GLOBAL TREND OF SUBSTANCE USE

Addiction is a global challenge with health and nonhealth hazards. According to the Global status report (2018) on alcohol and health, alcohol is the most common substance of abuse in the world, with an estimated burden of 100.4 million cases globally. The dangerous use of alcohol caused 2.8 million deaths (5.3% of all fatalities). The disability-adjusted life years due to alcohol and drug use are 4.2% and 1.3%, respectively. Cannabis and opium also have a substantial burden.1

Changes in the pattern of substance use have been seen in recent years worldwide. Although youth drinking has declined, particularly in some of the heavier-drinking parts of the world, trends are in the opposite direction in many places, especially in Asia.1 Besides, a study that looked into the trends of substance use from 1995 to 2018 showed that although there was an overall decrease in consumption of tobacco and alcohol, there was an alarming increase in the use of other illegal substances which expose the society to new challenges on fronts of recognition, legislation, and treatment as well. This study pointed toward the increasing abuse of prescription drugs, also presenting a challenge to the health-care providers.2

There are some regional variations in pattern and nature of substance use, the European region has a higher prevalence of episodic alcohol and tobacco use while North America has a higher use of cannabinoids, opioids, and cocaine.

As per the analysis of the United Nations Office on Drugs and Crime (UNODC) based on WHO disease burden and mortality estimates (2015), there is an increasing trend of global deaths directly related to use of drugs. There is a substantial increase of 60% in death rate (168,000) in recent years as compared to the year 2000 (105,000). In the age group of 15–64 years, the annual prevalence of people who use drugs has increased from 4.9% to 5.6% in the decade 2006–2016. However, the prevalence of people having substance use disorder (SUD) in this group has remained stable at around 0.6%.3

The 5th WHO-UNODC Expert Consultation discussed the rising problem of nonmedical use of prescription medications, including opioids and benzodiazepines, as a severe public health problem. It reported that 35 million people misuse opioids annually, and opioids account for 70% of diseases and deaths associated with drug use.3

Tobacco is one of the biggest public health threats the world has ever faced (1.25 billion smokers). It kills about 8 million people a year (7 million direct use). Heaviest burden (80%) is observed in low- and middle-income countries. Alcohol is one of the most commonly consumed substances worldwide. It is responsible for 5.1% of the global burden of disease. It causes over 200 disease and injury conditions and is responsible for 14% of total mortality among the age group of 20–39 years.1 As per the WHO report in 2018, 3 million deaths (5% of total deaths) were related to alcohol use.

There is an increase in the global area under poppy cultivation by more than a third in 2017, and there is a global increase in opium production by almost two-thirds in recent years. In March 2019, WHO-UNODC had mentioned that 119 countries had reported a cumulative...
total of 899 New Psychoactive Substances (NPS) and a 110% jump in reports of new opioids in a mere 3 years period. However, shifting trends have been observed in East and South East Asia.[2]

Cannabis continues to be the most widely used drug worldwide. The prevalence of cannabis use is highest in Africa and Asia, followed by the Americas and Europe. Cannabis, with an estimated 192.2 million users in the previous years, is still a very widely used drug. Global cannabis use at least once in the year 2016 in the population aged 15–64 is 3.9% and among young people (15–16 years) is 5.3%.

There is an estimated global production of cocaine around 1.41 tonnes, which is 25% higher than in previous years. There is a global increase (2006–2016) in cocaine users; estimated global users are around 18.2 million.[4]

There was a sharp shift in the synthetic drugs and NPS market in East and southeast Asia, from opiates to methamphetamine, toward the end of the 2000s. Increased amounts of methamphetamine seizures and a decline in drug retail prices in East and South East Asia indicate the drug’s availability has increased. Western and Central Europe are hubs for tablets being sold as “ecstasy.” These tablets have been found to contain various other NPS other than MDMA in recent years.[5] NPS has various nicknames such as plant fertilizer, herbal incense, room deodorizers, aphrodisiac tea, social tonics, new and emerging drugs, and research chemicals. These NPS are mostly marketed through the dark web of cyberspace.

**INDIAN SCENE**

In February 2019, The Ministry of Social Justice and Empowerment, Government of India and National Drug Dependence Treatment Centre, AIIMS, New Delhi, released the report on the Magnitude of Substance Use in India that presented the major findings of the National Survey on Extent and Pattern of Substance Use in India. This was the first attempt in India’s history to provide accurate estimates of the country’s use of substances both at the level of the country as a whole and in each state.[5]

Alcohol is the most common psychoactive drug among Indians. Around 14.6% (10–75 years) of the population consume alcohol, that is to say, there are approximately 16 crore people in this country consuming alcohol. Ninety percent of these consumers are dependent on alcohol. The alcohol intake in men is significantly higher (27.3%) than in women (1.6%). The key drinks are Country liquor or Desi sharab (around 30%), Spirits or Indian Made Foreign Liquor (around 30%), beer in 21%, home-brewed alcohol in 11%, and other forms of alcohol in 8%. Chhattisgarh, Tripura, Punjab, Arunachal Pradesh, and Goa are the states with the highest incidence of alcohol consumption.[5]

The next widely used drugs in India after alcohol are cannabis and opioids. Approximately 2.8% of the population (3.1 crore persons) claim to have used some cannabis products during the preceding year. Among the problem users, around 40 lakhs were bhang users, and about 50 lakhs were users of illicit cannabis products such as ganja and charas. Around 2.1% of the country’s population uses opium or derivatives such as poppy husk, known as Doda/Fukki, heroin, and other synthetic opioids, as well as its impure form—like smack or brown sugar. Heroin (63 lakhs) followed by pharmaceutical opioids (25 lakhs) and opium (11 lakhs) constitute the problem users. The number of people who injected drugs is estimated to be about 8.5 lakhs in India. The commonly used injectable form of opioids were heroin (46%) and pharmaceutical opioids (46%). Most of the people with injectable drugs account for unsafe injection procedures. Sikkim, Arunachal Pradesh, Nagaland, Manipur, Punjab, Haryana, and Mizoram have the highest prevalence.[5]

The survey indicates that a large number of people use inhalants and sedatives. Current users of sedatives (nonmedical, nonprescription) are approximately 1.08% of 10–75–year–old Indians (about 1.18 crore people). The current prevalence of inhalant use among children and adolescents (1.17%) is higher than that of adults (0.58%).

The prevalence of cocaine users is small as compared to the Western world. There are currently 10.7 lakh cocaine users in India. Maharashtra has the highest number of users (90,000), followed by Punjab, Rajasthan, and Karnataka.[5]

**Resources in India**

We have a huge population to cater (>134 crores), but resources are limited. India has approximately 9000 trained psychiatrists and about 1800 clinical psychologists. We have 122 Government-run de-addiction centers, 29 Drug Treatment Centres (DTCs), and 216 Opioid Substitution Therapy (OST) centers. There are only 216 MD seats in Psychiatry as of now. There is a huge treatment gap for substance users as only a small proportion has access to treatment services. Only 1 in 38 persons with alcohol dependence had reported getting any help for their problems. Similarly, 1 of 4 people who are dependent on prescription drugs has ever sought any help. The rates of hospitalization/in-patient treatment for drug and alcohol disorders are still lower.[6] Taking into account the significant care gap in the country, India needs to invest in developing care services to provide support to those in need. Optimum allocation of resources is crucial based on evidence from this survey.

**TECHNOLOGY ADDICTION**

Another domain of addictive behavior that witnessed a meteoric rise in the past few decades, faster than almost
every other addiction, is that of excessive Internet use. By mid of 2019, Asia had about half of the world’s Internet traffic. India reports to have about 560 million active Internet users and pulls about a quarter of Internet traffic in Asia. Internet addiction (IA) was described in detail by Young who later, also provided a tool to measure the same. Much of the research work that followed described it as a rising problem, especially in adolescents and young adults. An Indian study of high school students found 11.8% to be suffering from IA and using the Internet with an average of 2.5 h/day. The overwhelming majority of this time was spent on social networking, chatting online, or gaming. Although results from other studies have been variable among college students, they do highlight the fact that about 10%–15% of students have been using the Internet for >2 h a day and >6 h in some instances. According to the latest survey conducted by the Department of Psychiatry, KGMU, 2019, almost 10% population of Uttar Pradesh have >3 h/day use of the electronic gadgets. The vast majority of the time is allocated to social networking and gaming.

This is creating a pattern, where the young population is hooked on to screens more than engaging in real interactions. This is taking away the time that could be otherwise spent on useful and practical learning, recreation, and other skill development. Studies have also shown that this is increasing the psychological distress among the students. The use of the Internet and gadgets has increased exponentially in the past two decades. India stands second in the world in terms of Internet use, with approximately 560 million Internet users. Fast technological improvements have increased the accessibility and use of Internet in all age groups tremendously since the past decade, giving rise to the threat that many individuals, especially adolescents, will be affected by IA. Although IA is not officially recognized as a distinct behavioral disorder yet, in the context of rapidly growing internet use, IA has been recognized as a global concern. It seems necessary to have some effective measures for the prevention and management of IA. Multi-model treatment of IA looks promising, but the focus should also be on prevention. People should be made aware of the negative consequences of irresponsible Internet use. Achieving a balance between the provision of adequate internet facilities and the protection of the public from the hazards of Internet use poses a challenge for policymakers. Mental health professionals should be aware of IA and work toward the implementation of preventive, diagnostic, and treatment strategies. India has the youngest population in the world, but it is our responsibility to inculcate the right habits among next generation so that we do not lose the power of our young just in surfing online and make sure that they are available in the real world instead of a virtual one only. Considering the magnitude of this problem, many departments of psychiatry have started the problematic use of technology clinics.

India is a developing country with its young population as its major strength for the future. Hence, it is crucial to give importance to the rising problems of substance use and addictive behaviors. As the younger population is at higher risk of such patterns of addiction, it should be central to policy development. Novel treatment strategies and awareness campaigns should be guided by epidemiological and sociodemographic factors to focus efforts for fruitful results.

Table 1 summarizes the prevalence of the use of various substances.

### MEDIA PORTRAYAL

Media has a huge impact owing to its wide reach and its easy availability and accessibility to most of the population. Popular print and electronic media are now emphasizing mental health issues, including substance use disorders. Bollywood has joined hands with famous spiritual gurus to fight against drug addiction and slogans like “Drug-Free India” and “Join Hands-Save Life” have been coined. There has been a shift in the focus of Bollywood movies from casual, glorified, and dramatic use of drugs to increased awareness regarding the harmful effects of substance use. There are advertisements in televisions, newspapers regarding helplines, and treatment clinics. Social media has also spread awareness. However, sensationalizing the value of drug seizures, glorifying the benefits of alcohol, stigmatizing the drug users, shadow advertising, and ignoring success stories remain areas of concern.

### CARE MODELS

There is no uniform and consistent model for the management of substance use disorders. Guidelines vary widely over countries, regions, and even across centers. The first Indian Psychiatric Society Clinical Practice Guideline (CPG) was published in the year 2006 as an attempt to streamline the care of substance use disorders. Subsequently, revised CPG was published in the year 2015–2016. However, the care models used by different centers lack uniformity. There is limited evidence on the treatment and preventive strategies of drug abuse with very few studies from the developing countries in general and India in particular. The research shows that rates of tobacco

| Table 1: The prevalence of use of various substances in India |
|---------------------------------------------------------------|
| Name of substance | Prevalence in India (%) |
|-------------------|------------------------|
| Alcohol           | 14.6                   |
| Cannabis          | 2.8                    |
| Opioids           | 2.1                    |
| Sedatives/hypnotics| 1.08                   |
| Inhalants         | 0.7                    |
| Internet addiction| 10 (Uttar Pradesh)     |
use, harmful alcohol use, and illicit drug use can be reduced by a combination of regulatory, early intervention, and harm reduction approaches.[13]

**Drug use management strategies**

Management strategies include three steps:

1. **Demand reduction strategies**—include strategies to reduce the desire to use drugs and to prevent/reduce/delay initiation of drug use
2. **Supply reduction strategies**—include strategies to disrupt the supply and availability of drugs
3. **Harm reduction strategies**—include measures to reduce the negative impact of drug use on individuals and communities.

India has a large at-risk population for substance use disorders, and there is a huge treatment gap. As per the National Mental Health Survey (NMHS) 2015, there is a treatment gap of 86.3% for alcohol use and 91.8% for tobacco use.[10] Considering this, we need effective and easily available services for the management of these disorders. Management of SUD includes demand reduction strategies, supply reduction strategies, and harm reduction strategies. To cut down the supply, various government organizations such as the Department of Revenue, Narcotic Control Bureau and Central Bureau of Narcotics are taking various legislative steps toward stopping illicit use and supply of illicit medications. One of the major harm reduction strategies is the needle exchange program by the National AIDS Control Organization (NACO) to reduce needle sharing among injecting drug users. To reduce the demand for psychoactive substances, various nongovernmental organizations (NGOs), government hospitals, along with Ministry of social justice and empowerment are running various preventive and rehabilitation programs. In addition, many government hospitals/medical colleges and private setups are providing deaddiction services to persons with substance use disorders, including DTCs and OST centers.

A number of interventions have been used to reduce substance use disorders, including legislative measures, to control the use of substances. However, despite applying strict legislative control, a significant reduction in substance use has not been observed, emphasizing the need for other strategies. Currently, major stakeholders for de-addiction services are tertiary care centers, including medical colleges, De-Addiction centers, and District Mental Health Programme centers. Other stakeholders include Integrated Rehabilitation Centres for Addicts (IRCs), which are supported by government, NGOs, and the private sector, including private medical colleges and private psychiatrists. Despite these efforts, we still have a huge treatment gap for psychiatric illnesses, especially for substance use disorders. In addition to demand reduction and prevention of substance use, we need to develop more treatment facilities and de-addiction services in India.

**CHALLENGES AND OPPORTUNITIES**

One of the biggest challenges in the management of SUD is the scarcity of workforce. In a large multi-country survey supported by the WHO, it was found that the Global estimate of the treatment gap is 78.1% for alcohol abuse and dependence. Conditions are worse in India, with a treatment gap of 97.2% for alcohol use disorders.[14,15] NMHS reports a treatment gap of 90% for SUD, and one of the most common reasons for such a huge treatment gap is the lack of adequately trained professionals in the field of substance use disorders.[16] To address the burden of mental disorders and the shortage of qualified professionals, the Government of India has launched the National mental health program in 1982. This program was re-strategize in 2003 to include two schemes, namely the modernization of state mental hospitals and up-gradation of the psychiatric wing of medical colleges, and later on, in the year 2009, workforce development scheme was also included in it. Under this scheme, there is provision for training of general health professionals involved in primary health-care services for providing mental health services, increasing postgraduate (PG) seats in Psychiatry, and involvement of NGOs.[17]

Another issue is the limited availability of de-addiction centers in India. Further, all tertiary care centers are not well equipped to take care of substance use disorders. There is a scarcity of in-patient services and a serious lack of funding. However, in recent years focus of the government has shifted to mental health. Currently, the focus is on the development of PG psychiatry department in already established medical colleges, increasing the number of MD psychiatry seats, and expansion of district mental health program to all districts to ensure the availability of psychiatric services. Provisions for development and strengthening of in-patient services in the government sector, private sector as well as the involvement of various NGOs to provide in-patient services are also being made available.[17] Still, we do not have sufficient infrastructure, workforce, and funding to cater to such a huge population. Hence, there is a need for increasing fund allocation for human resource development, ensuring the availability of essentials medications, development of rehabilitation services for patients with substance use disorders, strengthening of DTCs, and increasing Information, Education, and Communication (IEC) activities. Comorbid medical illness is very common in patients of substance use disorders, therefore an effective collaboration with other medical disciplines to ensure holistic management needs to be developed.

To address this huge treatment gap, there is a need to reduce the stigma and increase awareness regarding substance use disorders, liaising with general and AYUSH practitioners, educating and liaising with traditional healers, and
developing efficient referral systems. In recent years, the pattern of substance use disorders is changing. Now, there is an early age of onset of addiction involving adolescents, weekend binging patterns, use of multiple substances, and increasing use of party drugs. To address these issues, there is a need for intense IEC activities and implementation of school mental health programs, including information regarding the harmful effects of substance use in the school curriculum.\[10]\n
GOVERNMENT INITIATIVES

The changing scenario of addiction care has brought along praiseworthy initiatives from the government. One such change is the setting up of a 24 × 7 national toll-free drug de-addiction helpline number to help the victims of drug abuse. Recognizing the challenge the country is facing, the health ministry had also issued an advisory to the states and Union Territories to prepare an Action Plan, which includes conducting sensitization and preventive education programs in schools and colleges throughout the year. Similarly, some of the initiatives taken by the Ministry of Social justice and Empowerment to reduce drug abuse include the use of print, electronic, and social media for creating awareness in regional languages. Celebrating the International Day against Drug Abuse and Illicit Trafficking on June 26, every year by holding functions and organizing exhibitions to sensitize the people about the ill effects of drug abuse is another welcome step. Implementation of a “Central Sector Scheme of Assistance for Prevention of Alcoholism and Substance (Drug) Abuse” is also appreciable. Under this scheme, financial assistance is provided to eligible NGOs, Panchayati Raj Institutions, Urban Local Bodies, etc., for running and maintenance of IRCAs. National Awards are also conferred to individuals and institutions to recognize their efforts and encourage excellence in the field of the prevention of substance abuse.\[18]\n
Awareness generation program with Society for the Promotion of Indian Classical Music and Culture Amongst Youth in children and youth about the harmful effects of substance abuse in 156 schools is running in 22 districts of Punjab.

Anational action plan for drug demand reduction (2018–2023) has been made to create awareness and educate people regarding drug use, developing human resources and facilitating research, training, documentation, innovation, as well as the collection of relevant information to strengthen the above-mentioned objectives. The objectives include provisions for a whole range of community-based services for patients with SUD. The action plan enlists formulating and implementing comprehensive guidelines, schemes, and programs using a multi-agency approach for drug demand reduction to alleviate the consequences of drug dependence amongst individuals, families, and society at large. It lists out various steps such as training of doctors in Government Hospitals in de-addiction, supporting other hospitals in setting up de-addiction and treatment facilities, developing minimum standards of care, and inclusion of rehabilitation and social reintegration programs for victims of drug abuse. NACO and the Ministry of Health and Family Welfare are implementing Targeted Interventions Programme to offer prevention and care services to high-risk populations such as injecting drug users. One of the proposals can be the inclusion of screening for early identification of common SUDs (Tobacco and Alcohol) at the recently established Wellness centers. Individuals thus identified can be referred to appropriate facilities (DMHP team or nearest medical college or NGOs or Private setups).

POLICIES AND LEGISLATION

There are government policies related to substance use, namely National Narcotic Drugs and Psychotropic Substances policy, which endorses a combination of supply, demand, and “Harm Reduction” approach. It is to be noted that the National health policy of 2002 did not mention drug abuse/dependence as a major area of concern. The earlier legal approach was to discourage substance use by imposing harsh punishments and banning the use of substance completely. However, the recent amendments have permitted the scientific and medical use of these substances. However, there is no “National Policy” since alcohol is a state subject. There are wide variations among states; some states follow prohibition (poorly enforced), and others allow liberal marketing. Tax/excise structure is highly variable, which favors the consumption of high alcohol content drinks over low-alcohol ones. Compared to most other countries, the Indian tobacco use scenario is dominated by smokeless/chewing tobacco. Policies regarding the prohibition of advertising and marketing tobacco products exist, but there are many loopholes (e.g., surrogate advertising). Tobacco cessation clinics exist but are not integrated well with other addiction treatment facilities.

Decriminalization and legalization of cannabis have brought about increasing recreational use in some countries. Thus, decriminalization and harm reduction with light regulations is probably the best policy to deal with relatively “soft” drugs such as cannabis. Excessively harsh legal measures give rise to an unregulated criminal market, and excessively light measures lead to the unregulated legal market. Hence responsible legal regulation is the need of the hour.
CONCLUSION

In a country of >134 crores, there are a lot of challenges in addiction management. Some of these include high patient burden, scarcity of workforce in mental health, inadequate infrastructure, poorly equipped de-addiction centers, inadequate funding, poor coverage of national programs, high treatment gap, and lack of implementation of laws.[5]

However, big challenges provide big opportunities too. There is a huge scope of availing the facility of government schemes and projects. Sensitization and collaboration with traditional healers will increase the reach and popularity of interventions. Awareness and sensitization of users to own the responsibility will improve the outcome. Expanding the horizon of self-help groups will lead to the overall development of society and the betterment of the individual. The most important issue facing the future of care in India is the challenge of integrating services. Inter-departmental collaboration and co-operation is a must for the schemes to succeed. Political will is required to ensure that the magnitude of the addiction crisis is properly understood, and funding should be provided to tackle the menace. Finally, educating the users and society about the ill-effects of substance use and providing information about accessible and affordable treatment is required.

Future recommendations

Scientific evidence-based treatment needs to be made available for people with substance use disorders. There is a need to move away from the “De-Addiction Centre” model and focus on outpatient “Drug Treatment Clinics” along with community-based treatment. This will ensure better coverage and acceptability among users. Massive investments need to be made for capacity building. Leveraging the benefits of information technology will require an overhaul of the existing infrastructure. To sensitize medical professionals from an early age, there is a need to incorporate Psychiatry (which also includes addiction) in the MBBS curriculum as an independent subject. Government programs targeting addiction in India need to be expanded to involve NGOs and private setups. The monitoring of these institutions should be carried out in the least restrictive way. The young population is especially at risk and should be the focus of evidence-based substance use prevention programs. Awareness programs targeting increased treatment-seeking behavior and decreasing stigma in society are one such step. Prevention strategies based on international standards to increase protective factors and reduce risk factors should be implemented properly. Community and family participation is essential in such interventions. UNODC’s global project to disseminate family skills training programs in different regions of the world (Project GLO-K01) for the prevention of drug use, HIV/AIDS, and crime among young people should be implemented across the nation.[19] In India, a lot of activities are being conducted by various ministries to target drug use. However, to ensure better utilization of resources and have a goal-directed approach, there is an urgent need for collaboration and integration between the Ministry of social justice and empowerment and the Ministry of health and family welfare, like the integration between IRCA and DMHP, etc. There should also be a collaboration between ministries of AYUSH and Youth affairs. At the state level, the similar collaboration between Health and family welfare and Medical education ministries is desirable. Some additional recommendations are mentioned in Table 2.

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