Analysis of National Mental Health Policy of India- 2014

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Contents

Introduction: 4
Rationale: 5
Aim: 6
Objectives: 6
Methodology: 7
Analysis: 7
Where does India stand in terms of Mental illness: 7
Mental Health scenario in India: 11
The National Mental Health Program: 13
The National Mental Health Policy -2014 15
Policy Analysis: 23
The Way Forward: 25
References: 27

Introduction:

Mental Health is defined as a state of wellbeing where individuals realize their own abilities, can cope with normal stressors of life, can work productively and fruitfully and are able to make positive contributions to the community.

Historically use of Mental, Neurological and substance use diseases has been given a low priority as compared to non-communicable and communicable diseases [10]. This has led to less resource allocation to Mental Neurological and Substance disorders (MNS), which grew silently and went un-noticed until 2001 when WHO declared the year as Mental Health year, which defined the gravity of MNS disorders. According to Global Burden of disease survey there has been a rapid increase in the incidence and prevalence of MNS disorder by 37.6% that is from 133.6 million in 1990 to 183.9 million in 2010. The burden of MNS in terms of DALYs has increased from 5.4% in 1990 to 7.4% in 2010[13]. According to the global burden of disease, neuropsychiatric disorders accounted for 6.8% of DALYs in 1990, which has increased to 12% in 2013 and is projected to increase to 15% by 2020, worldwide. [1,16]. The projected increase in the percentage of mental and behavioral disorders is mainly due to demographic and epidemiological shift, because of population growth and changing age structure, which leads to increase in number of people suffering from a certain illness. For instance, there would be a substantial increase in the senile dementia, due to increase in life expectancy of people living to the age of 65 years and beyond.[1]

Currently, around 450 million people are suffering from any kind of mental illness. According to the projections, one person out of four will be affected from mental illness at least once in lifetime. [16]. Depression is among the top ten causes of disability and according to the projections would soon rank to be the second cause of global burden of disease.[16]. In

the burden of disease caused due to mental neurological and substance disorders depression ranks number one followed by anxiety disorders, drugs use disorders followed by alcohol abuse [13]. Suicide is becoming one of the major causes of mortality, a million people commit suicide every year and around 10-20 million attempt it. [16, 9] There has been a massive increase in the incidence of suicides and is projected to increase from 1.8% of global burden of disease in 1998 to 2.4% of global burden of disease by 2020, it has been projected that approximately 1.53 million people will die from suicide, on an average one death in 20 seconds and an attempt every 1-2 seconds [9]. It is further reported that 90% of those who commit suicide have a psychiatric diagnosis at the time of death, which makes mental disorder one of the leading cause of suicide. [9]

Largest burden of mental disorders and suicides is concentrated in Asia, mainly South East Asia, the prevalence of mental disorders in Asia ranges from 18-30% in urban and 28-36% in rural areas.[3,9] Moreover suicide rates is higher in Asia, given the size of the population of India and China, 30% of the world's suicide cases are committed in these countries alone. The suicide rate in India is almost equivalent with half of the global suicide rate.[9]

Rationale:

Mental illness forms almost one-sixth of all health related disorders, it constitutes around 26 percent of all non-communicable diseases in India. According to future projections there would be a sharp increase to 15% of DALY caused due to mental health disorders by 2020. This might be due to increase in population and changing demographics, life-style, lack of social support and insecurity. In a study by National Commission on Macroeconomics and Health (NCMH) suggests that at least 6.5% of the Indian population suffers from some form of mental disorders, with no difference between rural and urban population [8]. In 2014 in a

report by WHO, showed that around 32% of the worlds suicide occurs in India- 258,000 of 804,000 in 2012, which accounts to 21 suicide deaths per 100,000 people which is almost twice the worlds average.[7] In view of the above cited challenges, National mental health policy-2014 needs to be reviewed to know if it has addressed the concerns affecting the status of mental health in India in terms of prevention aspects, diagnosis and treatment possibilities.

Aim:

To review the existing National Mental Health Policy-2014 of India in terms of coverage of mental health issues, identification and inclusion of the relevant issues with appropriate implementation mechanism.

Objectives:

- To provide insights on the current mental health scenario in India using secondary data
- To review the previous mental health policies.
- To review the current national Mental Health policy-2014
- To identify the extent of coverage of mental health issues under National Mental Health Policy
- To provide recommendations for its improvement

Methodology:

Review of literature was done for the context of this paper, studies related to prevalence of mental health disorders were searched from Pub Med and Google Scholar. National Mental Health Policy-2014 (NMHP-2014) was reviewed, along with the reports published by WHO pertaining India and the Mental Health initiatives. The previous National Mental Health Program and District Mental Health Program were also reviewed along with the Published studies.

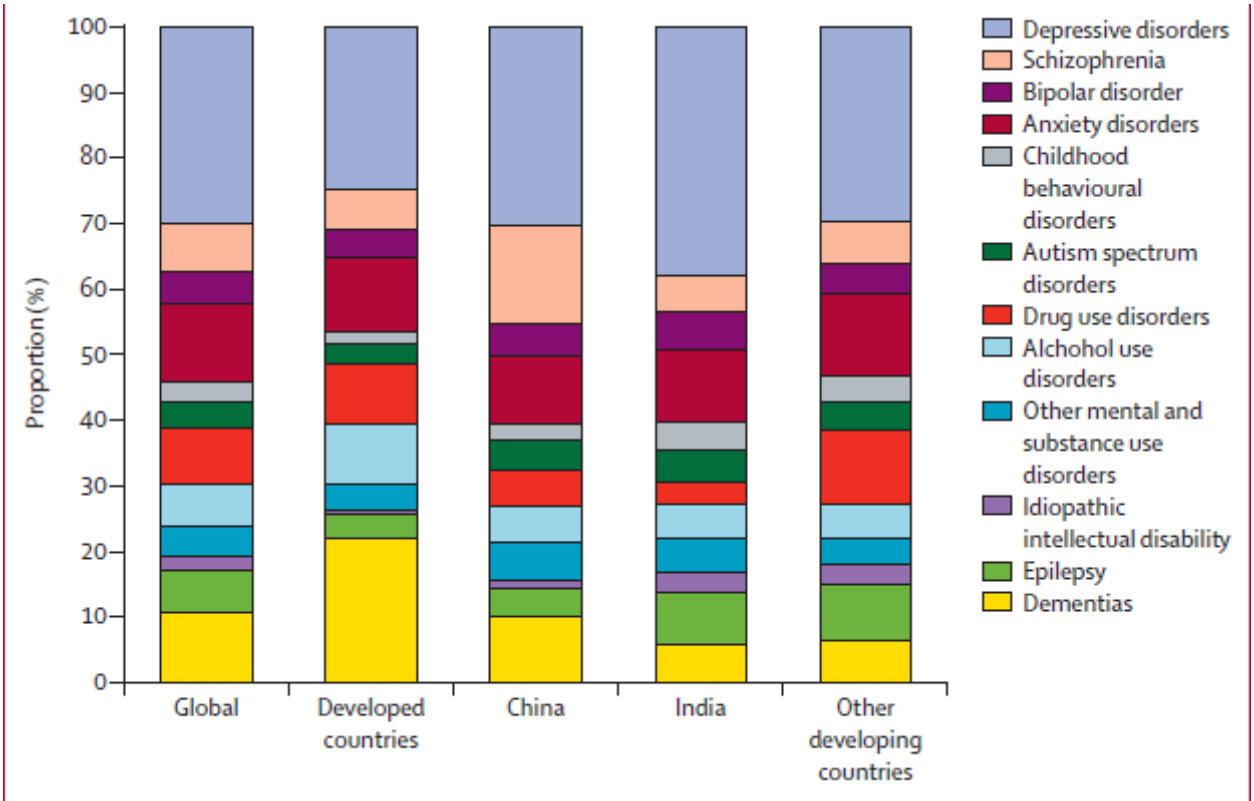
Analysis:

Analysis of the Policy was done as a part of review of literature and secondary data. This included the current mental health scenario of India, along with the future projections in comparison to the developed and the developing Nations. Detailed analysis of the current NMHP-2014 was carried out highlighting the aptness and limitations of the policy which was concluded with recommendations.

Where does India stand in terms of Mental illness:

Globally three quarters of the burden of mental neurological and substance disorders lie in developing countries, of which 15% is accounted to India. The burden of mental neurological and substance use in India is around 50% of the total burden of non-communicable diseases, similar to other developing countries. Mental neurological and substance use disorders account for around 31 million DALYs in India, which is around 6%

of the disease burden, this is projected to rise to 7.2% of the total disease burden, around 38 million DALYs, with depression being the leading cause of DALYs, which is similar to the scenario in other developing countries, where depression is the leading cause of disability. However, the scenario is different in developed nations where the leading cause of disability is dementia. The graph shows the burden of mental neurological and substance use disorders in India compared to global burden of disease.[10] The graph compares the burden of mental illness in India with the world. The scenario of mental illness is similar to that in the developing nations, where majority of the population is suffering from depression and the burden due to dementia is only a small proportion, while the burden due to dementia is higher in China and other developed nations. This indicates that the major proportion of the Indian population suffers from depression followed by schizophrenia, bipolar disorder and anxiety disorder.



Source: The burden of mental, neurological and substance use disorders in china and India

The graph below indicates DALYs due to mental neurological and substance disorders, and its age wise distribution, with comparison between India and China. It shows that burden of mental illness is high in the age group 15-34 years making it a priority

population.[10]

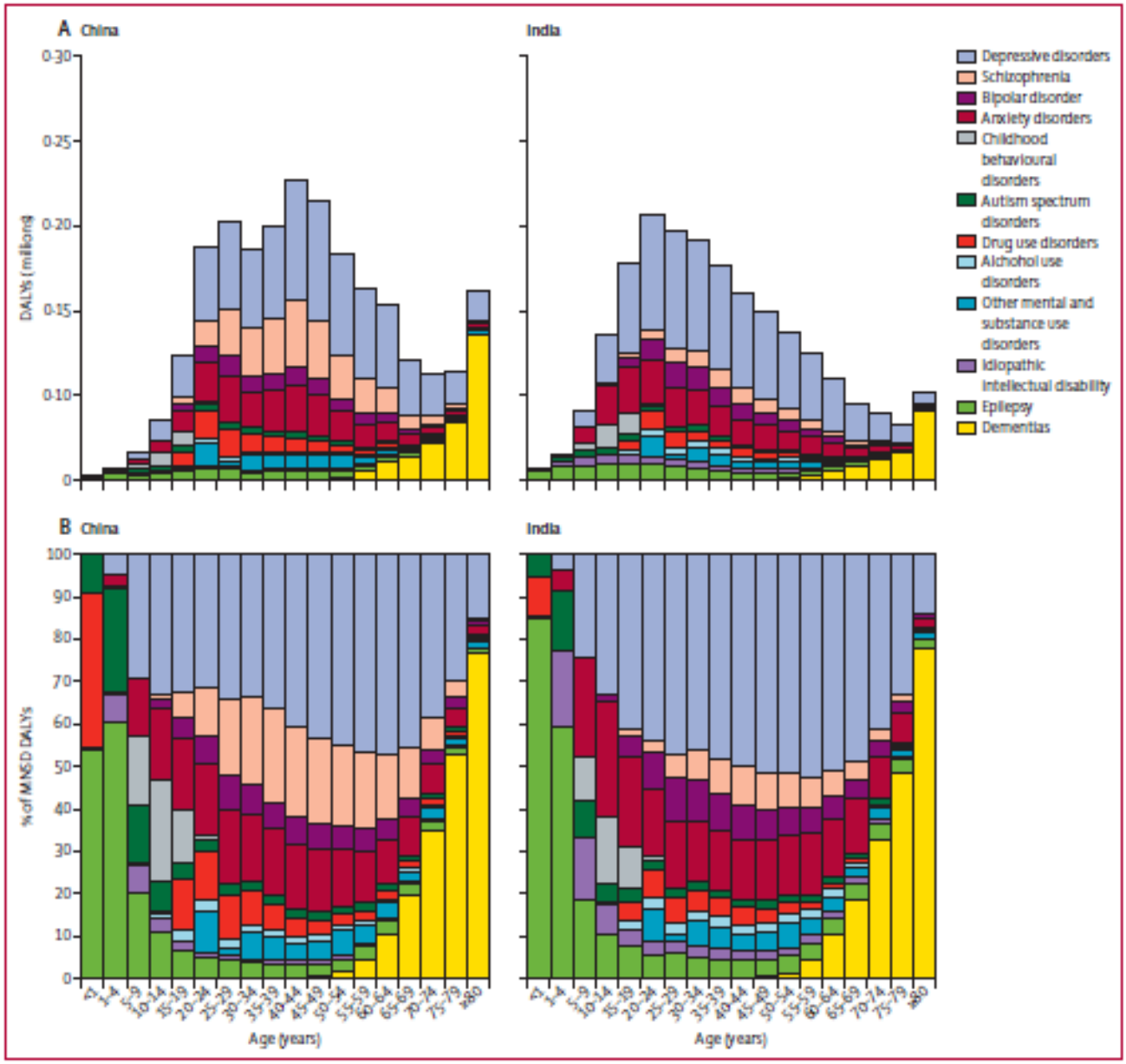


Figure 3: Number of disorder-specific DALYs (in millions; A) and proportions of all mental, neurological, and substance use disorder DALYs (B), by disorder for women in China and India, 2013

DALYs=disability-adjusted life-years. MNSD=mental, neurological, and substance use disorder.

Source: The burden of mental, neurological and substance use disorders in china and India

With constant growing population of India and increased life expectancy, the mental neurological and substance use disorders are estimated to increase by 7.2 million DALYs,

reaching to 38.1 million by 2025. [10]Therefore burden of disease reduction strategies are required. India has come up with a mental health policy to deal with the disease burden.

Mental Health scenario in India

Mental illness burden in India constitutes nearly one-sixth of the health related disorders, this is approximately 26% of the burden of priority non-communicable disorders is occupied by mental disorders [8] . India has reported a tremendous rise in the suicide rates, there has been a 27% increase in suicides between 1995 and 2005 with suicide rate of 10.5 per million which has now increased 21 per million people almost twice as the worlds average [7,8] Increase in suicide rate is just one indicator of the burden of mental illness in India. A study by National Commission on Macroeconomics and Health(NCMH) states that at least 6.5% of the Indian population suffers from some or the other mental illness.[8]The estimated prevalence of mental disorders in India ranges from 9.5 to 103 per 1000 population, the prevalence of individual psychiatric disorders per 1000 population in the Indian population is around : Psychosis (15.4), epilepsy (4.4), mental retardation (6.9), and neurotic disorders (20.7)[1,6].

The wide range of prevalence rates of mental disorders ranging from 9.5 to 103 per 1000 population indicates a lacunae in psychiatric disorders, the discrepancies are mainly due to the following reasons; case definition : when the definition of mental disorder fails to define a clear boundary, for instance when the threshold for defining a case is very low the prevalence rate for the disease will be high.[5,6] Under-reporting of the case due to stigma related to mental illness or inability to diagnose a case due to lack of trained manpower required to diagnose and treat mental illness[5,6] This hampers proper planning and policy making of mental health and also affects the distribution of resources.

Care givers burden

In India, the family as a unit forms to be an integral part of care giving for persons suffering from mental illness, the demands of being involved in the care of mentally ill patient takes a toll on the care-givers mental health status, currently 70-80 million care-givers needs are unaddressed.

Barriers to access and deliver mental health:

The greatest barriers to access services for mental health problems from the community side is due to the lack of people's knowledge about services for mental health illness, the stigma related to mental health, lack of help-seeking behavior, perception of people of the existing services including inadequate infrastructure, inadequate knowledge and information to the service providers.[8,12,15]

The barriers from the provider side which hinder in appropriate delivery of mental health services are mainly due to mental health being low public priority agenda which cause meager financing, and lack of interest of the donors. Furthermore, skewed distribution of the mental health resources in the urban areas prevents people residing in rural areas to seek treatment from formal health set-up. Treatment from traditional healers which is otherwise common in India, gets preference in case of mental health as mental illness is still largely perceived as the possession by the devil, particularly in remote rural areas. People trust traditional healers' more than seeking treatment from formal professionals. In addition, in India, training of medical students and psychiatric residents occur in medical hospital settings only where there is lack of adequate infrastructure and supervision.[8,12,15] Another major barrier is the inability to integrate mental health care into primary health care system,

because of over-burden of the primary care providers due to high patient load , lack of supervision and inconsistent supply of essential medicines[8]. This is amplified by the lack of trained human resources for delivery of mental health services.[12,8]

Human Resources and Infrastructure

Currently also India lacks sufficient trained mental health workforce rate per 100,000 population, there are 0.30 Psychiatrists, 0.07 mental health social workers, 0.07 Psychologists, and 0.12 mental health nurses, which adds up to total of 0.6 mental health workers per 100,000 population. There are 43 inpatient mental hospitals for a population of 1.2 billion which means that there are only 0.004 inpatient beds per 100,000 populations. There are 4000 mental health population indicating 0.329 out-patient facility per 100,000 populations.[17,18]. This workforce is skewed towards urban area, causing a 40-60 fold deficit in the mental health workforce. [2]

The National Mental Health Program:

India was the first post colonial independent country to have a reform for mental health. The national mental health program was created before three decades in 1982. The National Mental Health Program created in 1982, integrated workforce specialized in delivery of mental health services and non-specialized health workforce, who had no specialization in mental health services, but was a part of health care delivery system but, it failed in fulfilling its purpose of increasing availability and accessibility of providing mental health care, leading to stagnation of the program. Again in 1996, District Mental Health Program (DMHP) was launched because of the unleashment of human rights violations in psychiatric

and religious institutions. DMHP integrated community care as a part of integration of primary secondary and tertiary care. [2]. This was followed by reinvigoration of NMHP with an increase in budget of the program. This led to the training of medical officers on delivery of mental health services. Several reasons can be quoted for the failure of the NMHP and DMHP like:

- Lack of Governance: It lacked transparency and accountability, this in addition with inadequate leadership due to which the government failed to understand the gravity of mental health scenario and thus failed to integrate mental health into their agenda. Moreover there was absence of accountability and transparency, inadequate monitoring. Lastly it lacked participatory and inclusive decision making.[2]
- Financial barriers
- Delivery of mental health services mainly due to poorly motivated and trained health workforce [2].

As of 2015, DMHP should have been implemented in 241 out of 626 districts, but its success largely differs from state to state because of difference in allocation of budget state wise. DMHP is limited to psychiatric outreach clinics, therefore majority of people access mental health services in district health centers rather than primary health centers.[10]

Launch of National Mental Health Policy in 2014 came as a ray of hope to the underlying mental health issues. The policy aims to promote and prevent mental illness, remove stigma related to mental health and ensure equity in health care delivery while emphasizing vulnerable population. It also recognizes the relationship between social environment and mental health care.

The National Mental Health Policy -2014

The policy is built up on the vision to promote de-stigmatization and desegregation of mental health and enabling recovery of mental illness and prevention of mental illness by providing universal access to everyone. The policy is conducive and aims to provide a holistic approach to mental health which is inclusive and incorporates integrated care for the people suffering from mental illness and their care-givers.

Premise on which it is based

The fundamental principles on which the policy is made:

- Equity : Mental health services should be available to every individual without any discrimination, should fulfill the needs of the needy despite of the residence (rural/urban sensitization)
- Justice: The needs of the vulnerable and excluded members should be considered and delivered.
- Integrated care: The mental health services should be integrated in primary health care and provision of comprehensive services to the patients who need chronic care.
- Evidenced based care: Emphasis should be given to evidence based care and research.
- Participatory and rights based approach: The human rights of persons suffering from mental health should be protected and promoted; moreover care-givers rights should also be protected.
- Governance and effective delivery of services should be ensured by the respective governments.
- Overall ensure quality, value based services and holistic approach to mental health.

Issues it covers

People suffering from mental illness and their caregivers face a lot of issues that hinder them to access mental health services or the delivery of effective mental health services. Certain issues are addressed in the policy to fulfill the goals and objectives of the mental health policy:

- Stigma: One of the very common issue due to which most of the people suffering from mental illness do not seek treatment is stigma. Caregivers might be reluctant to seek treatment due to the stigma and discrimination faced by such people. The policy addresses this issue and encourages the Government, media and the community to encourage discussions in order to improve mental health services and scenario in India.
- Rights Based Approach: The Policy envisages a rights based approach to deliver services and ensure rights to the people affected by mental health and encourages that there should be more discussion in Public space to uphold the rights of people.
- Vulnerable Populations: Certain populations are at a higher risk of developing of mental illness and are devoid of mental health services such population are identified in the policy and encourages the government, media, and community to focus on such populations and ensure quality care to such people. The vulnerable populations bear a disproportionate and higher burden of mental illness. The vulnerable population mentioned in the policy include inter alia children (both school going and out of school),women, economically and socially deprived, older persons and persons with disabilities. The following conditions can increase the vulnerability:

- Poverty: Poverty is directly linked with mental health; people from lower socio-economic class are more vulnerable to suffer from mental health. Lack of mental health services and out of pocket expenditure can also push people towards poverty and make them more vulnerable.
- Homelessness: Homelessness, Poverty, and mental health have a vicious cycle leading them to mental illness. Such persons have a dearth of care-givers, or family and there is no provision for care and support.
- Persons inside custodial institutions and orphanages with Mental Illness: Persons inside custodial institutions are more prone to mental health like women and children in rescue homes, beggar homes or prisons. Children living in orphanages and orphans lack a support system or care givers throughout lifetime. There are inadequate mental health services for such population and also there has been a neglect regarding the needs of vulnerable population.
- Children with Persons with mental Health Related population: Children with mental health related problems are vulnerable due to inadequate care, parenting, schooling as well as poverty.
- Elderly Care Givers: These people are themselves at a vulnerable stage physically and mentally. Their unmet needs have a negative impact on their mental health status. The care givers burden is very high and their efforts often go unnoticed, the care givers can also be adolescents, single person responsible for livelihood and others.

  - Internally Displaced persons or Persons affected by disasters or emergencies: Due to a demographic shift from rural to urban areas, or persons affected by natural disasters are at a high risk of developing mental illness.
  - Other Marginalized People including commercial sex workers, people suffering from human trafficking, victims of riots, sexual minorities bear disproportionate burden of mental illness.

- Adequate Funding: In order to realize the vision and mission of the policy, there is a requirement of adequate funds, which has been highlighted in the policy and encouraged the states to increase allocation to mental health activities in the country and extend the District Mental Health Program. This has been enhanced in the recent Mental Health Bill passed by Rajya Sabha, allocating only 1% of the budget to mental health with states making comparable allocations. The amount allocated to mental health is less than what is required to cater the needs of the people suffering from mental illness, but the allocation has increased from 0.83 % in 2011 to 1%, which is a positive step. The Policy also encourages the flow of funds through interdependence between different departments such as social welfare, women and child development, school education. It is imperative to incorporate mental health into all these departments. Moreover, the policy encourages supporting the work of the NGOs in order to achieve a collaborative and sustainable response.
- One of the issues that is touched upon by the policy is the care-givers or the family's burden in order to support the person suffering from mental illness. The policy envisages this burden and throws light on care-givers burden and in providing them with adequate support, information or financial support. Moreover, the policy

emphasizes on inter-sector collaboration both within and outside the health department like education sector, employment sector, housing and others.

It covers the issues related to institutional care like limited access, inadequate staff and funds which compromises quality of care, therefore the policy aims to connect institutional care with community care both in private and public sector. In addition to that the policy encourages intersectoral collaboration with schools, employment, housing or social sectors since the needs of persons with mental health cannot be met only with health sector. Moreover, the mental hospitals in the country are in a bad shape and skewed towards urban areas, the policy encourages community care along with institutional care.

In addition to that, in order to sustain and to reduce the mental health burden in India it is imperative to generate knowledge by continuous research in the field of mental health and its implementation, finding answers to key questions like how to provide effective treatment, causes of mental illness which would aid in reduction of mental illness in the country. The Policy encourages performing Research and Monitoring and Evaluation in the field and provide evidence based care to the people suffering from mental illness.

The Policy aims to provide a holistic approach to mental health by providing a safe physical and social environment by integrating community care into it.

Implementation Plan

There are some strategic directions and recommendations provided in the policy to implement the policy. Each strategic area explained above is listed down to accomplish the vision of the policy.

Effective Governance and accountability for Mental Health requires the Government to develop relevant policies and allocate adequate budget for the same. In addition to that it includes involvement of the other stakeholders like family members, care-givers to motivate and encourage them in the implementation and monitoring of policies. Therefore, it encourages the central, state and district government to develop and plan a monitoring system for the sustainability.

Promotion of Mental Health includes the involvement of the Anganwadi workers and school teachers to cater to small children and their needs; it also includes educating the mother on parenting skills and education by redesigning of the angawadi centers, training anganwadi workers so that they can support and build confidence in the parents and the caregivers to understand the physical and mental needs of the persons suffering from mental illness. Furthermore, it encourages active participation of school teachers to build the knowledge of parents and facilitate positive environment for growth and development of children.

It encourages action to change the poor living conditions, develop a conducive environment at the workplace, schools as these are some conditions which make people vulnerable to mental illness It emphasizes on Life School Education Program (LSE) to be provided to children and young people via schools or youth clubs and early diagnosis of signs and symptoms related to mental illness in adolescents as majority of the mental illness begin from adolescents. The teachers should therefore be trained to detect early signs and symptoms equipped with a friendly environment. Furthermore, it promotes dissemination of

reliable information related to mental health to be easily available publicly and to supplement them with help lines, websites for easy flow of information. In addition to that, programs to reduce risk factors for women's mental health and include gender sensitization programs are also encouraged. In order to provide a holistic approach it envisages the involvement of AYUSH practitioners for promotion of health.

Prevention of mental illness and reduction of suicide and attempted suicide; it begins with addressing and elimination of stigma and discrimination towards mental illness and suicide or attempted suicide in addition, it encourages early treatment of people suffering from mental illness to participate in social and economic activities. Implement suicide reduction programs through help lines, involvement of community by training community leaders to detect early signs of suicide, and to set up crisis intervention centers as a part of DMHP, also to frame guidelines for media in reporting of suicide. This has been highlighted in the bill passed in Rajya sabha, which adopts a medical approach to attempted suicide, which blocks criminal charges against suicide [11]. It involves the facilitation of persons suffering from mental illness to improve their employability and encourage free communication of mental health to sensitize the people and reduce stigma.

One issue which is touched upon in the recommendation in the Policy is to address the issue of drug and alcohol abuse by developing a specific plan for reduction of drug and alcohol abuse.

Under universal access to mental health services, the policy mentions definite strategies to ensure universal access to mental health services by increasing range of availability of services in all Government health facilities not just for the person suffering but also for the family or the care-givers. Therefore it encourages implementation of screening programs for

early identification and treatment of persons suffering from mental illness. Furthermore to improve the infrastructure and funding for the mental health services, including monetary compensations and tax exemptions to the care-givers along with assisted shelters and domiciliary care for the persons suffering from chronic mental illness. The recent mental health bill aims to ensure the right to access mental care by everyone at an affordable rate and the availability of the mental health services at the district and the state levels with functional medical institutions in addition to free supply of essential mental health medicines at the government institutes.

To improve availability of adequately trained mental health human resources and to reduce the gap between requirement and availability of mental health services the policy emphasizes on training the existing man power, encourage training for all primary health care workers, integration of mental health training programs in all fields. In addition to that, it encourages forming of group of community based care by training of the existing care-givers. It also envisages training of auxiliary midwives and introduction of diploma courses for training of nurses in the field of mental health. The policy recommends more jobs to be envisaged in the government sector to encourage youngsters to take up such courses.

Under community participation, the policy envisages community participation by improving housing for the homeless, implementation of education and vocational training programs and to improve the social welfare of the people suffering from mental illness. Lastly, the policy emphasizes on a comprehensive research agenda to improve epidemiological basis for mental health and reduce the burden of mental illness.

A mental health action plan 365 is also released along with the policy, which explicitly mentions the functions to be performed by each stakeholder to achieve the goals and

objectives of the Policy. It mentions roles to be played by the central and state government, civil society organizations, users and care-givers, private corporate schools and colleges, private health care providers, medical colleges, media, research and academic institutes.

Policy Analysis:

The Policy therefore is inclusive in nature and tries to protect the human rights of the mentally ill and their care givers. The policy seems to be highly conducive in which seeks to promote, prevent and cause overall inclusion of the mentally ill persons by providing accessible and affordable care.

The policy acknowledges severe cross cutting issues like stigma related to mental illness, violations of the human rights of the people suffering from mental illness and their care givers by encouraging discussions in public and involving various stakeholders like Governments, Schools, Anganwadi Centers and NGOs encouraging people to seek treatment from the professionals.

The policy tries to address the infrastructure gaps in the system and aims to improve the infrastructure by reforming the institutions providing mental health care and incorporating community care along with institutional care. In addition to that the policy aims to address the human resource gaps by training the current workforce including anganwadi workers and school teachers for early detection and treatment of mental illness. In addition to that in order to increase workforce the policy encourages initiating diploma courses for workers so that a specialized cadre could be developed which is a positive step to increase the workforce. The policy also encourages the youth to take up courses related to mental illness by encouraging the government to make more job opportunities. In order to meet the current burden of

mental illness in the country around 140,000 psychiatrists are required[8]. Encourage youngsters to take up courses and building up a new specialized cadre would take up time which would serve in long term but in order to meet the current needs of the country it is imperative to train the current workforce and encourage community based care. The suicide rates have been highlighted in the policy and efforts have been made to address this issue by using a medical approach to it by introducing help-lines, enabling access to treatment by encouraging persons suffering from mental illness to participate in social activities to reduce exclusion, moreover to create an environment where persons with mental illness are enabled to take part in regular activities.

The efforts of the care givers and their unmet needs have been recognized in the policy and it encourages them to form community based care and provide them with emotional and financial support.

While there are strategies to address the barriers to mental health care, there is no mention to increase the workforce or infrastructure in the rural areas since majority of the infrastructure is skewed in urban areas. Moreover increasing partnership with private institutions would increase the out of pocket expenditure of the people which would further prevent them to seek services and also the health insurance in India does not provide exclusive coverage to treatment of mental illness.

The policy has also addressed issues due to which the previous National Mental Health Policy failed which were due to lack of governance, financial constraints, as well as inadequate manpower. These issues have been addressed in this policy by segregating and clearly mentioning the functions of each stakeholder. Moreover the policy identifies the need

of financial resources and provides measures to make the policy sustainable by supporting the work of NGOs working in the field.

Lastly, to address the wide range of prevalence rates in the country, to reduce the burden of disease by disseminating knowledge, improve efficiency of services and providing evidence based services by incorporating research and monitoring and evaluation as an important aspect of mental health.

The policy fails to address the role of traditional healers in the treatment of mental illness, as they form one of the major stakeholders in the field of mental health since mental illness till date in India is considered to be a devils sign or possessed by demons. Therefore majority of the population would prefer going to a traditional healer rather than to seek treatment from professionals.

The policy also does not address the relevance of mental health in youth as vulnerable population, as majority of the population is composed of youth in the country and the rising number of suicide and depression amongst youth is a great concern.

The Way Forward:

Mental illness has an enormous stigma attached to it making it difficult for the people who are suffering and their care givers. The policy addresses major issues faced by the people suffering and aims at increasing awareness among public in order to eliminate stigma and protect the human rights violation. It is therefore necessary to create awareness related to mental illness, make people realize that every individual is equally susceptible.

In order to make people access good quality services it is imperative to remove barriers from the provider side like the behavior of providers towards a person suffering from mental illness, as staff might harbor discriminatory attitude towards people suffering from mental illness. Moreover, in India the most common explanatory model for such illness is due to socio-cultural beliefs and thus people prefer going to traditional healers. Therefore it is necessary to create awareness among people to seek treatment from professional providers as compared to traditional healers. In addition to that, education and awareness can also be generated among the traditional healers regarding the importance of seeking treatment from professionals and training traditional healers in the mental health program could prove to be beneficial, it would cater to the rural population where there is dearth of mental health services and since majority of the population prefers traditional healers it would provide them with appropriate services and also generate official employment for traditional healers. Furthermore in order to cover gap between demand and supply the current staff and the community could be trained for task sharing interventions as suggested by WHO in the mhgap. Also programs like m-health which is being implemented in Tamil Nadu can be put in place to cover the treatment gap the primary care providers can be connected to the professionals in urban area through m-health to provide effective services.

The policy is inclusive in nature and approaches mental health in a holistic manner, the recommendations provided in the policy are pertinent to the mental health scenario of the country, and if implemented in the approved manner might reduce the burden of disease in the coming years.

Mental Health is principal to not just personal ell being but also family relationships and successful contribution to the society. The total numbers of people affected, the disability

associated with it and the fact that effective treatment is available will improve the quality of life of the patient, the care-giver as well as the society.

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