the imposition of the death penalty discretionary; (b) expanding the law's objective to encourage medicinal and scientific use in order to balance drug control and availability; (c) introducing the terms "management" and "recognition and approval" of treatment centres to allow for the establishment of evidence-based treatment approaches; and (d) creating a new category named "essential narcotics drugs" for regulating certain essential narcotics uniformly across the nation. Regardless, there are a number of parts of the legislation that need fixing. The death penalty, inequitable cooperation among government agencies, the criminalization of drug use and consumption, and the act's reliance on quantity-based sentencing (which renders the offender's motives and role irrelevant) are among the most significant points of criticism.

Mental Healthcare Act (MHCA) 2017

Among the mental illnesses defined by the MHCA 2017 are SUDs. The rights-based approach of the statute has been praised. The statute safeguards those struggling with addiction from mental health facilities that engage in harsh and inhumane treatment. To that end, state mental health review boards conduct regular evaluations and mandate that all mental health facilities be registered. In addition, the inclusion highlights the fact that SUDs were health concerns, not only difficulties with law and order. There are certain negative aspects of MHCA concerning SUDs, notwithstanding these positive developments. The word "abuse" is used, which is no longer utilized by the current system of categorization, and thus is considered antiquated. When seen together, SUDs constitute a singular entity. Both the scope and severity of drug use disorders are not well defined. In addition to protecting people with mental illness against cruel and humiliating treatment, the MHCA 2017 sets out a number of other basic rights. Considering that reports of human rights breaches and cruel treatment are often made in the guise of substance use disorder therapy, this is particularly crucial.

Rights of Persons with Disability (RPWD) Act 2016

In order to be in line with the United Nations Convention for the Rights for Persons with Disabilities (UNCRPD), which was approved in 2007, RPWD 2016 succeeded the persons who have disabilities (PWD) Act 1995. Using a rights-based approach, the legislation ensures that every individual with a handicap is treated with respect. The notice in the gazette states that anyone with any diagnosis of "mental illness" are qualified to receive disability benefits. Among the mental illnesses defined in the MHCA 2017 are SUDs. When all of these factors are considered, a person having SUD might be certified as having a disability.4 The present law aims to remove stigma and attitudes that prevent many psychiatrists from approving disability compensation for people with SUDs.3, 5 Substance abuse poses a significant threat to public health and is a major contributor to disability worldwide.6 Consequently, it is critical to recognize the significance of impairment irrespective of diagnosis. Additionally, certification, benefit supply, and the quantification of impairment as it pertains to SUDs are not without their share of difficulties. Advocating for the autonomy and liberties of individuals with mental illness, the MHCA 2017 & RPWD 2016 constitute rights-based acts. Consequently, everyone involved must treat persons with SUD with compassion and non-discrimination.

Drug Policy in India

In 2012, the GOI initiated a national policy for NDPS for the first time. The goal was to reaffirm India's determination to tackle the drug scourge comprehensively and to provide guidance to different ministries/departments, state governments, foreign organizations, and NGOs. The policy

outlines the government's involvement in helping drug "addicts" with treatment, rehabilitation, and reintegration into society. A national survey on drug abuse is to be conducted, doctors at government hospitals to be trained in de-addiction, other hospitals to be assisted in establishing de-addiction and treatment facilities, facilities specifically for female patients to be established, minimum standards for care to be followed by "de-addiction centres," and rehabilitation as well as social reintegration programs for addicts to be a part of every government-run treatment centre are all enumerated in the policy as an effort to reduce drug demand. The policy goes on to say that the commercial sector has seen the rise of several "de-addiction centres," and that the government of India would establish criteria for these facilities to follow, as well as provide accreditation to those who succeed. The strategy has adopted a stance that is at odds with preexisting international policies.7 Below are a some of the issues:

1. It seems like supply reduction is the policy's primary objective.
2. There is no indication of the treatment as would be given to PWUDs in the policy paper.
3. The document fails to recognize opioid substitution therapy as a treatment, even though it is founded on research. Instead, it is used to encourage injectable users to misuse the drug orally, as stated in the policy.
4. The policy's understanding of harm reduction concepts is not grounded on evidence.
5. Inmates must submit to random drug testing and harm reduction programs are outright forbidden.

National mental health program (NMHP) 1982

Launched in 1982, the NMHP aims to make mental healthcare services more accessible, foster community involvement, and use current knowledge towards social development. One of the most important parts of the program involves the District Mental Health Program (DMHP) 1996. Substance use disorders have always played a significant role in NMHP, and the World Health Organization (WHO) has called for more funding for these programs via the MHGAP action program. But the NMHP has under heat for allegedly ignoring SUDs in its execution. For instance, other from lorazepam, no medicines for treating SUDs are included in the list of pharmaceuticals that should be offered at Primary Health Centres (PHC). Efforts to include substance use disorder (SUD) treatment into primary care were made by the GOI's most recent Wellness and Health Clinics (HWCs) project in 2018. Medications for substance use disorders (SUDs), such as naltrexone, naloxone, and thiamine, are covered extensively in the operating guidelines. How much for this integration of substance use disorder treatment in primary healthcare centres is truly feasible, both now and in the future, is an open question. To better distribute resources and provide treatment to all those in need, NMHP breaks down mental disease into smaller categories, such as psychotic spectrum disorders, substance use disorders (SUDs), rather than treating the whole spectrum as a single entity.

Central sector scheme for prevention of alcoholism and substance (drug) abuse 1985

From 1985 to 1986, the Ministry of Social and Justice Affairs (MOSJE) ran a program called the Central Sector Scheme of Assistance in the Prevention of Alcoholism other Substance (Drugs) Abuse. This program provided funding to non-profits and other groups that could help identify addicts, provide them with counselling, treatment, including rehabilitation services. It became part of a larger combined system in 2008 when it joined the system's social services program. This program provides grants to non-profits and other qualifying entities so that they may carry out various activities, including the operation and upkeep of Integrated Rehabilitation Centres for Addicts (IRCA). The National Action Plan on Drug Demand Reduction (NAPDDR) 2018 also incorporates the plan, which is a recent development.

Drug de-addiction program of India 1988

One other important initiative that the MoH&FW, GOI established in 1988 was the Drug De-Addiction initiative (DDAP). By offering a stipend for treatments of SUDs, it functions at chosen government medical institutes. Patients with substance use disorders would have access to high-quality inpatient care at six prestigious hospitals and other facilities as part of this program's 30-bed "De-addiction Centres" (DACs). State medical institutions and district hospitals also took part in the program's expansion over the following four to five years.

Governments at the state level collaborate with DDAP. With the exception of the states in northeast India, which will receive an extra 0.2 million ₹ a year as additional recurring assistance, the federal government will cover the upfront costs of infrastructure, while the individual states will be responsible for the ongoing costs of workforce and supplies. This led to the establishment of 122 DACs under DDAP (up to 2017). However, only a small number of hospitals get full funding, and that doesn't even account for ongoing expenses, with the exception of the northeastern states. The participating institutions include the All-India Institute for Medical Sciences in New Delhi, the Post Graduate Institute for Medical Education and Research in Chandigarh, the National Institute for Mental Health and Neurosciences in Bengaluru, or the Jawaharlal Institute for Postgraduate Medical Education as well as Research in Puducherry. In 2002, the institute was designated as the "National Drug Dependence Treatment Centre" (NDDTC). The DDAP, Government of India, has its node center at the NDDTC in New Delhi.

Priority areas of focus for DDAP and its limitations

The primary goals of DDAP are capacity building and the provision of high-quality healthcare. Paramedical and paraclinical personnel, as well as non-specialist medical officials, get ongoing education on substance use disorders and how to treat them. Part of this process also includes writing guides and manuals for various healthcare professions.

Substance Abuse Monitoring System is another domain of DDAP's operations. As part of this effort, we must ensure the timely collection of data from all DACs so that we may analyze treatment seeker profiles and drug usage patterns, as well as track any changes in these trends at the government-run DACs.15 In order to learn the system's weaknesses, DDAP has also established a mechanism to track how DACs in India are operating. Funding, a skilled and committed team, record keeping, community-based activities, and inadequate treatment adherence were the identified hazards. The DACs, in contrast, were based on a concept whereby the federal and state governments shared responsibility for mostly inpatient treatment. As a result, the

approach had relatively limited success.

As a result, Drug Treatment Clinics (DTCs) emerged as part of an alternate plan to bolster the program. The federal government directly funded the salaries and pharmaceutical costs of DTCs, which followed a strategy that focused on outpatient therapy. There are now 27 DTCs operational nationwide. The original financing plan of one-time infrastructural assistance from the federal government and recurrent support from the states was not very successful, as several specialists on substance use disorders in the nation have pointed out. This is another area where the DDAP may need some improvement. Additionally, they have brought attention to the fact that this program or its viability must be closely watched at all times.

Recent Developments in DDAP

A new acronym for "National Program of Tobacco Control & Drug Addiction Treatment" (NPTCDAT) has been recently coined to include both the DDAP and the NPTC." Tertiary care programs targeting NCDs and e-health include NPTCDAT as one of eight.16 Furthermore, three additional tertiary care institutes were added to the list of providers: the Central Institute for Psychiatry in Ranchi, India; Ram Manohar Lohia Hospital in New Delhi, India; and AIIMS in Bhubaneswar. From 2019 to 2021, the aforementioned institutions will get an average expenditure of ₹45-51 crores from DDAP.

National AIDS Control Program and PWID

In order to lower the risk of HIV among people living with HIV and their sexual partners, harm reduction is seen as an important method. The main harm reduction techniques used by NACO are the Needle Syringe Exchange Program (NSEP) & Opioid Substitution Therapy (OST). In 2007, as part of an NGO model, the National AIDS Control Program (NACP) officially incorporated OST as a method to prevent HIV among injection drug users (IDUs). NACP II mainly focused on NSEP and other activities. The aforementioned OST had previously been supplied by a handful of NGOs prior to this merger. A collaborative health care paradigm has been in place since 2010 that involves government hospitals in providing OST treatments. Government hospital psychiatric departments partner with non-governmental organizations (NGOs) to serve as OST centers (GO-NGO model).

"Directly Observed Treatment" refers to the administration of OST (most often buprenorphine) at NACP-affiliated clinics called OST centers. On the other hand, during the COVID-19 pandemic, doorstep delivery and take-home dosage were also introduced recently. Among all the high-risk populations covered by NACP, the prevalence pf HIV among PWID is at 6.26% countrywide, according to HIV sentinel surveillance 2017. Recent estimates indicate that 232 OST centers provide coverage to 28% (n = 41,215) of PWID, whereas 204 PWID-targeted intervention locations cover 0.168 million PWID.17 Nevertheless, it is critical to increase the harm reduction component of drug control measures immediately in light of the present number patients PWID in India, as reported in the National Survey 2019.

National Viral Hepatitis Control Program (NVHCP) and PWID

Launched in 2018, the NVHCP aims to reduce the incidence, morbidity, and mortality caused by hepatitis B and C; eliminate hepatitis C nationwide by 2030; and fight hepatitis. The prevalence of both hepatitis B and C is greater among PWID. They require extra care since they have a greater risk of death and morbidity from all causes. Given the striking similarities between the HIV/AIDS transmission mode and hepatitis B and C, NVHCP collaborates with NACP to ensure that important groups, including PWID, get comprehensive prevention and management services. Screening for HCV is given to PWID as part of a complete package for harm reduction treatments, and they are among the particular populations specified for first targeted screening under the program.

National Action Plan for Drug Demand Reduction (NAPDDR) 2018

"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." This authority to establish centers for the identification and treatment of addicts and the supply of NDPS goes into Section 71 of the NDPS Act, 1985. The NAPDDR was created to ensure that the act's and NDPS Policy 2012's goals are effectively implemented. The optimal way to decrease the incidence of drug use in the nation is a multipronged approach, which has been widely acknowledged. The establishment of "District De-Addiction Centres" in different disadvantaged districts receives financial assistance from the MoSJE.

Nasha Mukt Bharat Abhiyan

The MoSJE is spearheading this initiative, which is part of NAPDDR. An extensive outreach effort is part of the campaign. A live dashboard, as well as information, educational, and communication resources, are available on the website. Furthermore, important parties like IRCAs are launching awareness campaigns on various social media platforms as well as in local communities. To further spread knowledge in the community, internship opportunities are also being given to teenagers and young adults.

Ayushman Bharat Pradhan Mantri Jan Arogya Yojna 2018

In 2018, the Ayushman Bharat Pradhan Mantri Jan Arogya Yojna (AB PM-JAY) was started by the GoI with the aim of achieving UHC.18 It is based on two main points: first, the establishment of wellness and medical centers (HWCs) to alleviate the burden of rising healthcare expenditures on individuals and families; and second, the improvement of universal, complete primary healthcare with the introduction of health insurance programs to about 500 million Indians.19 In a nation like India, where health care receives a pitiful share of GDP, this is being developed to serve the 1.3 billion people who live there, all of whom have different socio-demographic profiles and health care demands. Each family may get up to ₹0.5 million in cashless care per year off a floater basis, that includes around 1,350 medical & surgical operations. Another unique feature of this initiative is the development of 0.15 million HWCs throughout India.20

Getting help for a mental disorder was never covered by Indian health insurance until recently. A person's mental health should be "treated as comparable to persons having physical illness throughout the provision of all health care," according to the MHCA 2017. and "It is imperative that all health insurance companies establish mental health benefits that are comparable to those offered for physical illness treatment."21 Including disorders brought on by psychoactive substances, this plan covers a total of seventeen mental health issues. Health insurance companies ignored this fact and continued to exclude mental illness and substance use disorders from their lists of covered conditions. In this nation, mental disorders are now also considered covered conditions, thanks to a lot of lobbying and engagement from important players in mental health.22 The GoI has shown its dedication to improving mental healthcare für its population and has taken a bold stand against the stigma that individuals with SUDs endure by including mental illness & SUDs in the AB PM-JAY plan.

Recent evaluations have focused on the implementation of that innovative health insurance program. The coverage, effect, and use of the AB PM-JAY plan were examined by Sriee *et al*. (2021). The study took place in a rural catchment surrounding a medical college & hospital near Chennai, Tamil Nadu. Out of 300 families, 77.33 percent were familiar with the insurance scheme. While 47.24 percent of families used this program's healthcare services last year, just 42.33 percent were really insured.23 Ayushman Bharat coverage varies greatly throughout Indian states, according to a separate study by the National Health Authority. In the northern parts of India, such as Bihar and Haryana, only around 20% of the public was aware of the initiative, in contrast to the 80% in Tamil Nadu.24 An ongoing assessment is necessary to gauge the scheme's visibility and adoption rate, which might serve as a proxy for its success in reducing India's healthcare expenditures. There must be an immediate and independent assessment of how well this plan addresses substance use disorders and mental illness.

National Telemental Health Program (NTMHP) 2022

In its most recent Union Budget (2022-2023), the GoI introduced the NTMHP. Facilitating the availability of mental health care is the goal of NTMHP. NIMHANS, located in Bengaluru, would serve as the hub for 23 Tele-Mental Health Centres for Excellence spread around the nation. The IIIT, also in Bengaluru, will provide technological assistance to these centers.31 Free tele-counseling services (toll-free number 14416) are being provided nationwide, mostly in underserved and distant regions, as a result of the Tele-Mental Health Assistance & Networking Across States (Tele-MANAS) program, which was launched by NIMHANS after this announcement under the MTMHP.32 Medical universities, mental healthcare facilities, district hospitals, as well as other state and federally funded mental health services will be the primary points of contact for Tele-MANAS as it relates to local mental health care. Over the course of two months, Tele-MANAS reportedly got more than twenty thousand calls.

In the future, the NTMHP hopes to establish connections with other government health programs. Both the e-Sanjeevani network (the national teleconsultation service) and the Ayushman Bharat Digital Mission (the backbone for the country’s digital health infrastructure) are part of this.33 Since the NTMHP is a relatively new weapon in the GoI's arsenal of mental health policies, it has not yet been fully put into action. Although Tele-MANAS will cover substance use disorder treatments, how exactly it will work is unclear.

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