MENTAL HEALTH CARE IN INDIA TODAY - CHALLENGES IN SCALING UP SERVICES

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Introduction

Severe mental disorders (SMDs) are chronic and enduring conditions that contribute hugely to global burden of disability and mortality (Charlson *et al.*, 2016; Gabbard & Crisp-Han). In low and middle-income countries (LMICs) SMD sufferers face impediments to their clinical and functional recovery, protection of human rights, social inclusion, and participatory citizenship (Chatterjee S, 2003). There are major barriers in access to appropriate care. Further, limited resources lead to large treatment gaps which in turn heighten vulnerability and disadvantage. Stigma and discrimination add to this disadvantage and vulnerability(Chatterjee *et al.*, 2003; Kohn R, 2004; Patel, 2007; Saxena *et al.*, 2007; Vos *et al.*, 2015). Many people living with SMDs languish in large hospitals, abandoned by family and forgotten by policymakers.

The context of India's mental health program

India brands itself as incredible and rightly so. It's remarkable political, economic, and cultural transformation over the last five decades has made it a geo-political force to reckon with. As, the largest democracy of the world, this country has access to highly skilled technical communities that have the acumen to turn political promises into reality.

Despite the fact that India's spending on health is low and even more scarce in mental health, amongst Low and Middle Income Countries (LMICs), India was one of the first to launch its national mental health program in 1982. India acknowledged and included in its program key features of a robust mental health care program that global mental health talks of today, almost four decades earlier (Das, 2014).

In 1975, the World Health Organization (WHO) brought out its report on organization of mental health services in developing countries, which was an important milestone. The launch of this report gave impetus to a series of developments that shaped India's mental health care post-independence (World Health Organization, 1975). The National Institute of Mental Health and Neuro Sciences (NIMHANS) started its Community Psychiatry Unit (in 1974 (National Institute of Mental Health and Neurosciences, 2018) which, in years to come, would lay the foundation of community based mental health care in the country. WHO launched a multi country study to develop and examine a model to provide basic mental health services through the existing health system (World Health Organization, 1975). The study that became famous as the Raipur Rani experiment, for the first time brought to light the kind of mental health problems prevalent in a rural community (Murthy *et al.*, 1978). In two villages of the Raipur Rani block, 2% of the population was detected to have a treatable neuropsychiatric condition like schizophrenia, depression or epilepsy (Murthy *et al.*, 1978; Wig *et al.*, 1981). At about the same time, the country was trying out other community-based programs. The NIMHANS's Sakalwara program, promoting community based care was one such pilot, which coincided with the declaration of Alma Ata (Van Ginneken *et al.*, 2014). Based on these, India announced the launch of the District Mental Health Program in 1996 which was over subsequent years, scaled nationally (Nadja van Ginneken, 2014).

The extent of mental health care needs in India

The first comprehensive national mental health survey was conducted in 2016. Data from this survey places current mental morbidity of individuals above the age of 18 years at 10.6%

excluding tobacco use disorders and lifetime population prevalence at 13.7%. Translated to real numbers, the report reflects that nearly 150 million people currently need intervention for a mental health condition. The lifetime prevalence for severe mental disorders is 1.9% with a current prevalence of 0.8%. This prevalence is two to three times higher in urban metros as compared to rural and other urban areas (Gururaj *et al.*, 2016). Based on the population census figures of 2011 (Government of India, 2011), this translates into 10 million people currently living with a severe mental illness.

The role mental hospitals play in care for severe mental illness

Forty-three psychiatric hospitals set up 100 - 150 years ago and operating within a legal framework inherited from British colonial rule (Thornicroft G, 2009) constitute 80% of all available psychiatric beds (World Health Organization, 2014). At the end of 2015 there were 6,829 patients staying in 30 of the 43 mental hospitals; of these 16% had been there for more than five years, some for 3-4 decades (Gururaj *et al.*, 2016). The infrastructure and standards of care are poor. There are no clear pathways to discharge and successfully integrate former patients into the community, especially women and those abandoned by families (NHRC, 2012). In general people living with a severe mental illness in India tend to have large unmet needs associated with poverty, meaningful engagement, intimate relationships, lower levels of education and persisting symptoms (Ernest *et al.*, 2013; Kulhara *et al.*, 2010). India spends 0.06% of its health budget on mental health with no data available on what proportion is invested in such long stay hospitals (Patel V, May 18 2016). Unlike the global North, India has continued to add new mental hospitals, and since 2001 new ones have been established in the states of Haryana, Tripura, Himachal Pradesh and Bihar (Varma, 2016).

Mental hospitals, their governance and reform are important considerations to the successful implementation of the Mental Health Care Act (MHCA), 2017. 35,000 of the available 56,600 beds are in these hospitals. We have 10 beds each in the 723 district hospitals and 30 beds each in the 479 medical colleges. As per international standards, what is needed is 50 beds per 100,000 population. In the mental hospitals, a substantial proportion of the psychiatric beds is occupied by the homeless mentally ill (Math *et al.*, 2019; Nagaraja & Murthy, 2008).

Mental health legislation in India

India got its first mental health legislation under British rule in 1858. This act largely focused on rules for setting up and running of mental asylums. The 1912 Lunacy Act saw the first winds of change where it moved mental asylums from inspector generals of prisons to civil surgeons. The legislation also mandated the appointment of specialists in psychiatry as full time officers and all asylums were brought under central government rule. This act continued into Independent India until it was replaced by the mental health act of 1987. The 1987 act continued in its emphasis of psychiatric institutions reforming many provisions of the 1912 act and bringing vigilance over the conditions in psychiatric hospitals (Ganju, 2000; Kala & Kala, 2007; Van Ginneken *et al.*, 2014). The 1987 mental health act has only recently been replaced by the mental health care act of 2017 which is aligned to the principles of UNCRPD (India, 7th April 2017).

The Government of India (GOI) ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007 (Narayan & John, 2017). This means that the country is obligated to align all its laws to the Convention. Both The Persons with Disabilities Act 1995 and The Mental Health Act 1987 needed a thorough revision in order to be aligned to the UNCRPD. The Government of India launched The Mental Health Policy in 2014 and the Mental Health Act was notified on 29th May 2019 .

The preamble of the MHCA 2017 aims to provide mental health care services for Persons with Mental Illness (PMI) and also protect, promote and fulfil the rights of such persons whilst providing mental health care services. This is a progressive rights based and patient centric act. The drafting committee that was formed through representation from civil society, service users, caregivers and sector experts, along with the government leadership that played a pivotal role in the journey from draft to bill, had a futuristic vision of social welfare and responsibility which is articulated throughout the act. The mental health policy and the Mental Healthcare Act are thus based on principles of equity, justice along with integrated and evidence based care (India, 7th April 2017)

India is a country with extensive mental healthcare needs to spread over a large and complex geography. This is complicated manifold by the fact that India's healthcare investment is low rendering primary care weak and tattered. Integrating a rights based mental health care framework in the absence of universal healthcare poses immense challenges.

Human resource and mental health care service delivery.

The critical component of mental health services is the trained human resource that delivers care. Section 31(3) of the MHCA indicates an obligation on the government to make efforts to meet internationally accepted guidelines for mental health care professionals across different levels based on population norms. This requirement needs to be fulfilled within a 10-year period from the commencement of the Act (India, 7th April 2017). There are several elements that makes it extremely challenging to meet this stipulation.

Based on international guidelines, India will need per Lakh population an additional 30,000 psychiatrists, 37,000 psychiatric nurses, 38,000 psychiatric social workers and 38,000 clinical psychologists. What we have currently is 9000 psychiatrists, 2000 psychiatric nurses, 1000 clinical psychologists, and 1000 psychiatric social workers. At current rates of training it will take 42 years to meet the requirement for psychiatrists, 74 years for psychiatric nurses, 76 years for the psychiatric social worker, and 76 years for clinical psychologists, assuming both general population and mental health human resources) remains constant (Math *et al.*, 2019).

Though India produces the largest number of doctors anywhere in the world through its 134 private and 137 government medical colleges (Sood, 2008), the cost of educating one doctors is at about 1 Crore INR (Math *et al.*, 2019). We do not even know the costs of training a psychiatrist or the other mental health professionals.

Research suggests task shifting and task sharing as the way forward to meet this huge treatment deficit with deployment of the community health worker cadre (Patel, 2007). This requires thought and coordination along with a systematic effort at skill building with the necessary supervision mechanism in place.

The MHCA, 2017 has three implementing statutory agencies. They are as follows: (a) Central Mental Health Authority at the centre (CMHA), SMHA State Mental Health Authority and the District Review Boards. While this is a huge opportunity to get in a broad based stakeholder involvement from civil society, it entails a great amount of capacity building for effective execution of function. As of now, many states have not even formulated the state level guidelines for implementing the MHCA.

The cost of care

The continuum of mental health care services requires medical, psychological as well as rehabilitative services. Our country has a huge gap in terms of treatment option even more so for the psychological and rehabilitative services.

The amount spent varies based on the mental health condition. The median monthly is estimated to be Rs 2250 for Alcohol Use Disorders, Rs 1000 for Schizophrenia and other

psychotic disorders and Rs 1500 for Depressive Disorders. These total minimum costs are based on the median out-of-pocket expenditure (Gururaj *et al.*, 2016). The cost of only these three conditions and that too largely medical care will cost the government approximately 698 Crores (Math *et al.*, 2019).

Section 18(6) of the Mental Healthcare Act mandates the government to make mental health treatment provision from the Community Health Centre (CHC) upwards (India, 7th April 2017). India envisaged decentralised and integrated mental health care service delivery under is District Mental Health Program (DMHP) launched in 1996 under the National Mental Health Program. Currently the DMHP is present in approximately 70% of districts across the country, however services have remained largely centralised available only at the district level through a very small DMHP team that is simply unable to reach care throughout the district (Singh, 2018).

In-patient care services as well as rehabilitative services are needed to be provided. These call not just for trained human resource, but also for infrastructure and coordination and collaboration with other departments within governments, the sills and employment sector and civil society at large.

Economic costs of untreated mental illness

Untreated mental health conditions constitute both direct and indirect costs to governments and society at large. Direct costs involve the costs of treatment and indirect costs account for productivity loss of the person as well as the caregiver due to time lost because of the illness, procurement of treatment as well as time lost due to loss of functionality or disability levels. These costs are huge and are currently largely borne by families increasing vulnerability, indebtedness and further entrenchment into poverty.

Conclusion

The Mental Healthcare Act 2017 of India is an excellent example of political will, government leadership and coordination with civil society and sector experts. It is the essential first step in providing comprehensive and integrated mental healthcare services equitably. This act is a visionary act that will need amalgamated action from all stakeholders to turn this vision into reality. While Government investments in health care itself and specifically mental health care need both an increase as well as a shift towards care provision in community settings, that by itself will not translate the vision of the Mental Health Care Act into reality. One example of this is that mental health is not specifically mentioned as an area for Corporate Social Responsibility under the Companies act 2013 limiting CSR engagement. Mental health is no longer a problem of the ‘them and yonder’ this is staring in our face and is a reality of our lives in the form or our loved ones, friends and acquaintances needing care and support. The number of people with mental illness left homeless is our reality. We as a society will need to step up and participate in taking care of our own.

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