National Humans Right Commission

Online Short Term Internship Program (OSTI)- April, 2022

MENTAL HEALTH ISSUES: RESEARCH, POLICIES, AND CHALLENGES: THE INDIAN SCENARIO

Date: 29 April, 2022|Group 3|Guided by: Ms. Shaivi Pandey, JRC

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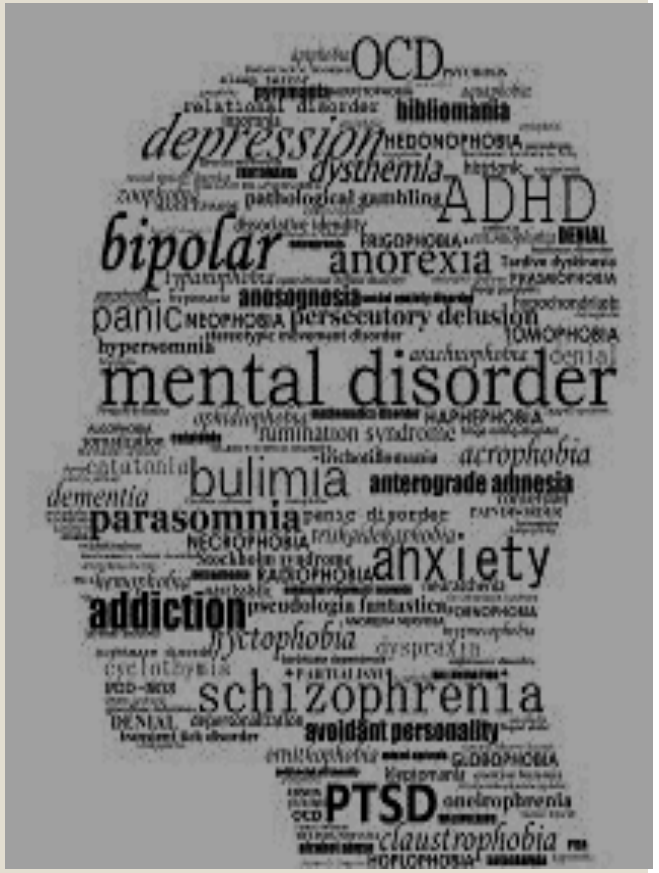
INTRODUCTION

- According to WHO Mental health is a state of complete **physical**, **mental** and **social well-being** and not merely the absence of disease.
- Mental illness refers to a wide range of mental health disorders that affect your mood, thinking, and behaviour.
- Health encompasses the composite union of physical, spiritual, mental, and social dimensions according to the World Health Organization (WHO), which recognizes that **“mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful, become creative and active citizens.”**
- A person with mental illness is entitled to treatment with the same **dignity** and decency as any other human being. His human rights flow from the fundamental **right to life as in Article 21** of the Indian Constitution
- In September 2015, mental health was included in the **UN Sustainable Development Goals (SDGs)**.
- In this historic step, the United Nations (UN) acknowledged the burden of disease of mental illness and defined mental health as a priority for global development for the next 15 years.



SOME WORRYING STATISTICS

- **13%** of disability- adjusted life years lost is because of mental disorders, with years lived with disability with depression being the leading cause (GLOBAL BURDEN OF DISEASE STUDY 2013)
- **300 million** – estimated population suffering from depression, equivalent to 4.4% of world's total population
- According to a study conducted by the National Institute of Mental Health and Neurosciences, India, in 2016, across 12 different states, the prevalence of depression for both current and lifetime is **2.7%** and **5.2%**, respectively
- Approximately **1 in 40** and **1 in 20** people are suffering from past and current episodes of depression all over the country
- Lifetime prevalence of mental disorder is **13.7%** as a whole, which would mean at least **150 million Indians** are in need of urgent intervention
- Over the next 10 years India will account for **one-third** of the global burden of mental illnesses, a figure greater than all developed countries put together.

MANIA

BIPOLAR

OBJECTIVE OF THE RESEARCH

- **To Analyse Government initiatives on empowering people in early detection and prevention of mental illness in India.**
- **To explore the initiatives by Government of India to overcome the shortage of mental health care workforce to provide adequate mental health service in India.**
- **Review the policies and programmes of India and to find out lacuna between policies and the implementation.**

Research Methodology

Secondary form of research has been used for above objectives using various data from online and offline sources
The paper is based on secondary data put together on mental health research, policies and challenges.

This study sets out to explore analyses and gain insight into mental health in India. Firstly various government and international organizations research on mental health and its challenges were studied elaborately. Along with that evolution of the Mental Health Policy in India was studied with its precursory Act and various judgments given by judiciary. There is an in-depth analysis of Mental Health Policy 2014 in this paper that highlights the positive and negative areas in it. A quantative as well as qualitative approach was selected as the most appropriate method for this exploratory research study.

RESEARCH

ICMR - mental disorders to the total disease burden in India in terms of DALYs increased from 2.5% in 1990 to 4.7% in 2017.

NMHS 2016 was conducted on a nationally representative sample of 34802 individuals, sampled from 12 states of India.

WHO 2005 report attributed 31·7% of all years lived-with-disability to neuropsychiatric conditions: the five major contributors to this total were unipolar depression (11·8%), alcohol-use disorder (3·3%), schizophrenia (2·8%), bipolar depression (2·4%), and dementia (1·6%).

UNICEF Only 41 percent of young people between the ages of 15 and 24 in India say it is good to get support for mental health problems.

CENSUS 2011 Mentally ill persons were enumerated for the first time.

Ministry of Health and Family Welfare

It is estimated that there are 3800 Psychiatrists, 898 Clinical Psychologists, 850 Psychiatric Social Workers and 1500 Psychiatric Nurses in the country. Recent estimates for State/UT wise details of trained mental health personnel's are not available.

There are three centrally run mental health institutes, 40 State run mental hospitals and 398 Departments of Psychiatry in various medical colleges (183 in Government and 215 in private) across the country equipped to treat patients suffering from mental illness.

◦ Renowned Medical Institute In India

1. **NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE**
2. **INSTITUTE OF HUMAN BEHAVIOUR AND ALLIED SCIENCES, NEW DELHI**
3. **INSTITUTE OF PSYCHIATRY (CIP), RANCHI**

Case Study

Kerela

Kerala is one of the few states that has a mental health policy. Kerala also has one of the highest budgetary allocations for mental health 1.16% of its total health budget. Most of the other states do not even allocate separate funds for mental healthcare.

The state administered UNARV, a model for adolescent mental health in schools at district level in 2007.

The Mental Health Action Trust (MHAT) is a Not-for-Profit organization that provides free, comprehensive, community-based, volunteer-led, cost-effective mental health care to the poorest people of the localities they serve, including the wandering homeless mentally ill.

Gujarat

Integration of religious and faith-based practices with modern mental health care interventions in religious and traditional healing places can immensely help communities; such a programme was started in 2007 in Gujarat at the Holy Shrine of Mira Datar Dargah in the district of Mahesana.

Quality Rights Gujarat Project is an innovative intervention to improve existing mental health services by reorienting services from a purely medical approach to a holistic, comprehensive and participatory approach that values and emphasizes on empowerment, autonomy, recovery and integration into the family and community

STATUTES

Mental Health Policy Plan, WHO (2005)

UNCRPD, 2007

- Undertake appropriate measures
- Art 2. Legal capacity
- Art 3. Access to support

RPWD, 2016

- Quality MH services
- Include vulnerable groups

MHA, 1987

MHA, 2017

- Right to information
- Right to confidentiality
- Right to make an advance directive
- Right to free legal aid and complain

PROGRAMMES


National Mental Health Program
Mental illness
Rehabilitation
Prevention and Promotion of mental health
District Mental Health Program
Modernisation of public psychiatric hospitals
Promotion of psychiatric in medical colleges
Community based in Mental Health Care
National Tele-mental Health Program
National Drug De Addiction Program
Virtual Conferencing Guidelines, 2021

Policies

National Mental Health Plan-365 (2013) (MHAP)

- To describe roles of each state holders

National Mental Health Policy, India (2014)

- To enhance understanding of MH in the country.
- To reduce the stigma
- provide universal access
- To reduce the risk of suicide
- To enhance financial allocation

National Health Policy of India (NHP, 2017)

- creation of specialists through public financing
- create a network of community members to provide psychosocial support
- To leverage digital technology

TABLE 1.

Timeline of the Major Policies/Plans/Acts/Laws Concerning National Mental Health Policy (NMHPolicy), India (2014)

Year	Policies/Plans/Acts/Laws, and the Implementing Agency	Aim/Goals
2005	Mental health policy, plan, and program (2005) (part of mental health policy and service guidance package), *WHO*	To present evidence-based guidance for the development and implementation of mental health policy, plans, and programs.
2007	United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007), UN	To promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and promote respect for their inherent dignity.
2013	Mental health action plan (2013–2020), *WHO*	To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights, and reduce the mortality, morbidity, and disability for persons with mental illness (PWMI).
2013	National mental health plan-365 (2013), *Govt. of India*	Delineating the envisaged roles and responsibilities of the stakeholders to facilitate achieving the objectives enshrined in the NMHPolicy
2015	Rights of persons with disabilities act (2016), *Govt. of India*	To give effect to the UNCRPD and for matters connected with it.
2017	Mental Healthcare Act (2017), *Govt. of India*	To provide mental health care and services for PWMI and to protect, promote, and fulfil the rights of such persons during delivery of mental health care and services and for matters connected therewith or incidental to it.
2017	National health policy (2007), *Govt. of India*	Envisages the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health-care orientation in all developmental policies, and universal access to good quality health care services, without anyone having to face financial hardship as a consequence; to be achieved through increasing the access to, improving the quality of, and lowering the cost of health care.

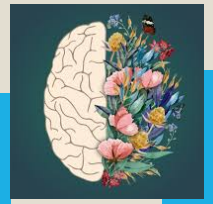
PRECEDENTS

- **Chandan Kumar Bhanik vs. State of West Bengal (1988)** - "Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues".
- **Sheela Barse vs. Union of India and others -** Admission of non-criminal mentally ill persons in jails is illegal and unconstitutional.
- **State of Gujarat and Another vs. Kanaiyalal Manilal and others** - Cost maintenance to be borne by the Government in case of mentally ill persons under Section 78 of the Mental Health Act .
- **Francis Coralie Vs Union of Delhi -** Right to life does not mean a mere animal-like existence but a more meaningful life, a life of physical and mental integrity.
- **State of Punjab and Others vs. Mohinder Singh -** The state government has a constitutional obligation to provide health facilities and denial of medical aid due to non-availability of beds in government hospitals amounts to violation of Article 21 .
- **Rakesh Ch. Narayan vs. State of Bihar -** Certain cardinal principles were laid down by the apex Court.
- **B.R. Kapoor and Anr. vs. Union of India -** The Supreme Court instructed the New Delhi administration to take immediate steps to set up a mental hospital-cum-medical college with sufficient autonomy to bring about quality changes in patient care.
- **Dr. Upendra Buxi vs. State of U.P. and others** - NHRC on its part conceptualised and translated to action a Project on Quality Assurance in Mental Health Care in the country and gave important recommendations.

CHALLENGES

POLICY (MHA, 2017)

- Mental Health Establishments
- Escaping from responsibility
- Admission criteria
- State's Despotism
- Funding Issue
- Half-way homes
- Mental health units at prison
- Mental Health Review Board



GENERAL

- Access
- Affordability
- Awareness
- Treatment gap
- Insensitivity towards mentally ill
- Inadequate Budget allocation
- Human Resource shortage
- Minimal Collaboration & Rehabilitations
- Poor monitoring & Evaluation of Health Programmes

VULNERABLE GROUPS

- LGBTQIA+
- Prisoners
- Increased Education Competition
- Unemployment
- Farmers suicide

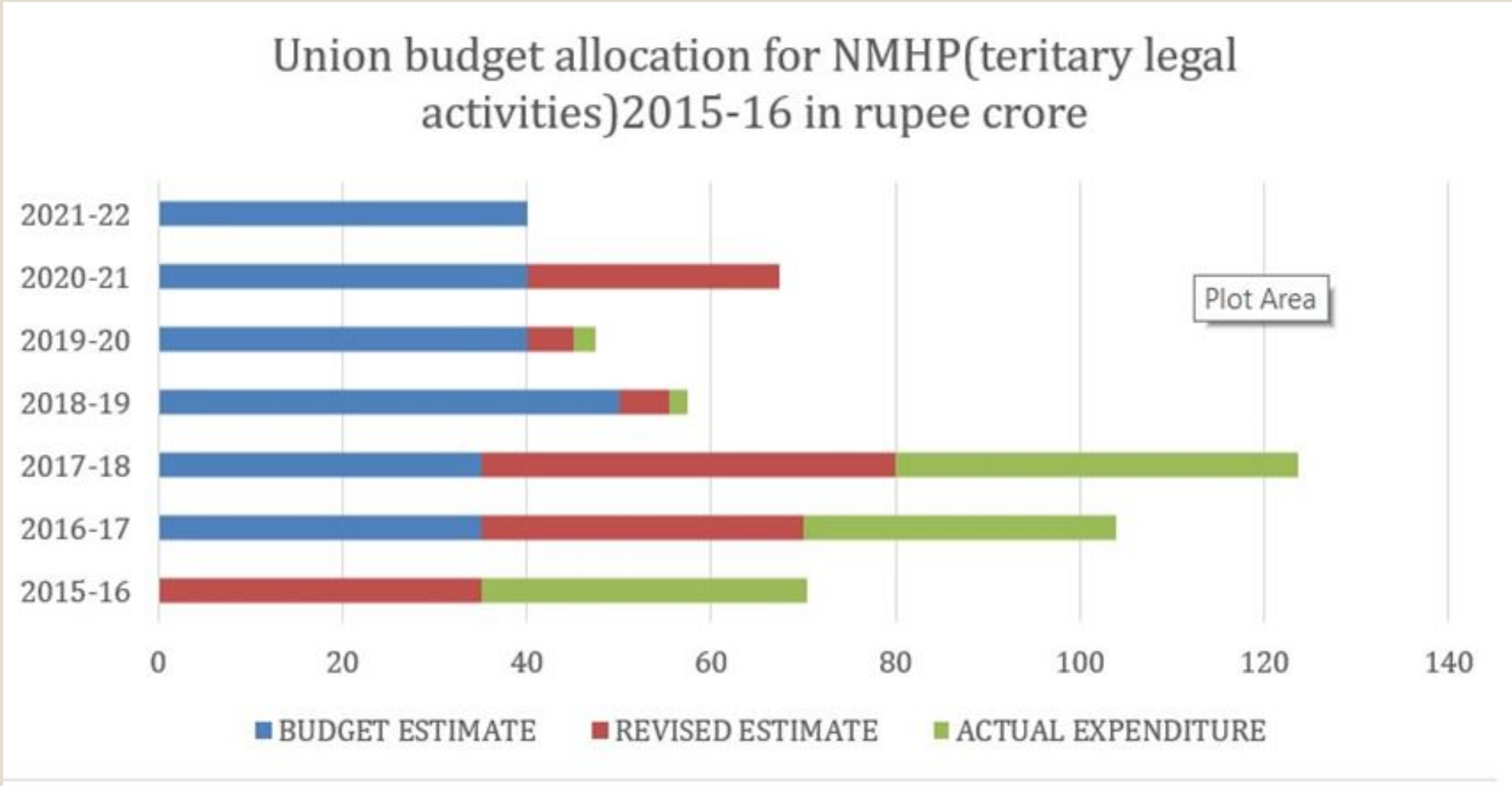


Fig. Union Budget allocation for mental health programmes, Source: India mental health observatory for Budget or mental health, Analysis of union budget 2021-22

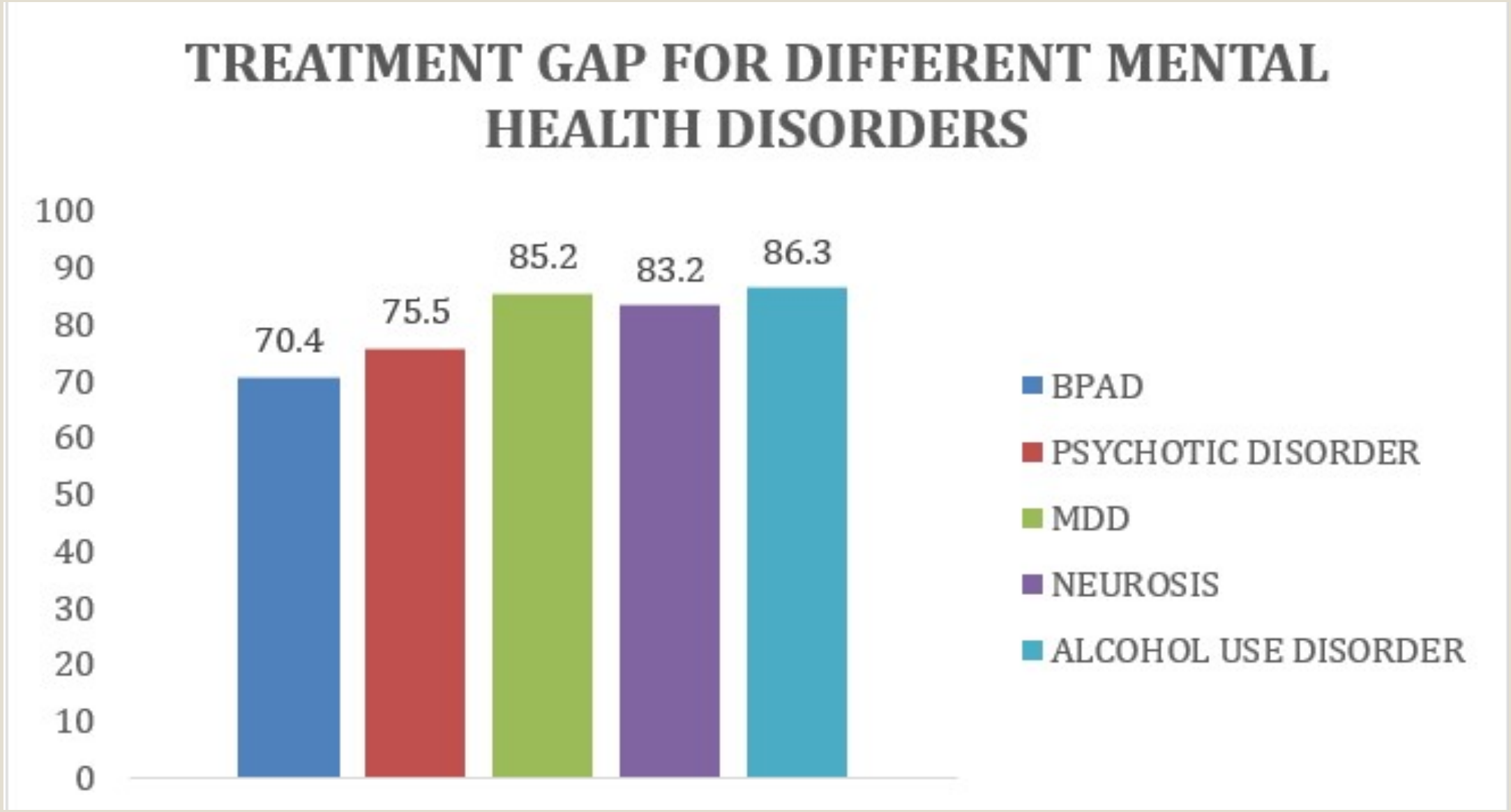


Fig. Treatment gap between various disorders, Source: NHMS 2016 Summary report

Summary.pdf (nimhans.ac.in)bClosing the treatment gap - PMC (nih.gov)

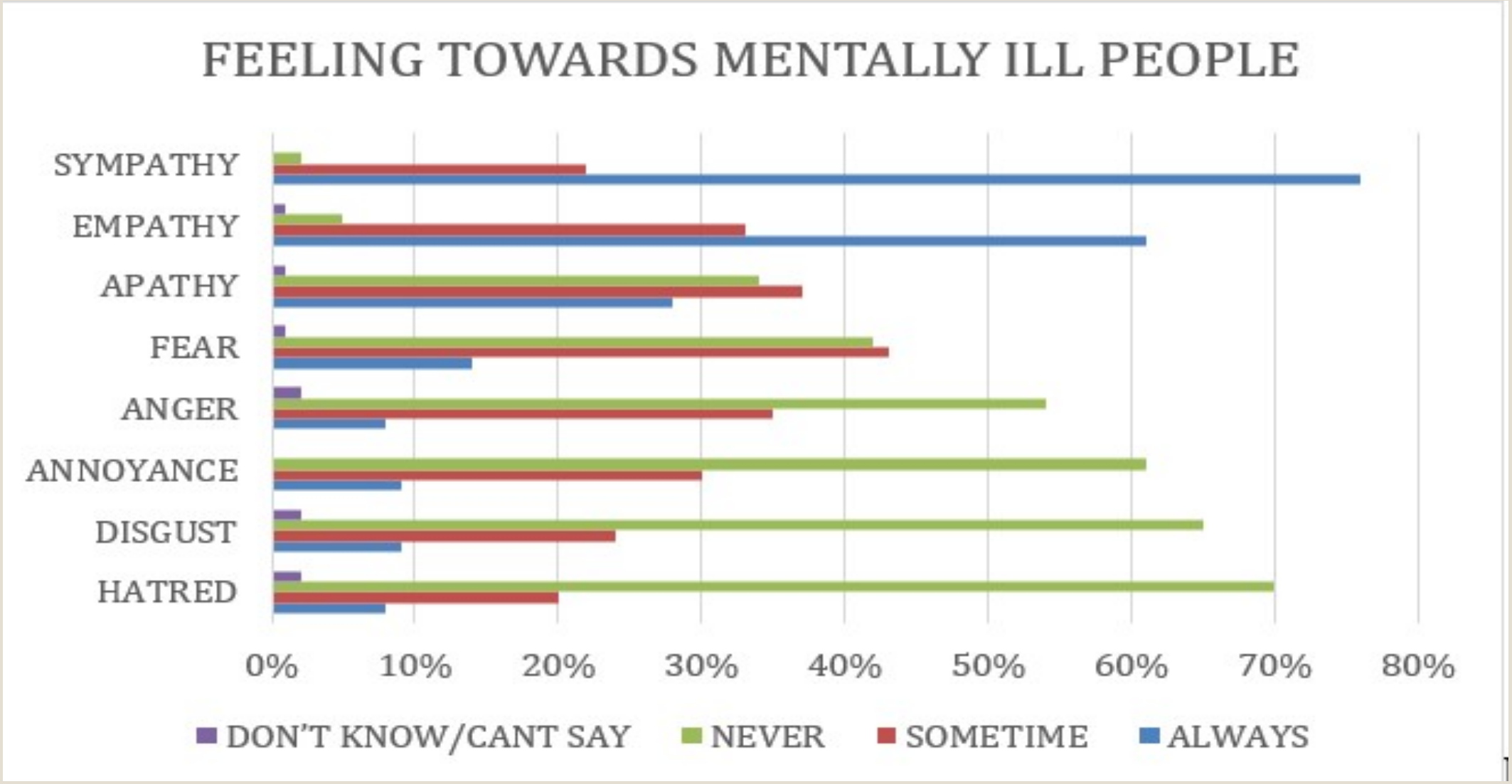
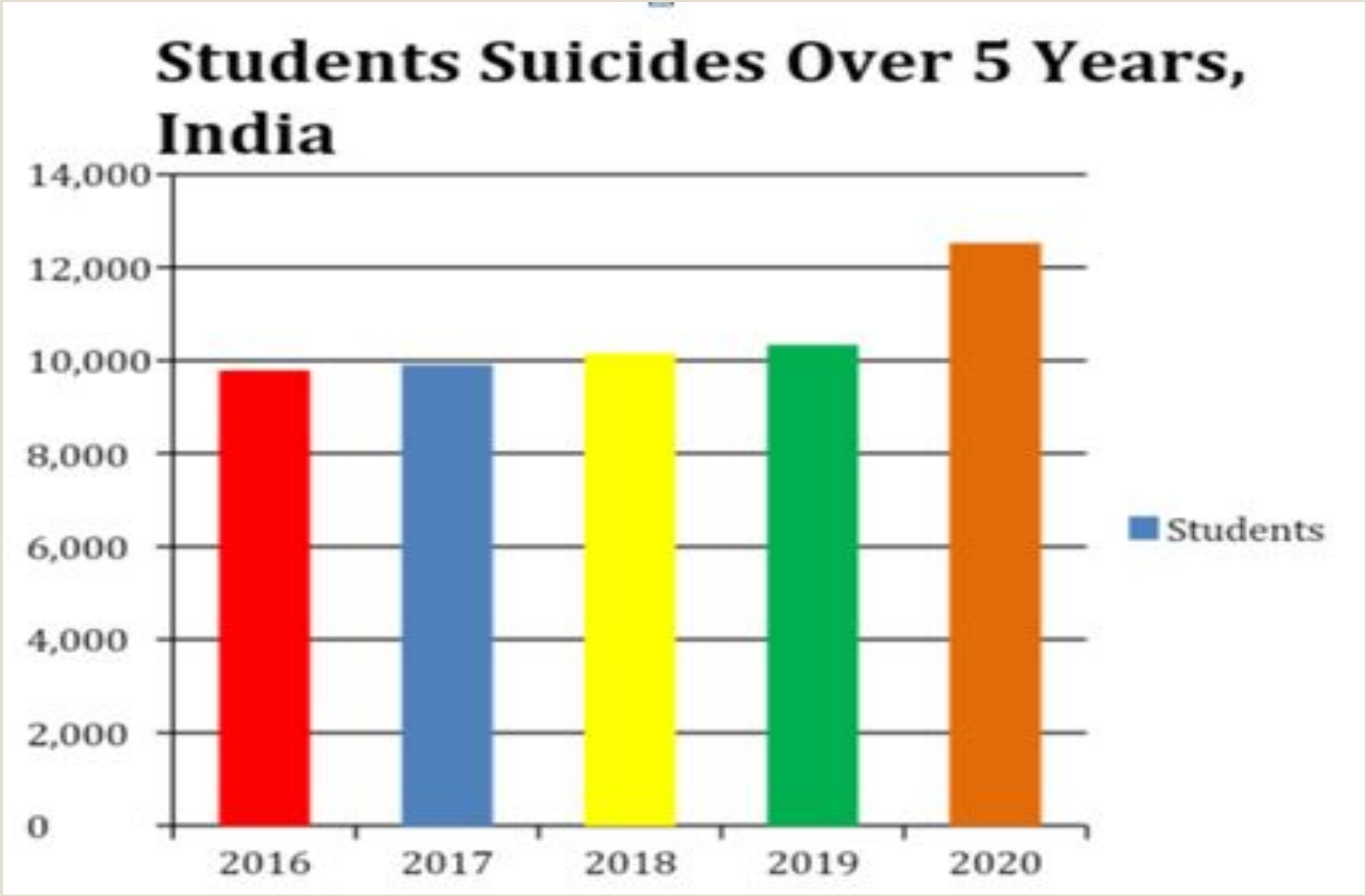
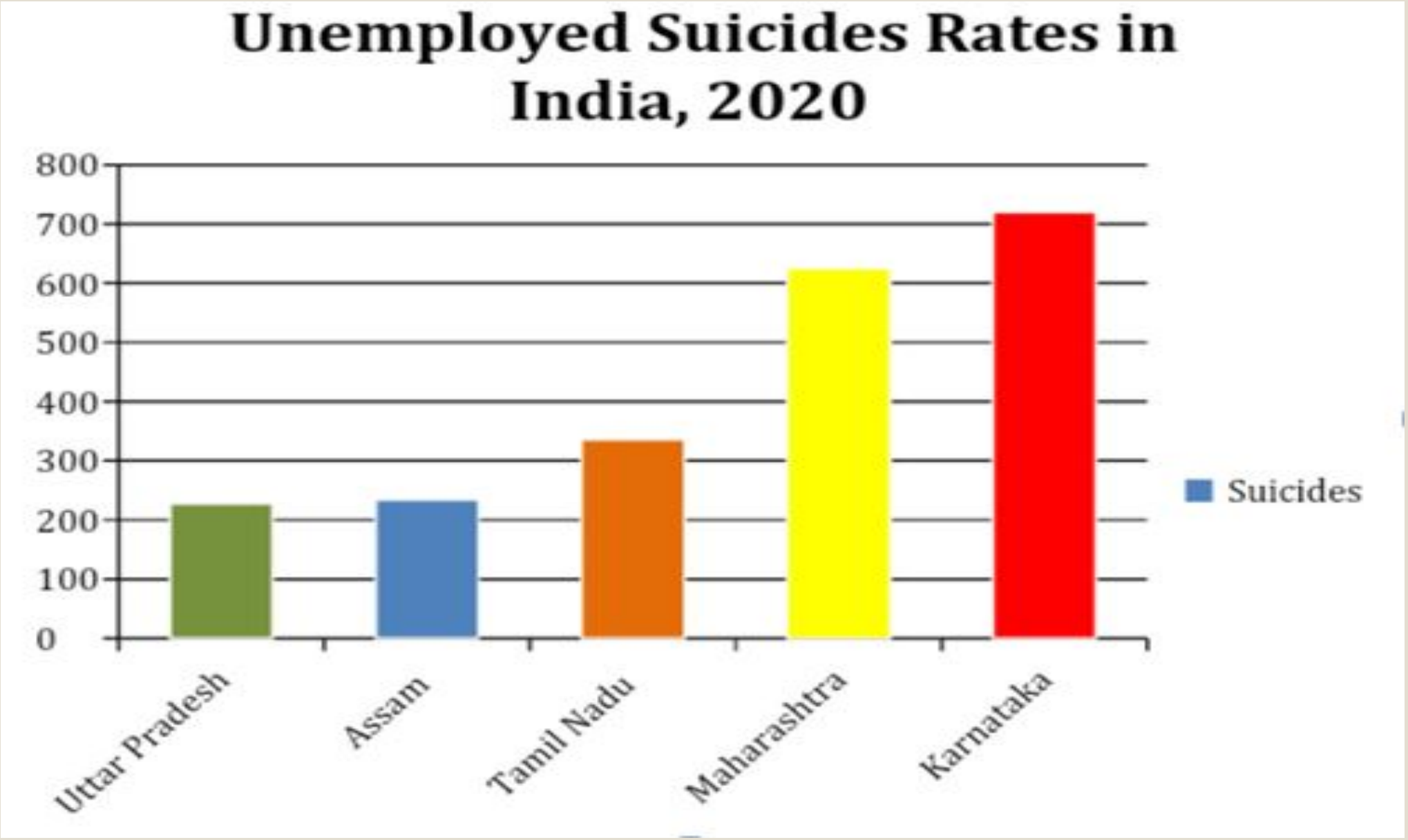


Fig. Public feeling towards mentally ill, Source: live love laugh foundation survey, 2018



Source: National Crime Records Bureau (NCRB).



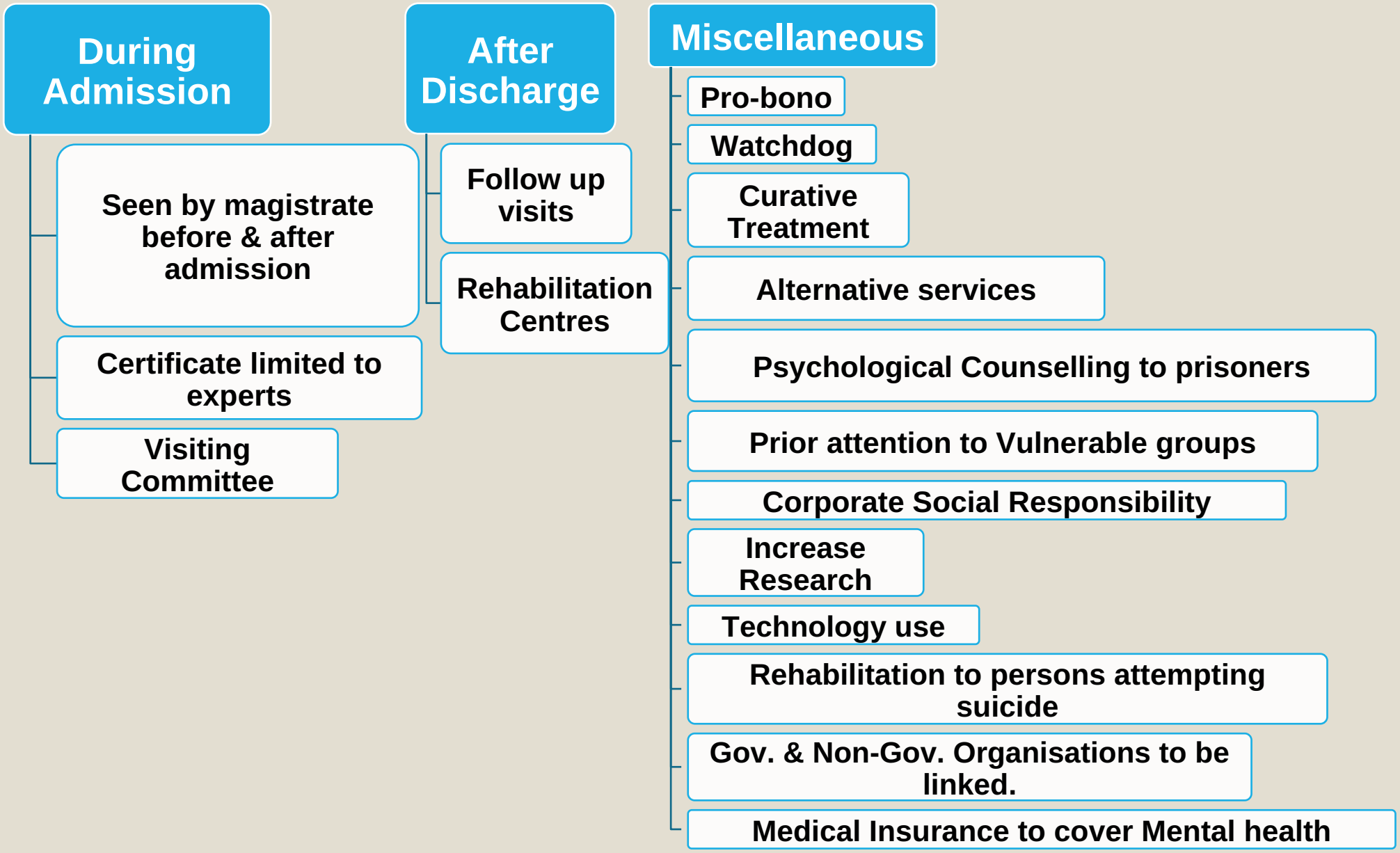
Source: National Crime Records Bureau (NCRB).

RECOMMENDATIONS

Policies

- **Mental Health Act, 2017**
  - Emergency Ambulances/ Escort
  - Rehabilitation after release
  - Pre-Trial assessment
  - Convalescent home & psychiatric hospital
  - Choice of treatment
- **Persons with disability act, 1995**
  - Half- way homes
  - Certificate of temporary disability
  - Representation in Central Coordination Committee
- **Narcotic Drugs & psychotropic Substances act, 1985**
  - Life Time Immunity
  - Different Between offender groups
  - Action group based


Education policy
Integrated approach to treatment, training, teaching & research
Re-Integration into mainstream
Undergraduate / Diplomas / Post-graduate
Schools & Hospitals need to have psychologists
Community outreach programmes
Para-Professionals
Social Workers in mental Hospitals
Arrangement for care & support of families
Hospital level
Pay condition improve of staff
Outdoor clinics
Good will
Prior Magistrate consent on ECT


During Admission
Seen by magistrate before & after admission
Certificate limited to experts
Visiting Committee
After Discharge
Follow up visits
Rehabilitation Centres
Miscellaneous
Pro-bono
Watchdog
Curative Treatment
Alternative services
Psychological Counselling to prisoners
Prior attention to Vulnerable groups
Corporate Social Responsibility
Increase Research
Technology use
Rehabilitation to persons attempting suicide
Gov. & Non-Gov. Organisations to be linked.
Medical Insurance to cover Mental health

Conclusion

Policies should be-

Mental Health ∝ crime


We Can Talk About It, I Am Here"
#SPEAKUP
Smile Again
MENTAL ILLNESS IS NOT A
NO HEALTH WITHOUT MENTAL HEALTH
YOU ARE NOT ALONE
Self care isn't Selfish

#SPEAK UP


MATTERS
STOP
To HEALING
Don't be So hard on Yourself
YOUR MENTAL HEALTH IS A PRIORITY
DEPRESSION PANIC ATTACKS and ANXIETY is REAL
Don't Suffer Silently #SPEAKUP
SELF-CARE IS HOW YOU TAKE YOUR POWER BACK

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Short Video On Mental Health Awareness– 1 min

https://drive.google.com/file/d/1D4s83HM324PA3O0MCR_PZvtLmdfarPmY/view?usp=sharing

“What mental health needs is more sunlight, more candor, and more unashamed conversation.”

- Glenn Close

Thank You!!!

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29 APRIL, 2022

Guided by - Ms. Shaivi Pandey

SUBMITTED BY: GROUP 3

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ACKNOWLEDGEMENT

Presentation, inspiration and motivation have always played a key role in the success of any venture. We feel to acknowledge our indebtedness and deep sense of gratitude to NHRC for providing us with the research project **"Mental Health Issues: Research, Policies, and Challenges: The Indian Scenario".** We would like to express our sincere thanks to our Project Mentor **Ms. Shaivi Pandey** whose valuable guidance and supervision helped us to complete the research paper. The reports would not have been possible without the valuable feedback and necessary inputs which become the core research area of the project. We are also immensely grateful to NHRC's authority for allowing us to collaborate as a part of a team of students from different colleges and different backgrounds from all over India. It was a one-of-a-kind experience and a highly sought-after chance. We would like to express our gratitude to everyone who helped us to finish this report.

Above all, to the great Almighty, the author of knowledge and wisdom for his countless love. Also, we are extremely grateful to our family and friends for their everlasting motivation.

We thank you.

DEFINITIONSAND TERMINOLOGIES

Mental health is a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community. Mental Health is not just absence of mental disorder. It refers to the broad array of activities directly or indirectly related to mental wellbeing. This is in keeping with the **World Health Organization's definition** of health: **A state of complete physical, mental and social well-being and not merely the absence of disease.**Mental Health is also related to promotion of mental well-being, prevention of mental disorders and treatment and rehabilitation of people affected by mental disorders.

Mental health problems refer to conditions ranging from psycho-social distress affecting a large number of people to mental illness and mental disability affecting a relatively small number of people.

Mental illnessrefers to specific conditions such as Schizophrenia, Bipolar Disorder, Depression or Obsessive Compulsive Disorder.

Mental Disabilityrefers to disability associated with mental illness. While mental illness is a medical construct, disability is better understood using a medico-socio model and the two terms are used synonymously sometimes. It is important to note that not all persons with mental illness will have a disability, although many will experience it due to various barriers which may hinder their full and effective participation in society on an equal basis with others.

Persons with mental illness and persons (s) with mental health problems refer to persons who have mental illness and mental health problems respectively. It is necessary to emphasize that mental health illness or mental health problems do not constitute a person's identity and that a person and an illness and/or problem are distinct from each other.

Persons affected by mental illness include person(s) with mental illness and significant others such as family members and caregivers.

Recovery is defined as a process of change through which individuals improve their health and wellbeing, live a self-directed life and strive to reach their full potential.

ABSTRACT

In this research paper, we have studied and addressed the implications on Mental Health, research that has been done till now pertaining to issues of mental health, policies, programmes, challenges and their recommendations. Early intervention can help reduce the severity of an illness. It may even be possible to delay or prevent a major mental illness altogether. Learn and study on the fundamental rights of Mentally Ill person. We have also analysed the case studies on particular states in India namely Kerala, Gujrat, Tamil Nadu etc. to understand India's progress towards Mental Health. We can also conclude that Mental Health Policies needs to be revisited. There are various general Challenges that lies ahead on Mental Health based on our research case affects numerous sections and groups of the Indian society. We have also given recommendation and solutions that can be put forth with the aim on achieving the gap of India's progress towards efficient implementation of Mental Health policies and challenges."Just as with other medical illnesses, early intervention can make a crucial difference in preventing what could become a serious illness"

Keywords*: Mental health, Mental illness, Depression, Anxiety, disability, case study, bi-polar disorder, Mood disorder, DHD, autism spectrum, panic, OCD ,phobia ,depression, bipolar, mood disorders, eating , personality, PTSD, Psychotic including schizophrenia.*

INTRODUCTION

"What mental health needs is more sunlight, more candour and more unashamed conversation." -Glenn Close

Mental Health is an integral and essential component of health. The **WHO** constitution states: "**Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.**" An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

Health encompasses the composite union of physical, spiritual, mental, and social dimensions according to the World Health Organization (WHO), which recognizes that "mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful, become creative and active citizens." Mental health is significantly different from general health as in certain circumstances mentally ill people may not be in a position to make decisions on their own.[i]

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism, mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience. On the other hand, a mental disorder or mental illness is an involuntary psychological or behavioural pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture.[ii]

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support. Stress, genetics, nutrition, perinatal infections and exposure to environmental hazards are also contributing factors to mental disorders.[iii]

The pandemic has had a huge impact on people's mental health, both positive and negative. The lockdowns have given some people an opportunity to work (or study) from home, enabling them to spend more time with their family and build relationships. This, in turn, can enhance psychological wellbeing and a feeling of contentment. But the larger population is faced a strong negative impact of COVID-19 on their mental health. For example, COVID-19 positive patients often suffer from depression, anxiety, and post-traumatic stress related to the disease. Frontline workers often face stigma from their community and family and have to deal with the fear of getting infected. They also suffer from burnout, anxiety, and insomnia related to overwhelming workloads. Studies reveal that mental health issues like anxiety, depression, stress, psychological distress, loneliness have emerged progressively among the general population during the COVID-19 outbreak. Increased suicidal ideation and suicide, specifically among youth are an important concern during this time, which could be triggered by the isolation during the quarantine during the lockdown period.

Mental illness lasts for a protracted period and has a lifelong impact which gradually results in a poor quality of life.[iv]

Those who suffer rarely get access to appropriate medical counselling and treatment as their families try to hide their condition out of a sense of shame.[v] This attitude not only harms patients but also leaves them vulnerable to exploitation, abuse, neglect, and marginalization.[vi]

The global burden of disease report states that mental disorders account for 13% of total disability-adjusted life years lost[vii], with years lived with disability with depression being the leading cause.[viii] Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: A systematic analysis for the global burden of disease study 2013. [ix]

Over 300 million people are estimated to suffer from depression, equivalent to 4.4% of the world's total population. Various researches have demonstrated the close association of mental disorders as precursors of a wide range of acute and chronic conditions such as non-communicable diseases, injury and violence, and poor maternal and child health conditions. [x]

According to a study conducted by the National Institute of Mental Health and Neurosciences, India, in 2016, across 12 different states, the prevalence of depression for both current and lifetime is 2.7% and 5.2%, respectively[xi]. Approximately 1 in 40 and 1 in 20 people are suffering from past and current episodes of depression all over the country.[xii]

This survey has shown that the lifetime prevalence of mental disorder is 13.7% as a whole, which would mean at least 150 million Indians are in need of urgent intervention.[xiii] Mental illness in vulnerable age groups such as adolescent and in geriatric population accounts for more than half of the total burden.[xiv]

Another report regarding the projected burden of mental illness conveys that it will increase more rapidly in India than the other countries over the next 10 years and will account for one-third of the global burden of mental illnesses, a figure greater than all developed countries put together.[xv]

In spite of this big burden of mental health issues, unfortunately, it continues to be misunderstood in developing countries like India.[xvi]

Another critical aspect is the existing infrastructure and workforce in our country to address this health challenge. There are just about 40 mental institutions (out of which only nine are equipped to provide treatment for children) and fewer than 26,000 beds available for a nation comprising 150 billion people.[xvii]

The WHO report on the Mental Health Atlas reveals that there are just three psychiatrists, and even lesser number of psychologists for every million people in India, which is 18 times fewer than the commonwealth norm of 5.6 psychiatrists/100,000 people.[xviii]

Keeping in view the massive health burden of mental illness in our country, existing inadequate infrastructure/workforce, the social stigma attached, and glaring shortcomings of Mental Healthcare Act 1987, it becomes imperative for the government and various stakeholders to

address these issues. There is also a need to work on the country's international obligation toward the mentally ill people as per the Convention on Rights of Persons with Disability (2007) and its optimal protocol.[xix]

Hence, a patient-centric bill that safeguards available, affordable, and accessible mental healthcare services was a long due in India.[xx]

A person with mental illness is entitled to treatment with the same dignity and decency as any other human being. His human rights flow from the fundamental right to life as in Article 21 of the Constitution which includes:

- Right to living accommodation, food, potable water, education, health, medical treatment, decent livelihood and congenial existence
- Right to privacy, speedy trail (if involved in any criminal offence) information and means of communication[xxi]

TYPES OF MENTAL ILLNESSES:

1) Anxiety disorders

According to the Anxiety and Depression Association of America, anxiety disorders are the most common types of mental illness. People with these conditions have severe fear or anxiety, which relates to certain objects or situations. Most people with an anxiety disorder will try to avoid exposure to whatever triggers their anxiety.

Examples of anxiety disorders include -

a) **Generalized anxiety disorder (GAD):**The American Psychiatric Association define GAD as disproportionate worry that disrupts everyday living. People might also experience physical symptoms, including

- restlessness
- fatigue
- tense muscles
- interrupted sleep

About of anxiety symptoms does not necessarily need a specific trigger in people with GAD. They may experience excessive anxiety on encountering everyday situations that do not present a direct danger, such as chores or keeping appointments. A person with GAD may sometimes feel anxiety with no trigger at all.

b) PANIC DISORDERS: People with a panic disorder experience regular panic attacks, which involve sudden, overwhelming terror or a sense of imminent disaster and death.

c) PHOBIAS: There are different types of phobia:

- Simple phobias: These might involve a disproportionate fear of specific objects, scenarios, or animals. A fear of spiders is a common example.
- Social phobia: Sometimes known as social anxiety, this is a fear of being subject to the judgment of others. People with social phobia often restrict their exposure to social environments.
- Agoraphobia: This term refers to a fear of situations in which getting away may be difficult, such as being in an elevator or moving train. Many people misunderstand this phobia as a fear of being outside.

Phobias are deeply personal, and doctors do not know every type. There could be thousands of phobias, and what might seem unusual to one person may be a severe problem that dominates daily life for another.

d) Obsessive-compulsive disorder (OCD): People with OCD have obsessions and compulsions. In other words, they experience constant, stressful thoughts and a powerful urge to perform repetitive acts, such as hand washing.

e) Post-traumatic stress disorder (PTSD): PTSD can occur after a person experiences or witnesses a deeply stressful or traumatic event. During this type of event, the person thinks that their life or other people's lives are in danger. They may feel afraid or that they have no control over what is happening. These sensations of trauma and fear may then contribute to PTSD.

2) Mood disorders:

People may also refer to mood disorders as affective disorders or depressive disorders. People with these conditions have significant changes in mood, generally involving either mania, which is a period of high energy and elation, or depression. Examples of mood disorders include:

- **Major depression**: An individual with major depression experiences a constant low mood and loses interest in activities and events that they previously enjoyed. They can feel prolonged periods of sadness or extreme sadness.
- **Bipolar disorder**: A person with bipolar in their mood, energy levels, levels of activity, and ability to continue with daily life. Periods of high mood are known as manic phases, while depressive phases bring on low mood.
- **Seasonal affective disorder (SAD)**: Reduced daylight triggers during the fall, winter, and early spring months trigger this type of major depression
- It is most common in countries far from the equator.

3) Schizophrenia disorders:

Mental health authorities are still trying to determine whether schizophrenia is a single disorder or a group of related illnesses. It is a highly complex condition. Signs of schizophrenia typically develop between the ages of 16 and 30 years.According to the NIMH, The individual will have thoughts that appear fragmented, and they may also find it hard to process information. Schizophrenia has negative and positive symptoms. Positive symptoms include delusions, thought disorders, and hallucinations. Negative symptoms include withdrawal, lack of motivation, and a flat or inappropriate mood.

4) Psychosis:

People affected by psychosis can experience delusions, hallucinations and confused thinking.. Psychosis can occur in a number of mental illnesses, including drug-induced psychosis, schizophrenia and mood disorders. Medication and psychological support can relieve, or even eliminate, psychotic symptoms.

5) Paranoia:

Paranoia is the irrational and persistent feeling that people are ‘out to get you’. Paranoia may be a symptom of conditions including paranoid personality disorder, delusional (paranoid) disorder and schizophrenia. Treatment for paranoia includes medications and psychological support.

6) Eating disorders:

Eating disorders include anorexia, bulimia nervosa and other binge eating disorders. Eating disorders affect females and males and can have serious psychological and physical consequences.

Learning about developing symptoms, or early warning signs, and taking action can help. Early intervention can help reduce the severity of an illness. It may even be possible to delay or prevent a major mental illness altogether.

MENTAL HEALTH AND SUSTAINABLE DEVELOPMENT GOALS

The critical role of mental health in achieving global development goals has been highlighted by including mental health in the Sustainable Development Goals. In September 2015, mental health was included in the UN Sustainable Development Goals (SDGs). In this historic step, the United Nations (UN) acknowledged the burden of disease of mental illness and defined mental health as a priority for global development for the next 15 years. On the road to this achievement, many individuals and organizations have played a role in contributing to the inclusion of mental health in the SDGs, one of which is the global initiative called Fundamental SDG. This group has urged the UN to include mental health in the new development goals, targets, and indicators.

REVIEW OF LITERATURE

Mental Health issues are one of the most pressing concerns worldwide. Mental health is one of the leading causes of disability and a burden economically and socially. Two of the most common mental health conditions, depression, and anxiety, cost the global economy US$ 1trillion each year. It affects all areas of life, such as school, work performance, relationships with family and friends, and the ability to participate in the community. In this paper we have undergone various papers and articles.

Untreated mental illness results in stigma, marginalization and discrimination often worsening one's quality of life. This leads to a substantial loss of social and human capital, adversely impacting a large number of individuals and families have been very well explained by ICMR. (ICMR official website).[xxii]

The National Human Rights Commission, NHRC conducted a Core Group on Health and Mental Health to understand the issues and rights of leprosy affected people during COVID-19 and gave important suggestions. Those suggestions have well understood and critically examined in this paper.(NHRC, Recommendations) [xxiii]

Timely review of developments in mental health care in India since the initial involvement of the NHRC through the 1999 quality assurance report given by D Nagaraja and pratima, was also looked upon while writing this research paper. (D Nagaraja, DPM, DM (Neurology))[xxiv]

There is an urgent need to infuse more financial and human resources that can be utilized in organizing awareness campaigns; mobilize community resources by training the community health workers, laypersons, and community members in rehabilitative services;[xxv] provide rehabilitative services at multiple levels (daycare and residential care, routine psychosocial activities, outreach activities, livelihood activities, etc.); and set up integrated CBR programs by various stakeholders.[xxvi]

India being a signatory to it, launched her national mental health policy (NMHPolicy) in 2014. [xxvii]

The policy was in concordance with WHO's mental health (MH) policy, plan, and program (2005), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007).

OBJECTIVE OF RESEARCH

- To Analyse Government initiatives on empowering people in early detection and prevention of mental illness in India.
- To explore the initiatives by Government of India to overcome the shortage of mental health care workforce to provide adequate mental health service in India.
- Review the policies and programmes of India and to find out lacuna between policies and the implantation.

RESEARCH METHODOLOGY

The paper is based on secondary data put together on mental health research, policies and challenges. This study sets out to explore analysis and gain insight into mental health in India. Firstly various government and international organizations research on mental health and its challenges were studied elaborately. Along with that evolution of the Mental Health Policy in India was studied with its precursory Act and various judgments given by judiciary. There is an in-depth analysis of Mental Health Policy 2014 in this paper that highlights the positive and negative areas in it. A quantative as well as qualitative approach was selected as the most appropriate method for this exploratory research study. After studying the policies and research on mental health in India its challenges were discussed among the group members and collectively recommendations were put forward. This paper comes with various limitations as it is based on secondary data and is put together on short period of time.

RESEARCH

ICMR - Indian Council of Medical Research

There was hardly any research on mental health in India till the time of independence. After ICMR initiated the first significant projects on mental health in 1960s, a series of studies were undertaken on psychiatric disorders in 1960s and 1970s, but on smaller study samples. Subsequently, ICMR organized a multicentric collaborative study on Severe Mental Morbidity at 4 centers – Bangalore, Baroda, Calcutta and Patiala from 1976-83. This was the beginning of ICMR task force projects on mental health research. ICMR formed task groups to initiate task oriented operational research programmes on areas which are directly related to the mental health problems specific to our country where additional knowledge would help in alleviation of morbidity from this disorder. There was active participation of mental health professionals from all parts of the country in these research programmes.

The projects carried out by task force groups and Centres for Advanced Research during last two decades (1982-2002) can be classified in 7 sections: (a) Community mental health, (b) Phenomenology, natural history and outcome studies, (c) Mental health indicators, (d) Child and adolescent mental health, (e) Drug/ substance dependence, (f) Suicide behaviour, (g) Mental health consequences of disasters.

In a study conducted by the ICMR in 2017, a grim picture of the country's mental health issues is revealed. According to the survey, which has now been published in the prestigious Lancet Psychiatry Journal, about 1 in 7 persons residing in India suffer from some form of mental disorder.[xxviii]

Key findings from the paper:

- In 2017, 197.3 million Indians (14.3% of the total population) were suffering from various mental disorders. Of these, 45.7 million had depression and 44.9 million had anxiety disorders.
- The contribution of mental disorders to the total disease burden in India in terms of DALYs increased from 2.5% in 1990 to 4.7% in 2017.
- Mental disorders were the leading contributor in India to years lived with disability (YLDs), contributing 14.5% of all YLDs in 2017. [xxix]
- Depression contributed 33.8% of all mental disorder DALYs in India in 2017, followed by anxiety disorders (19.0%), idiopathic developmental intellectual disability (10.8%), and schizophrenia (9.8%).
- Among the major mental disorders that manifest predominantly during adulthood, the prevalence of depression was 3.3%, anxiety disorders 3.3%, bipolar disorder 0.55%, and schizophrenia 0.25%. Among the mental disorders that have onset predominantly during childhood and adolescence, the prevalence for idiopathic developmental intellectual disability was 4.5%, conduct disorder 0.80%, attention-deficit hyperactivity disorder 0.42%, and autism spectrum disorders 0.35%.
- The prevalence of predominantly childhood and adolescent onset mental disorders was higher in the less developed northern states, and that of the ICMR/ PR UNIT/IIFO/2019/50 mental disorders manifesting predominantly during adulthood higher in the more developed southern states.

- There was a significant association between the prevalence of depression and suicide death rate at the state level, with this association slightly stronger in females than in males.
- The prevalence of depression, anxiety disorders, and eating disorders was significantly higher among females, and the prevalence of conduct disorder, autism spectrum disorders, and attention-deficit hyperactivity disorder was significantly higher among boys.
- The prevalence of depressive disorders increased with age in India in 2017, with the highest prevalence in elderly.
- The burden of mental disorders which manifest predominantly during adulthood increased in India from 1990 to 2017.
- The burden of mental disorders of predominantly childhood and adolescent onset decreased in India from 1990 to 2017, but this decrease was relatively less in the less developed states.

NHMS- National Mental Health Survey

NMHS was a unique collaborative endeavor undertaken across 12 states of India with active engagement of more than 400 persons during 2014-16. The project was **funded by** the Ministry of Health and Family Welfare, Government of India. It was **coordinated by** the National Institute of Mental Health and Neurosciences, Bengaluru. The National Mental Health Survey of India-2016 was conducted on a nationally representative sample of 34802 individuals, sampled from 12 states of India.[xxx]

Focus of NMHS

The NMHS was conceptualized to cover a representative national population, examine all priority mental disorders, focus on the treatment gap, service utilization, disability and impact along with an assessment of resources and systems in a sample of Indian states; simultaneously and with uniform methodologies. The population selected and interviewed was drawn based on scientific sampling methods by including individuals aged 18 years and above

Key findings of the survey

- **Mental disorders contribute to a substantial disease burden in India:** it is estimated that, excluding tobacco use disorders, mental morbidity of individuals above the age of 18 years currently was 10.6%. The lifetime prevalence in the surveyed population was 13.7%.
- **Prevalence of mental morbidity is high in Indian urban metros:** The prevalence of schizophrenia and other psychoses (0.64%), mood disorders (5.6%) and neurotic or stress related disorders (6.93%) was nearly 2-3 times more in urban metros
- **Common mental disorders affect significant sections of society:**
    - Common mental disorders (CMDs), including depression, anxiety disorders and substance use disorders are a huge burden affecting nearly 10.0% of the population.
    - This group of disorders are also closely linked to both causation and consequences of several non- communicable disorders (NCD), thereby contributing to a significantly increased health burden

- **1 in 20 people in India suffer from depression:**
    - The weighted prevalence of depression for both current and life time was 2.7% and 5.2%, respectively, indicating that nearly 1 in 40 and 1 in 20 suffer from past and current depression, respectively.
    - Depression was reported to be higher in females, in the age-group of 40-49 years and among those residing in urban metros. Equally high rates were reported among the elderly (3.5%)

- **There is a high prevalence of psychoactive substance use:**
    - Substance use disorders (SUDs), including alcohol use disorder, moderate to severe use of tobacco and use of other drugs (illicit and prescription drugs) was prevalent in 22.4 % of the population above 18 years in all the 12 surveyed states
    - The survey also revealed that 0.6% of the 18+ population were recognised with illicit substance use disorders (dependence + abuse) which included cannabis products, opioid drugs, stimulant drugs, inhalant substances and prescription drugs.
    - Among adult males this was 1.1%.

- **High suicidal risk is an increasing concern in India:** Nearly 1% of the population reported high suicidal risk. The prevalence of high suicidal risk was more in the 40-49 age group (1.19%), among females (1.14%) and in those residing in urban metros (1.71%).

- **Severe mental disorders are equally important:**
    - Nearly 1.9% of the population were affected with severe mental disorders in their lifetime and 0.8% were identified to be currently affected with a severe mental disorder.
    - The current prevalence of severe mental disorders in most states was less than 1%, excepting in Manipur and West Bengal.
    - **Productive age groups are affected most:** Males in the age group of 30 – 49 years were the most affected indicating that mental disorders contribute to greater morbidity in the productive population
    - **Both genders are affected – variation across disorders exists:**
    - The overall prevalence of mental morbidity was higher among males (13.9%) than among females (7.5%).
    - However, specific mental disorders like mood disorders (depression, neurotic disorders, phobic anxiety disorders, agoraphobia, generalised anxiety disorders and obsessive compulsive disorders were higher in females.

- **Children and adolescents are vulnerable to mental disorders:**

- Prevalence of mental disorders in age group 13-17 years was 7.3% and nearly equal in both genders.
- Nearly 9.8 million of young Indians aged between 13-17 years are in need of active interventions. Prevalence of mental disorders was nearly twice (13.5%) as much in urban metros as compared to rural (6.9%) areas.
- The most common prevalent problems were Depressive Episode & Recurrent Depressive Disorder (2.6%), Agoraphobia (2.3%), Intellectual Disability (1.7%), Autism Spectrum Disorder (1.6%), Phobic anxiety disorder (1.3%) and Psychotic disorder (1.3%)

- **Neurosis and stress related disorders affect women disproportionately:** Neurosis and stress related disorders affected 3.5% of the population and was reported to be higher among females (nearly twice as much as males).

❖ **Variations in prevalence exist at the regional and state levels:**

- While the overall current prevalence estimate was 10.6% in the total surveyed population, significant variations in overall morbidity are seen across the different surveyed states, ranging from 5.8% in Assam to 14.1 % in Manipur.
- Three states Assam, Uttar Pradesh and Gujarat reported prevalence rates less than 10%; in 8 of the 12 states, the prevalence varied between 10.7% and 14.1%

❖ **Epilepsy is an important public health problem:**

- Epilepsy is a major public health problem in India and several studies have documented its prevalence and characteristics.
- Under the NMHS, epilepsy was identified using the screener instrument recommended by WHO.
- The prevalence of epilepsy (Generalized Tonic Clonic Seizures) was 0.3%, with nearly 2 million persons requiring care

❖ **Persons with Intellectual disability need comprehensive management:**

- In NMHS, 2015-16, the assessment of Intellectual disability was undertaken using a screener instrument.
- The prevalence of this condition was 0.6% in the surveyed population, resulting in nearly 4 million persons requiring care.

NHRC – National Human Rights Commission

The Pilot Project implemented by SEVAC was carried from June to August, 2011 at Chamatkarik Hanuman Temple. Where the study backdrop shows that choice of shelter homes for homeless mentally ill in the country are religious places. The study field was a place of such kind which is located in the border of Maharashtra and Madhya Pradesh. It was highlighted in the study that the absence of mental health care and poor infrastructure have resulted the people living in this area approach the temple rather than going for a psychiatric care and treatment and

the living conditions of the mentally ill in the temple is deplorable since the study found that the patients were not adequately having the basic conditions like a place to rest, place to loiter, and more importantly left under open sky which indicates no proper shelter and no privacy of life. Also the scenes like a mentally ill are finding food from the garbage bins and quench thirst from drain water are witnessed hence the SEVAC had started the work in the year 2010 as to document the inhuman sufferings of mentally ill and also to ensure the treatment and rehabilitation is provided so as the matter was brought to the knowledge of NHRC in 2011.[xxxi]

The findings of the study show that the majority of the patients in the temple belong to the age group 70 where lack of treatment and care could lead them to chronic illness and ultimately they would become burden upon the community itself and even it was found that the sizeable amount of children from the age 3 years to 10 years stay in the temple along with the mentally ill parents where this has become a problem since the children have started imitating the behaviour and just sure of the mentally ill. Even the caregivers to the mental patients in the temple were exploited in different manners and it was very common to see the mental patients were kept in chains at the temple which is violation of the basic rights key recommendations as to responsibility of the state government to run a psychiatric clinic under the national mental health programme and also ensure the general treatment in the nearest hospital, starting one Anganwadi centre at temple premises. Responsibility of the temple committee was with respect to improving the sanitary system, providing drinking water, convincing the devotees not to dump the mental patients in the temple, and cooperating with the SEVAC team for successful implementation of the project. The program was for a duration of two years and financial assistance was requested from NHRC for conducting the activities.[xxxii]

The project operation oasis has been carried in 2003-2004 in three different fields like Jails, Vagrant homes, Destitute or Juvenile Homes by SEVAC supported by the NHRC. This study have been able to disclose that a large number of mentally ill go through is schizophrenia, manic depressive psychosis, substance related disorders and unspecified psychosis and also given out key recommendations as to improve facilities of care, treatment and rehabilitation. Recommendations as to enhancing the mental health care in the present world to me arrangements plus to get treatment for all mentally ill housed in different prison in west Bengal, building the capacity of prison personnel in order to identify the mentally ill among the prison population, it was evident that the coolest has become responsible in a way which respect you sending mentally ill to jail so it was recommended that police should have undergone mental health training programs, Also the study has addressed the vulnerable groups like women and juvenile should not be neglected.

Also the study has not only constricted its recommendations to be applicable in the state of West Bengal but to all the other states where large numbers of mentally ill are dumped in jails and custodial homes. Also the study has made certain specific suggestions with regard to establishing the psychiatric care in all the central jail and the district jail. 21% inmates of the rescue/juvenile homes are suffering from major psychiatric illness such as psychoses, schizophrenia, mood disorder and substance abuse.[xxxiii]

Charter on Patient's Rights- The Core Advisory Group on Health of NHRC has prepared the 'Charter of Patient's Rights' which draws upon all relevant provisions, inspired by international charters and guided by national level provisions, with the objective of consolidating these into a single document, thereby making them publicly known in a coherent manner. The role of the

Charter is to generate widespread public awareness and educate citizens regarding what they should expect from their governments and health care providers—about the kind of treatment they deserve as patients and human beings, in health care settings.

The NHRC Core Group on Health and Mental Health expresses serious concerns on those affected by mental health problems further aggravated during COVID-19 Pandemic. Some of the important suggestions were made such as

- Increase budgetary allocation for the mental health and in particular for the district mental health programme;
- Increase dedicated staff for psychiatric care without diverting them for other duties in health sector;

NSSO -The Indian National Sample Survey Organization

This report is named-NSS 58th round, report no. 485 (58/26/1), Disabled Person in India, 2002, and available in the public domain. This was the first-time mental illness and intellectual disability were covered by NSSO in the disability survey.

Census 2011

In the previous censuses, mentally disabled people were counted but there was no separate enumeration for them. **Mentally ill persons were enumerated in Census 2011** for the first time. Specific questions were laid down for enumerators to ask about mentally ill persons in a family.

- Thenumber of people with mental retardation is around 15.05 lakhs as shown by Census data 2011.
- Females having lower number of cases than males in case of both mental retardation and illness. Sex ratio, i.e., number of females per 1000 males is 729 calculated for mental retardation is 729, and that for mental illness is 738.
- In rural and urban areas in the proportion of the two types of mental health problems.
    - Proportion of mental retardation cases in rural areas is 10.25 lakhs, while in urban areas it is 4.8 lakhs.
    - In case of mental illness, the difference is slightly less with 4.95 lakhs in rural areas, and 2.27 lakhs in urban areas.
- Prevalence of mental health problems is found to be same in urban areas for mental illness, which is around 60 per 10 lakh population, while for mental retardation it is found to be higher in urban areas (127 per 10 lakh population) than rural areas (123 per 10 lakh population).
- The age composition graph of mental health problems from Census data 2011 shows that the occurrence of mental retardation cases is highest in the age group 10-19, while for mental illness it is in the age group 30-39. In both the cases, the age graph is seen to be rapidly rising as age increases, forming a peak in the adolescence and youth and declining gradually as old age approaches.

Ministry of Health and Family Welfare

- It is estimated that there are 3800 Psychiatrists, 898 Clinical Psychologists, 850 Psychiatric Social Workers and 1500 Psychiatric Nurses in the country. Recent estimates for State/UT wise details of trained mental health personnels are not available.[xxxiv]

- There are three centrally run mental health institutes, 40 State run mental hospitals and 398 Departments of Psychiatry in various medical colleges (183 in Government and 215 in private) across the country equipped to treat patients suffering from mental illness.
- There is no provision for direct funding of mental health care research under the extant District Mental Health Programme.[xxxv]

Details of expenditure incurred on research in the field of Mental Health (Rs. in lakhs)

S.No.	Institute	2011-12	2012-13	2013-14
1	National Institute of Mental Health and Neuro Sciences, Bangalore	4.16	11.08	19.70
2	LokopriyaGopinathBordoloi Regional Institute of Mental Health, Tezpur, Assam	85.79	38.43	50.52

WHO – World Health Organisation

- WHO's 2005 report attributed 31·7% of all years lived-with-disability to neuropsychiatric conditions: the five major contributors to this total were unipolar depression (11·8%), alcohol-use disorder (3·3%), schizophrenia (2·8%), bipolar depression (2·4%), and dementia (1·6%).

- WHO also states that the mental health workforce in India is not upto the mark and there is a huge shortage of psychiatrists and psychologists in the country as compared to the number of people suffering from mental health issues. WHO states that in India, (per 100,000 population) there are psychiatrists (0.3), nurses (0.12), psychologists (0.07) and social workers (0.07), while the desirable number is anything above 3 psychiatrists and psychologists per 100,000 population.

- WHO also estimates that about 7.5 per cent Indians suffer from some mental disorder and predicts that by end of this year roughly 20 per cent of India will suffer from mental illnesses. According to the numbers, 56 million Indians suffer from depression and another 38 million Indians suffer from anxiety disorders.

- According to World Health Organisation, the burden of mental health problems is of the tune of 2,443 disability-adjusted life years per 100,000 population, and the age-adjusted suicide rate per 100,000 population is 21.1.

- According to WHO's 2005 estimates, neuropsychiatric disorders account for 1·2 million deaths every year and 1·4% of all years-of-life lost; most of these are caused by dementia, Parkinson's disease, and epilepsy.

- According to the burden of mental disorders across the states of India: The Global Burden of Disease Study 1990–2017 – One in seven Indians were affected by mental disorders of varying severity in 2017 and the proportional contribution of mental disorders to the total disease burden in India has almost doubled since 1990.

- WHO also estimates that, in India, the economic loss, due to mental health conditions, between 2012-2030, is 1.03 trillions of 2010 dollars.

UNICEF reports - Mental health impact of covid-19 in children and young people

UNICEF took a comprehensive look at the mental health of children, adolescents and caregivers in the 21st century. According to the report, the COVID-19 pandemic has had a significant impact on children's mental health. Children in India appear reluctant to seek support due to depression, according to **a study by UNICEF and Gallup in early 2021** with 20,000 children and adults in 21 countries. Only 41 percent of young people between the ages of 15 and 24 in India say it is good to get support for mental health problems, compared to an average of 83 percent in 21 countries. In fact, India was the only country in 21 countries where only a minority of youths felt that people with a mental illness should reach out to others. In all other countries, the majority of young people (from 56 % to 95 %) feel that access is the best way to deal with mental health problems. It is found that about 14 percent of 15- to 24-year-olds in India, or 1 in 7, reported that they were generally depressed or had no interest in doing things. Half went from about a third of Cameroon, one in seven in India and Bangladesh, to ten in ten in Ethiopia and Japan. In 21 countries, 1 out of every 5 people is young.[xxxvi]

According to **the Indian Journal of Psychiatry** in 2019, even before the pandemic, at least 50 million children in India were affected by mental health problems; 80 - 90 percent did not seek support. India has spent only 0.05 percent of its health budget annually on mental health, according to Indian Journal of Psychiatry 2017.

According to **UNESCO** data, more than 286 million children reaching grade 6 have dropped out of school in India between 2020-2021. A rapid UNICEF survey in 2021 found that only 60 percent had access to digital classes. Many would not be able to continue their education.

RENOWNED INSTITUTES FOR MENTAL HEALTH IN INDIA

1. **NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE**

   The National Institute of Mental Health and Neuro Sciences (NIMHANS) is an Institute of National Importance governed by the act of Parliament titled NIMHANS Act, 2012. This institute is a multidisciplinary institute for patient care, academic pursuit and cutting-edge research in the field of mental health and neurosciences.

2. **INSTITUTE OF HUMAN BEHAVIOUR AND ALLIED SCIENCES, NEW DELHI**

   The Hospital for Mental Diseases, Shahdara was converted to 'The Institute of Human Behaviour and Allied Sciences (IHBAS) by a Supreme Court order in response to public interest litigation in 1993. IHBAS is the single best speciality hospital in mental health and for this, they got India Health Care Award 2012.

   Along with the services provided by them in the hospital, they also reached out to homeless people and other populations through community services under the District Mental Health

Programme (DMHP) in different districts across the Delhi State, they are actively working in **Chattarpur (South), Jahangirpuri (North-West), Dwarka (South-West), Timarpur (North), and Motinagar (West).** Their team also visits residential homes for the destitute but in one month they only visit 2 homes for delivering meta outreach services. In these districts, they also provide other services which include education and communication activities, mental health awareness and diagnostic camps on monthly basis, and various mental health training programmes for paramedical and non-medical personnel. They also moved a mobile van across the state rescue to homeless people who are mentally ill and need help. For doing and achieving all these activities IBHAS conduct various activities as stated below:

- Community Outreach Services under District Mental Health Programme
- Community Outreach Initiatives for Homeless Population
- Mobile Mental Health Unit (MMHU)

3. CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI

CIP is famous for eco-friendly, as it promotes mental health and also enhances the well-being of patients with the help of providing an eco-friendly environment. Their focus is not only to promote mental health or to cure patients but also to promote and save energy and the environment, that's why they use solar energy for lighting, water pumps, etc.

CIP aims to provide a normal and safe environment to their patients, they are not like other hospitals clocked with walls, and they allowed their patients to roam around the campus and feel normal and safe like other people. They encourage and support their patients with new initiatives as they focus on regular exercises, and indoor and outdoor activities.

CASE STUDY ON THREE STATES OF INDIA

STATE MENTAL HEALTH SYSTEM ASSESSMENT is systematic and comprehensive assessment to understand the various components of the mental health care system within the state.

Its main objectives were to-

- Assess the existing resources for mental health and programmes.
- And examine the mental health services available in the state.

KERALA

Kerala is one of the few states that has a mental health policy. Kerala also has one of the **highest budgetary allocations for mental health 1.16% of its total health budget**. Most of the other states do not even allocate separate funds for mental healthcare.

The state administered **UNARV,** a model for adolescent mental health in schools at district level in 2007. Students with behavioral therapy and academic problems from class 8-12 were counselled by their teachers who were trained in adolescent developmental psychology and mental health disorders. They were given cognitive behavioral therapy, problem solving skill therapy and anger management skills at the clinic. If there were family problems at home such as alcoholism or domestic violence, their parents were also given family therapy. Within this sample,95%of the students returned back to school. This programme was possible just because

of school teachers developing a model that can be implemented properly in areas with resource constraints.

The process of integration of mental health care with primary health care was initiated in the year 2011. The primary care doctors were trained to deliver mental health care in the government health facilities. This was achieved in coordination with the DMHP team. Subsequently, mental health care is being provided in 98 centers across the state. The DMHP, in turn, conducts about 28 clinics in a month across the district. These clinics serve as referral points for the primary care mental health services. In addition, ASHA's were trained to identify mental health problems and, after training, undertook active case finding surveys in 10-gram panchayats.

The Mental Health Action Trust (MHAT) is a Not-for-Profit organization that provides free, comprehensive, community-based, volunteer-led, cost-effective mental health care to the poorest people of the localities they serve, including the wandering homeless mentally ill. It aims to provide long term management of chronic mental disorders through a system of community-owned and managed care, supervised and run by MHAT. The organization operates through a network of community clinics. Local partners and trained volunteers function as effective mental health care coordinators.

GUJARAT

Integration of religious and faith-based practices with modern mental health care interventions in religious and traditional healing places can immensely help communities; such a programme was started in 2007 in Gujarat at the Holy Shrine of Mira DatarDargah in the district of Mahesana. The activities undertaken included-establishing linkage system between health professionals and mujavar's (local healers); educating mujavar on mental health, mental illness, its signs and symptoms; providing free mental health services to those suffering from psychological problems visiting the Dargah; referral of patients for medical treatment and creating awareness on mental health issues in nearby communities. The chain of care activities ensured continuity of care. The programme funded by the Department of Health and Family Welfare with guidance and monitoring by Hospital for Mental Health, Ahmedabad is considered successful as mental health services are available along with beneficial and harmless traditional health practices. The National Human Rights Commission has commented that this is an ideal community mental health program which can be replicated at other religious places within the country. Consequently, till date, nearly 376 faith healers have been trained on identification of mental health problems and more than 40,000 persons with mental illnesses from 12 states have received treatment with 60% of follow-up rate at 3 months. Faith healers refer an average of 10 patients per month; chaining of the persons with mental illnesses has stopped and there is an improved awareness regarding mental health in the communities

Quality Rights Gujarat Project is an innovative intervention to improve existing mental health services by reorienting services from a purely medical approach to a holistic, comprehensive and participatory approach that values and emphasizes on empowerment, autonomy, recovery and integration into the family and community. Implemented since 2014, 4 hospitals for mental health, 3 departments of Psychiatry in government medical colleges and 3 district mental hospital psychiatry aims to bring quality improvement in public mental health facilities, ensuring rights of persons to reduce disability, improving functioning of persons leading to improved health, social and development outcomes for service users. The basic objective of this project is to promote and protect the rights of persons with mental illness and mainstreaming such persons by

providing equal opportunities in the community. Mental health professionals at the public mental health services will be trained as per WHO Quality Rights Standards to provide quality care at these facilities and make persons with mental illness and their families aware of their rights. Quality Rights Gujarat is implemented in collaboration with Center for Mental Health Law and Policy at Indian Law Society (ILS), Pune, World Health Organization (WHO), Geneva, Center for Addiction and Mental Health (CAMH), Toronto; Schizophrenia Awareness Association (SAA), Pune; Schizophrenia Research Foundation, Chennai; Public Health Foundation of India (PHFI), New Delhi.

ASSAM

The **Integrated care for the needs of vulnerable persons with severe mental disorders (INCENSE**) programme. The INCENSE program is a novel partnership between two mental health institutions (LGBRegional Institute of Mental Health,Tezpur and Regional Mental Hospital,Pune) and non-governmental organizations (Parivartan and Sangath). The programme specifically targets people with severe mental disorders like long stay persons within hospitals, homeless persons and people with severe mental disorders living in the local communities. The activities include development of vibrant local networks with community agencies to support community housing, employment and livelihood options on a large scale, centred around the needs of individuals within and outside of the hospital.

ANALYSIS OF POLICIES

Mental health policy can be an essential and powerful tool to improve a population's mental health. Mental health policy is a government statement specifying values, principles and objectives for mental health. It can be implemented in the forms of mental health plans, programmes, strategies and legislation at multiple levels disorder. If properly formulated and implemented, mental health policy can be an essential and powerful tool for countries to improve mental health and reduce the burden of mental disorders. There are two types of laws when it comes to their binding effect i.e. Hard laws and soft laws.

Hard" laws refer to laws that are binding and enforceable internationally or domestically. "Soft" laws, on the other hand, are not binding. However, soft laws if well-constructed and reflect a broad consensus can become a model for future legislation.[xxxvii]

In the last 70 years, there have been a number of international conventions, declarations, covenants, etc., that have reference to mental illnesses/mental health of an individual. The Universal Declaration of Human Rights (UDHRs) was adopted in 1948. Article 1 of the UDHRs, adopted by the United Nations in 1948, provides that "all people are free and equal in rights and dignity" – "establishing that people with mental disabilities are protected by human rights law by virtue of their basic human rights.

India is a signatory to many of these international declarations and thus has an obligation to align her laws to suit these.

In India, some of the hard laws pertaining to mental health include The Mental Health Act, 1987; The Protection of Human Rights Act, 1993; Persons with Disability Act, 1995; The National Trust Act, 1999; Protection of Women from Domestic Violence Act, 2005; Protection of Children from Sexual Offences Act, 2012, and related legislations. A prominent statutory legislation regulating narcotics is the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985.

Strictly speaking, "soft" laws are not really laws at all; they are rules or policies that are quasi-legal and not binding. They are defined as having "hortatory" obligations, i.e., statements in the nature of promises. It is argued that in the course of time, these may become binding. Some examples include the National Mental Health Policy 2014 and the National Mental Health Programme (with its operational arm, the District Mental Health Programme).

The NMHPolicy has been heavily influenced by the guidelines/recommendations of the WHO and UN and has progressed with the launch of some of the crucial MH and related National legislation. The documents have been briefed in Table 1.

TABLE 1.

Timeline of the Major Policies/Plans/Acts/Laws Concerning National Mental Health Policy (NMHPolicy), India (2014)

Year	Policies/Plans/Acts/Laws, and the Implementing Agency	Aim/Goals
2005	Mental health policy, plan, and program (2005) (part of mental health policy and service guidance package), *WHO*	To present evidence-based guidance for the development and implementation of mental health policy, plans, and programs.
2007	United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007), UN	To promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and promote respect for their inherent dignity.
2013	Mental health action plan (2013–2020), *WHO*	To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights, and reduce the mortality, morbidity, and disability for persons with mental illness (PWMI).
2013	National mental health plan-365 (2013), *Govt. of India*	Delineating the envisaged roles and responsibilities of the stakeholders to facilitate achieving the objectives enshrined in the NMHPolicy
2015	Rights of persons with disabilities act (2016), *Govt. of India*	To give effect to the UNCRPD and for matters connected with it.
2017	Mental Healthcare Act (2017), *Govt. of India*	To provide mental health care and services for PWMI and to protect, promote, and fulfil the rights of such persons during delivery of mental health care and services and for matters connected therewith or incidental to it.
2017	National health policy (2007), *Govt. of India*	Envisages the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health-care orientation in all developmental policies, and universal access to good quality health care services, without anyone having to face financial hardship as a consequence; to be achieved through increasing the access to, improving the quality of, and lowering the cost of health care.

Following are some of the policies and legislations made by the legislature in the field of Mental health laws: -

I. ACTS

1. Mental Health Act (MHA-87)

This act was finally enacted in 1987 after a long and protracted course. Main features of the Act are as follows.

- Definition of mental illness in a progressive way and introducing modern concept of their treatment with stress on care and treatment rather than on custody.
- Establishment of Central/State Mental Health Authority to regulate and supervise the psychiatric hospitals/nursing homes and to advise Central/State Governments on Mental Health matters.
- Admission in special circumstances in psychiatric hospital/nursing homes. Provisions of voluntary admission and admission on the reception orders were retained.
- Role of Police and Magistrate to deal with cases of wandering PMI and PMI cruelly treated.
- Protection of human rights of PMI. Guardianship and Management of properties of PMI.
- Provisions of penalties in case of breach of provisions of the Act.

Though having many positive features, the MHA-1987 has been the target of criticism right since its inception. It is alleged to be concerned mainly with the legal procedure of licensing, regulating admissions and guardianship matters of PMI. Human right issues and mental health care delivery are not properly addressed in this Act.[xxxviii]

Because of a large number of very complicated procedures, defects and absurdities in the Act and also in the Rules made under the Act, it can never be implemented properly.[xxxix]

Human right activists have questioned the constitutional validity of the MHA, 1987 because it involves curtailment of personal liberty without the provision of proper review by any judicial body. [xl]

2. Mental Health Policy, Plan, And Program, WHO (2005)

It is one of the 13 documents released by the WHO for the policymakers and Planners to develop MH policy and Comprehensive strategies for improving the MH of populations. World Health Organization.[xli]

It is the central module that provides detailed information about the process of developing policy and implementing it through various plans and programs. Further, it guides on the need of and the roadmap for parallelly developing related legislations, policies, plans, and Programs to realize the goals of the MH Policy of the countries. [xlii]

3. UNCRPD (2007)

Another major development in the Field of disabilities (both physical and Mental) and global MH unfolded in the form of the UNCRPD. [xliii]

It obligated the member states to undertake appropriate measures, including legislative ones, to promote and ensure the human rights and fundamental freedoms for all persons with Disability (PWD) without any discrimination based on their Disability. According to article 2 of the convention, PWD will enjoy legal capacity on an equal basis for all aspects of life. Article 3 calls the state to take appropriate measures to provide access to support by PWD to exercise the legal capacity. Article 4 calls for safeguards to prevent abuses of the system of support required by PWD. There is no explicit prohibition of forced interventions in the UNCRPD, but neither does the Convention permit compulsory mental health care. [xliv]The NMHP of India (2014) is in concordance with the convention and has provisioned equity-, justice-, quality-, participatory-, right-based care for PWMI. It also ensures that MH care be provided in a destigmatizing manner to PWMI and their social integration be promoted.

4. Rights of Persons with Disabilities Act (RPWD, 2016)

The enactment of RPWD has given impetus to the NMHP in realizing its Goals. The provisions of the NMHP are in concordance with the country's RPWD (2016): ensuring the rights of PWMI, including the vulnerable groups (children and adolescents, intellectually disabled, etc.), by providing affordable, accessible, and quality MH services and rehabilitation and disability benefits.

5. Mental Healthcare Act (2017)

Mental Healthcare Act, 2017 – The Act ensures healthcare for people suffering from mental illness through health services funded by the Government. It decriminalises suicide, disallows sterilisation and solitary confinement of mentally unwell patients. The Act provides for the setting up of Central and State Mental Health Authorities for the training of medical professionals. The duties of central and state Government includes establishment of halfway homes, sheltered accommodation, and Supported accommodation, hospital and community based rehabilitation services. It also mandates insurance companies to provide mental health insurance.

The NMHP was framed in Concurrence with the draft MHCA (2017). The NMHP group was also entrusted with the responsibility to recommend changes, if any, pertaining to the draft MHCA. Some of the relevant aspects of the MHCA concerning NMHP include the rights to access MH care, community living, confidentiality, access Medical records, personal contacts and communication, legal aid, and make complaints against the MH establishment (MHE) for any deficiencies; capacity to make decisions; advance directive; nominated representative; suicide decriminalization; ensuring funds for the implementation of the provisions of the bill; and insurance for mental illnesses.

Following Rights are provided under Mental Health Care Act, 2017 [xlv]:-

- Right to make an advance directive
- Right to access healthcare services

- Right to free of cost healthcare services
- Right to live in a community
- Right to protection from cruel, inhuman and degrading treatment
- Right not to be treated under prohibited treatment
- Right to equality and non-discrimination
- Right to information
- Right to confidentiality
- Right to free legal aid and complain

6. Mental Healthcare(Rights of Person with Mental Illness) Rules, 2018

In exercise of the powers conferred under section 121 of the Mental Healthcare Act, 2017 (10 of 2017), the Central Government hereby makes the following rules :-

- Provision of half-way homes, sheltered accommodation and supported accommodation.
- Hospital and community based rehabilitation establishment and services.
- Reimbursement of the intermediary costs of treatment at mental health establishment.
- Right to access basic medical records
- Custodial institutions
- Method, modalities and procedure for transfer of prisoners with mental illness.

7. Mental Healthcare(Central Mental Health Authority) Regulations, 2020

The Central Mental Health Authority on 18th December 2020 has published the Mental Healthcare (Central Mental Health Authority) Regulations, 2020 in which it has specified the minimum standards for registration of mental health establishments.

II. PLANS AND POLICIES

1) National Mental Health Plan-365 (2013) (MHAP)

The launch of the National Mental Health Policy co-occurred with the release of the MHAP-365 to succinctly describe the roles and responsibilities of each stakeholder for a particular action. The major Stakeholders of the MHAP-365 are the Union GoI, the governments of states/Union territories, local bodies including Municipalities and Panchayati raj institutions, civil society organizations, PWMI, medical and health-care providers, medical colleges, academic and research institutes, schools, and colleges, private corporate sectors, and finally, media. MHAP-365 pointed out that although the complete attainment of the complex objectives may not be feasible in the short or medium term, it is nevertheless necessary to have directed and coordinated action plans.[xlvi]

2) National Mental Health Policy, India (2014)[xlvii]

The World Health Organization (WHO), in its world health assembly (WHA), 2012, resolved that "there is need of a comprehensive, coordinated response from the health and social sectors at the community level to address the issue of burden of the mental illness."[xlviii]

India being a signatory to it, launched her national mental health policy (NMHPolicy) in 2014.[xlix]

The policy was in concordance with WHO's mental health (MH) policy, plan, and program (2005), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007). Further, it aligned with and was supported by contemporary laws such as the Rights of Persons with Disabilities Act (RPWD, 2016), Mental Healthcare Act (MHCA, 2017),etc. Before NMHPolicy, India attempted to address the MH needs of the people of the country through National Mental Health Program (NMHP, 1982), and subsequently, through the District Mental Health Program (DMHP, 1996) with the purported objectives of ensuring the availability and accessibility of minimum MH care for all, encouraging MH knowledge and skills in general healthcare, and promoting community participation in MH service development.[l]

National Mental Health Programme has been the main MH service framework of the country till the launch of NMHPolicy. Since the NMHPolicy is an ambitious and idealistic policy with wide-ranging implications (including rights-based treatment, provision for community rehabilitation, etc.), its progress, to a large extent, is also determined by the constitution and performances of the supporting MH and allied (health and social welfare) plans/policies/laws. Consequently, NMHPolicy has not been free from criticism from different sections of society, especially regarding its ground-level implementation and performance.[li]

To draft the NMHPolicy, in April 2011, the GoI constituted a policy group, which gave rise to NMHPolicy in 2014. It is an inclusive policy where MH issues were addressed both in medical and nonmedical terms.

a) **Vision**: To promote MH, prevent mental illnesses, enable recovery from the mental illness, promotedestigmatization and desegregation, and socioeconomic inclusion of PWMI by providing accessible, affordable, and quality health and social care to all persons through their lifespan within a rights-based frame-work.

b) **Values and Principles:** The set ethos of the policy was equity, justice, integrated care, evidence-based care, quality, participatory and rights-based approach, governance, and effective delivery, value-based in all training and teaching programs, and holistic approach to MH.

c) Goals

- To reduce distress, disability, exclusion morbidity, and premature mortality associated with MH problems across the lifespan of the person
- To enhance understanding of MH in the country.
- To strengthen the leadership in the MH sector at the national, state, and district levels.

d) Objectives

- To provide universal access to MH care.
- To increase access to and utilization of comprehensive MH services by PWMI (including prevention services, treatment and care, and support services).
- To increase access to MH services for vulnerable groups.
- To reduce the prevalence and impact of risk factors associated with MH problems.
- To reduce the risk and incidence of suicide and attempted suicide.
- To ensure respect for rights and protection from harm of PWMI.
- To reduce the stigma associated with MH problems.
- To enhance availability and equitable distribution of skilled human resources for MH.
- To progressively enhance financial allocation and improve utilization for MH promotion and care.
- To identify and address the bio-Psycho-social determinants of MH problems and to provide appropriate interventions**.**

The policy highlighted some of the cross-cutting issues (stigma, right-based approach, vulnerable populations, adequate funding, support for families, intersectoral coordination, institutional care, promotion of MH, and research) and key strategic areas (effective governance and delivery mechanisms for MH; promotion of MH at the level of Anganwadicenter, schools, workplace, etc.; prevention of mental illness and reduction of suicide and suicide attempts; universal access of MH services [family-centric services, increasing the availability of the community-based rehabilitation (CBR) services, assisted living services, etc.]; improved availability of the trained MH human resources in the community; community participation for the MH and development; and research on MH and allied disciplines).

e) Issues with the National Mental Health Policy (2014)

The policy envisaged the delivery of MH services through an integrated care model. However, in reality, the training of general practitioners at the community level in this regard is meager. Although policymakers have envisaged providing holistic health care, including MH care, at the level of the primary health center, by setting up "health and wellness center" under the Ayushmaan Bharat Scheme (NHP, 2017) and collaborating with the private sectors/nongovernment organizations (NGOs), its implementation and outcome are yet to be evaluated. NMHPolicy outlines important aspects of justice for the vulnerable groups (homeless, orphaned children, children in conflict with the law [CICL], etc.). However, it requires a concerted effort from different stakeholders (legal experts, social-welfare organizations, educationists, etc.) who might, at times, have different mandates.[lii]

For instance, community rehabilitation and social inclusion of the PWMI can only be achieved if the executory bodies (educational institutes, employment sectors, and social-welfare groups) are ready to comply with the legislation in it's true spirit (providing reservations to PWD in education and employment, thereby promoting their social inclusion). Hence, a national-level coordination committee needs to become functional at the earliest to address this issue. Although NMHPolicy is provisioned for community rehabilitation of PWMI, its ground-level implementation is still abysmally low. This is attributable to the poor MH resources; sub-optimal

linkage among MH services, allied health facilities, and social welfare schemes; and lack of involvement of the community leaders, NGOs, and private sector.[liii]

3) National Health Policy of India (NHP, 2017)

The Government of India (GoI) launched NHP in 2017, aiming to inform, clarify, strengthen, and prioritize the role of the government in shaping health systems in all its dimensions.[liv]

NHP (2017) made certain provisions that support NMHPolicy:

(a) to increase the creation of specialists through public financing,

(b) to create a network of community members to provide psychosocial support to strengthen MH services at primary level facilities, and

(c) to leverage digital technology in a context where access to qualified psychiatrists is difficult.[lv]

8. Indian contract laws

According to Indian Contract Act, 1872, any person of sound mind can make a contract. Section 12 of the Act stipulates that a person is said to be of sound mind for the purpose of making a contract, if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interest. A person, who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind. A person, who is usually of sound mind, but occasionally of unsound mind, may not make a contract when he is of unsound mind. It means a PMI who is currently free of the psychotic symptoms can make a contract, whereas a person who is currently intoxicated or delirious cannot make a contract.

9. Marriage and divorce

Under Hindu Marriage Act, 1955, conditions in respect of mental disorders, which must be fulfilled before the marriage is solemnized under the Act, are as follows :

- Neither party is incapable of giving a valid consent as a consequence of unsoundness of mind.
- Even if capable of giving consent, must not suffer from mental disorders of such a kind or to such an extent as to be unfit for marriage and the procreation of children.
- Must not suffer from recurrent attacks of insanity.

The expression “mental disorder” means mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind and includes schizophrenia. The expression “psychopathic disorder” means a persistent disorder or disability of the mind (whether or not including sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment.

Marriages in contravention to the provision in respect of mental disorders come under voidable category. Voidable marriages (**sec 12**) are those which may be annulled by a decree of nullity on the given grounds but may continue to be legal till the time it is annulled by a competent court.

According to the **section 13 o**f the Act, divorce or judicial separation can be obtained if the person has been incurably of unsound mind, or has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent.

10. CRIMINAL LIABILITY

Indian Penal Code, 1860 states that "Nothing is an offence, which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law." McNaghten Rules define the criminal responsibility of mentally ill in our courts and it has been incorporated in the **sec 84**. It has been held by the Supreme Court that the law presumes every person of age of discretion to be sane and defense on ground of insanity needs to be proved. If defense is established on ground of insanity, such persons are committed to the Psychiatric Hospitals as per sec 471 (i) of the Cr.P.C., 1973. There have been instances of lesser sentence on account of mental illness. Where the feeling of life unbearable on account of domestic quarrels, a woman (accused) jumped into a well with her children, it was held that the only sentence that could be passed was the lesser sentence of imprisonment for life (AIR 1953 MB 61).

Sec 89, IPC provides protection for any action done in good faith for the benefit of a person of unsound mind by or by consent of the guardian or other person having lawful charge of that person. Sec 305, Indian Penal Code (IPC) provides for punishment of death or imprisonment of life for abetment of suicide by an insane person.

PROGRAMMES:

III. **National Mental Health Program**

The Government of India introduced the National Mental Health Program (NMHP) in 1982, addressing the heavy burden of mental illness in the community, and the complete lack of mental health care infrastructure in the country to address it. the District Mental Health Program in 1996. The program was redesigned in 2003 to include two programs, namely. Modernization of Public Psychiatric Hospitals and Promotion of Psychiatry in Medical Colleges / General Hospitals. The three main components of NMHP are Mental Illness, Rehabilitation, Prevention and Promotion of Mental Health. NMHP's key strategies are to integrate mental health with primary health care through NMHP, and they have the provision of tertiary care facilities to treat the mentally ill, and to end discrimination against mentally ill patients and to protect their rights through regulatory institutions such as the Central Mental Health Authority, and the State. Mental Health Authority. It is important to note that in India, there have been previous efforts to

improve mental health care as part of general health care, starting with a Bhore committee report. The formation of the NMHP, in 1982, became an important milestone in the development of mental health care in the country. However, India has changed in its political, social, economic, human and medical fields. There is a need for current NMHP methods to reflect these changes. There is also a need for the growing psychiatric sector to be involved in NMHP. How to identify population needs, utilizing existing public resources and fully involving various sectors of society.

IV. District Mental Health Program

The District Mental Health Program was in 1996. The program was redesigned in 2003 to include two programs, namely. Modernization of Public Psychiatric Hospitals and Promotion of Psychiatry in Medical Colleges / General Hospitals. The main purpose of the district Mental Health Program is to provide basic mental health care services at the community level and to integrate these services with other health services. They also see patients early and provide assistance to the community itself. The district Mental Health Program plays an important role in reducing the stigma attached to mental illness by raising public awareness. They also treat and rehabilitate psychiatric patients in the community.

V. Quality improvements in Mental Health Care

There are many new and ongoing ways in which to measure and improve the quality of mental health care. These programs include technological advances or standardized care and integrated efforts to find patient purchases and providers in continuous quality evaluation and improvement. International establishments in quality measurement include the World Health Organization (WHO) 's Assessment Instrument for Mental Health Systems, and the International Initiative for Mental Health Leadership, which provides reporting data, reporting capabilities, and data validation internationally. In health insurance rehabilitation measures that evaluates three aspects of quality of treatment success, safety and customer satisfaction. The plan states that indicators are collected in one place and published openly to promote continuous quality improvement.
As a first step, the Benchmarking Network needs a high level of engagement and strong leadership. Improving the quality of mental health care is a team game, requiring the cooperation of all different providers, the involvement of consumer advocates, and the use of resources and incentives from healthcare providers and programs.

VI. Community based in Mental Health Care

Community based health programmes have been implemented in a variety of settings and have provided a range of services. Community health worker programmes include disease prevention, treatment and health promotion activities, peer worker interventions tend to focus on providing emotional and moral support, advice and information, and targeted health education. Community health programs are locally based education and treatment programs available typically to individuals who are living in poverty or do not have health insurance coverage. Community health programs are usually non-profit and seek funding through health department programs, donations, and government grants.

Community Health Workers and Community members, after getting short-term training,provide a range of services including curative, preventive and promotive interventions. They are expected to act like bridges between the health system and the community.

VII. **Mobile Technology in Mental Health Care**

Mobile phones have increasingly assumed an important role in the treatment of mental disorders in high-income countries. When mobile phones affect Mental Health results in comorbidity with depression, anxiety, OCD, ADHD and alcohol use disorder. Excessive smartphone use is associated with difficulties in cognitive-emotion regulation, impulsivity, impaired cognitive function, addiction to social networking, shyness and low self-esteem. Overall, in terms of the relationship between screen use and both physical and mental health outcomes, there have been several studies that suggest higher levels of screen use in children and adolescents is associated with reduced physical activity, increased risk of depression, and lower well-being. In particular, technology has made a big impact on the treatment of chronic illnesses, such as major depression, because technology offers self-management strategies and significantly improves adherence to medications with reminders and messages of support.

VIII. **National Telemental Health Program**

Recognizing the mental health impact of the Covid-19 pandemic, Finance Minister Nirmala Sitharaman announced that the center will launch a national telemental health program. The pandemic has drawn attention to mental health issues affecting people of all ages. To improve access to quality mental health counseling and care services, a national telemental health program will be launched, the finance minister said in her Budget 2022 speech. The National Telemental Health Program will be a network of 23 telementalcenters of excellence including mental health. NIMHANS (National Institute of Mental Health and Neurosciences) will be the hub center and IIIT Bangalore will provide technological support to the mental health program. Dr GirdharGyani, director-general of the Association of Healthcare Providers (India), said the government's intention to focus on establishing 23 mental health centers will be beneficial in general and long-COVID patients in particular. Dr N.K. Pandey, chairman and executive director of the Asian Institute of Medical Sciences, said cases of depression and anxiety disorders are up about 25 percent globally and 35 percent in India alone. Dr Mona Duggal, Associate Professor (Community) at the Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, said the National Tele Mental Health Program will provide the necessary boost to the framework of telemedicine services and virtual clinics. The health sector has been allocated Rs.86,200.65 crore in the Union budget, up 16 per cent from Rs.73,931 crore in 2021-22, with the Government also announcing the National Tele Mental Health Program and running an open platform for the National Digital health ecosystem. Of Rs 86,200.65 crore, Rs 83,000 crore has been allocated to the Department of Health and Family Welfare while Rs 3,200 crore has been allocated to the Department of Health Research.

IX. **National Institute for Mental Health and Neuroscience (NIMHANS)**

The National Institute of Mental Health and Neurosciences (NIMHANS) is an institute of national importance governed by the Act of Parliament entitled NIMHANS Act 2012. This institute is a multidisciplinary institute for patient care, academic pursuit, and cutting-edge research in the field of mental health and neuroscience. The central government recognized its outstanding academic position, growth and contributions and declared it a "Deemed University" in 1994. In 2012, NIMHANS was awarded the status of an "Institute of National Importance". The Primary Care Psychiatry Program (PCPP) is an initiative of the Tele Medicine Centre, National Institute of Mental Health And Neurosciences (NIMHANS), Bengaluru, India, which has now developed into a Diploma in Primary Care Psychiatry (DPCP) course .as a sample course. The pilot experience in Mandya evolved into the DPCP course, which is a 1-year digitally driven online module in addition to a 10-day on-site course at NIMHANS. The Community Psychiatry Unit conducts various activities ranging from training, research, capacity building, outreach programs (camps) to community-based rehabilitation at the institute. The unit works across state and central governments to provide support for policy making, human resource empowerment, etc. under the National Mental Health Program in project mode. A multidisciplinary, state-of-the-art team means the unit delivers excellent public mental health services.

X. **National Drug De Addiction Program**

The Department of Health and Family Welfare operates a national “Drug Weaning Program (DDAP)” with the aim of providing affordable, easily accessible and evidence-based treatment for all substance use disorders through the state health facilities. They also build the capacity of healthcare workers to identify and treat substance use disorders. And the ministry has published the "Standard Treatment Guidelines for the Management of Substance Disorders and Behavioral Addictions." The Ministry of Social Justice and Empowerment implements “NashaMukt Bharat Abhiyan” (NMBA) in 272 identified vulnerable districts. The Department of Social Justice and Empowerment is running a project entitled Establishing and Implementing Capacity Building Mechanism for Addiction Treatment Facilities in India. The project organizes 5-day training workshops for staff from various government-run/supported/funded institutions set up to treat drug addiction in the country.

XI. **Virtual Conferencing Guidelines, 2021**

A virtual conference differs from a simple virtual meeting. It's also more involved than a webinar. They are often multi-day, hosted online, and can include keynotes, panel discussions, live entertainment, training, education and certification, sales product demos, solution sessions, industry trends/thought leadership, product training/launch, and more. The purpose of virtual conferencing is lead and demand generation, acceptance and retention, brand awareness and relationship building. A virtual conference is a great alternative or complement for hybrid events to an in-person conference. A virtual conference allows companies to reach a wide audience, as virtual conferences often result in eight times as many registrations as traditional in-person conferences. We've seen this firsthand. Our flagship onsite event, Cvent CONNECT, had over 4,500 attendees in 2019, but Cvent CONNECT Virtual, the same event but entirely virtual, had over 40,000 registrations. Of course, there's no substitute for in-person interaction, but a virtual

conference is a viable option when key demographics are spread around the world or when travel isn't an option. While many virtual conferences have been free recently, there is a shift towards some form of cost as this type of event becomes more mainstream. Virtual conferencing can help greatly increase brand awareness, networking opportunities, lead generation and more.

PRECEDENTS

- **Chandan Kumar Bhanik vs. State of West Bengal (1988)** – In this case the apex Court observed: "Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues".
- The Supreme Court, in the **HussainaraKhatoon vs State of Bihar**, held that speedy trial was an essential and integral part of the fundamental right to life and liberty enshrined in Article 21 of the Constitution. Soon after, in a public interest litigation (PIL), that of **VeenaSethi vs State of Bihar case in 1982**, the court was informed through a letter that some prisoners, who had been 'insane' at the time of trial but had subsequently been declared 'sane', had not been released due to inaction of the state authorities, and had remained in jail for 20 to 30 years. The court directed them to be released forthwith, considering the requirements of protection of right to life and liberty of the citizen against the lawlessness of the state.
- **Accused X v. The State of Maharashtra, 2019** – Crime and mental health has a long relationship. This case helps to understand this relationship. Petitioner relied upon Bachan Singh v. State of Punjab, 1982 case. The Hon'ble Supreme Court considered all factors that lead to crime but the brutality of crime and his tendency to commit such crime cannot be ignored. Therefore, the Court reduced the death sentence of life imprisonment.
- S**heela Barse vs. Union of India and others** – In this case the apex Court observed as under:
    - ✓ Admission of non-criminal mentally ill persons in jails is illegal and unconstitutional;
    - ✓ All mentally ill persons kept in various central, district and sub jails must be medically examined immediately after admission;
    - ✓ Specialised psychiatric help must be made available to all inmates who have been lodged in various jails/sub jails;
    - ✓ Each and every patient must receive review or revaluation of developing mental problems;
    - ✓ A mental health team comprising clinical psychologists, psychiatric nurses and psychiatric social workers must be in place in every mental health hospital.
- Financial obligation of a welfare state in a leading case, that of **State of Gujarat and Another vs. KanaiyalalManilal and others**, the Court referred to the provisions of cost maintenance to be borne by the Government in case of mentally ill persons under Section 78 of the Mental Health Act. The Court opined that in a welfare state like India, it is not merely a matter of grace, but a statutory obligation of the State Government to bear the cost of mentally ill persons.

- In **Francis Coralie Vs Union of Delhi**, it was held that the right to life does not mean a mere animal-like existence but a more meaningful life, a life of physical and mental integrity. Further, in **State of Punjab and Others vs. Mohinder Singh**, it was also stated that right to health is integral to right to life. The state government has a constitutional obligation to provide health facilities and denial of medical aid due to non-availability of beds in government hospitals amounts to violation of Article 21.
- Similarly, in **MahendraPratap Singh vs State of Orissa**, a case pertaining to the failure of the government in opening a primary health care centre in a village, the court held, "In a country like ours, it may not be possible to have sophisticated hospitals, but definitely villagers within their limitations can aspire to have a Primary Health Centre".
- **Rakesh Ch. Narayan vs. State of Bihar** – In this case certain cardinal principles were laid down by the apex Court. These are:
    - ✓ Right of a mentally ill person to food, water, personal hygiene, sanitation and recreation is an extension of the right to life as in Article 21 of the Constitution;
    - ✓ Quality norms and standards in mental health are non-negotiable;
    - ✓ Treatment, teaching, training and research must be integrated to produce the desired results;
    - ✓ Obligation of the State in providing undiluted care and attention to mentally ill persons is fundamental to the recognition of their human right and is irreversible.
- On the basis of two public interest litigations, **B.R. Kapoor and Anr. vs. Union of India (UOI) and Others** and **PUCL vs Union of India**, both relating to functioning of the hospital for mental diseases, Shahdara, Delhi, the Supreme Court instructed the New Delhi administration to take immediate steps to set up a mental hospital-cum-medical college with sufficient autonomy to bring about quality changes in patient care. This led to the formation of the Institute of Human Behaviour and Allied Sciences, IHBAS.
- In **Rakesh Chandra Narayan vs the State of Bihar and others**, the court gave various number of positive directions from the apex court and brought about a few qualitative changes and improvements in the management of the RMA, including the change of name to RINPAS and an autonomous status for the institute, a directive to the NHRC to monitor, supervise and co-ordinate the functioning of the institute from November 1997. Upon being entrusted this work, the Commission examined the scope and objectives of the remit of the Supreme Court, as also the manner in which the Commission should set about fulfilling the responsibilities assigned to it.

    - **Dr.UpendraBuxi vs. State of U.P. and others** - The apex Court requested the NHRC to be involved in the supervision of mental health hospitals at Agra, Ranchi and Gwalior. The Commission on its part conceptualised and translated to action a Project on Quality Assurance in Mental Health Care in the country. The recommendations in a capsule form are:
        - ✓ Immediate abolition of cell admissions;
        - ✓ Gradual conversion of closed wards into open wards;
        - ✓ Construction of new wards of shorter capacity (not more than 20) for use as open wards;
        - ✓ Streamlining admission and discharge procedure in accordance with provisions of the Mental Health Act, 1987;
        - ✓ Upgradation of investigation facilities;

- ✓ In-service training of all staff members;
- ✓ Ensuring supply of nutritive food of 3000 kilocalories per day to each patient;
- ✓ Developing occupational therapy facilities;
- ✓ Developing rehabilitation facilities including day care centres.

CHALLENGES:

Policies

1. MHA, 2017
    a. ***MENTAL HEALTH ESTABLISHMENTS*** – The state should provide all the care for the individuals admitted. The government wants to bring the private sector into it and the provisions have brought all MHE's private and public under its purview. The lacuna exists in here, as the government did not specify how the burden of the cost of treatments and aftercare will be addressed.
    b. ***ESCAPING FROMRESPONSIBILITY*** - The mentally ill patients can appoint their 'Nominated representative's with a simple statement, who will be furtherly addressing the issues and decisions to be taken on behalf of the PMI. The act stipulates that without an application from NR, a PMI cannot be admitted to the hospital against his or her wish. So, it is clear that the government of India is not willing to take the responsibility and covertly impose upon relatives and caregivers in the name of empowering them. The drawback of the provision is also that, the single persons would be at a disadvantage as, without NR, MHE would not be able to admit them. The procedure specifies that MO has to request the District review board to appoint an NR and it would take 7 or more days. Until then, such persons who may suffer at risk of suicide would remain in abeyance.
    c. ***ADMISSION CRITERIA***- It can be clearly observed in the act, that the state is not interested in creating a competent mental health workforce. In the UK, the psychiatrists are not given the decision power to recommend compulsory admissions until they complete specific mandatory training and get approval from the secretary of state. But in India, the mental health professional status is given to nurses, psychologists and social workers working in MHE. Their major work is to make a decision on individuals' mental health and admission criteria. Senior professionals with great experience are needed for this significantly difficult task. This legislation is silent on requirements or authorised process for the professionals to be involved in admission criteria.
    d. **STATE'S DESPOTISM** - According to section 100 of the MHA, 2017, the state can remove any person wandering in a public place if the police have 'reason to believe' that individual is mentally ill. The section specifies that The medical officer or mental health professional in charge of the public mental health establishment if on assessment of the person finds that such person does not have a mental illness of a nature or degree requiring admission to the mental health establishment, he shall inform his assessment to the police officer who had taken the person into protection and the police officer shall take the person to the person's residence or in case of homeless persons, to a Government establishment for homeless persons. There is no mention of using ambulances, instead of police vehicles for "forceful transport". Besides that, section 100(b) also mentions that, to take under protection any person within the limits of the police station whom the officer has reason to believe to be a risk to himself or others by reason of mental illness. In common parlance, the act empowers the state to enter a private residence without a magistrate's approval if the police have the reason to believe to do so.

e. ***FUNDING*** - The commitment to uplifting mental health care standards will not be possible without proper budget allocations. Section 18(11) The appropriate Government shall take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity are made for effective implementation of the provisions of this section. The terms-(i) "adequacy" means in terms of how much is enough to offset inflation;(ii) "priority" means in terms of compared to other budget heads;(iii) "equity" means in terms of fair allocation of resources taking into account the health, social and economic burden of mental illness on individuals, their families and care-givers. For a clear understanding, the terms 'enough to offset inflation', 'budget heads' and 'fair allocation of resources are just for documents and not for implementation purposes.

At present, the budget allocations for the health sector don't even constitute 2% of our GDP. The economic survey 2020-21 had strongly recommended an increase in public spending on healthcare services from 1% to 2.5% - 3% of GDP, as mentioned in the National Health Policy 2017. The union budget 2022-23 seems very disappointing for the healthcare sector. There is none in the budget for the National Mental Health Programme; the allocation is less than 0.05% of the total healthcare budget. It is clearly evident that the government's promises of' Proper Health' is far from reality. The Former Union Health Secretary remarked that A disappointing budget for health and education need to remember that roads and ports don't make sense if people are illiterate and sick.

f. ***HALF-WAY HOMES***- Section 18(2)(b) of the act mandates the state governments provide halfway homes and sheltered accommodation for PMI. The main intention of incorporating such provision is to provide care and rehabilitation to the discharged PMI's before their survival in the common society. But the Maharashtra state government had not established the required halfway homes and housed 186 PMI's in beggar homes, homes for women and old age homes which resulted in the death of three PMI's. In Gaurav Kumar Bansal v. Dinesh Kumar &Ors, the apex court had directed the states to rehabilitate persons cured of mental illness in halfway/long-stay homes prior to acceptance by their families. They deprecated the practice by states of re-designating old age homes and other institutions as halfway homes saying it will not serve the purpose of rehabilitation mentioned in the act. The bench led by Justices D Y Chandrachud and M R Shah stated that "there is no question of transferring them from mental health establishments to beggar homes or old-age homes".

g. **MENTAL HEALTH**- The act defines a prisoner with mental illness as a person who is under trial or convicted of an offence and detained in a jail or prison. The act mandates setting up a mental health unity at least one prison in each state. The act also mandates the mental health review Board to visit and inspect the prisons and seek information from medical officers. The prison Statistics India data, 2019 shows that inmates suffering from mental illness constitute 1.5% of the total prison population. In the case of Shankar SopanShikare vs the state of Maharashtra, the Bombay high court had held that there are no facilities like a separate cells for mentally ill patients in the central Jail and Government medical college and Hospital,

Aurangabad. The justice had further commented that "in terms of section 121 of the Mental Healthcare Act, 2017 the state government is yet to frame rules and not yet framed even in the year 2020. It is a sordid state of affairs that the police machinery, the jail authorities and even the courts below have the ignored the provisions of the Mental Healthcare Act,2017".

h. **MENTAL HEALTH REVIEW BOARDS**- Section 82 act mandates for the establishment of the Mental health review Board to address the violations of the Mental healthcare Act, 2017. The MHRB has the power to register, review, alter, modify or cancel an advance directive and to appoint NR, to decide the applications from a PMI. Despite the mandate of establishment for ensuring the proper mental healthcare services, many states had not established the MHRB's. Only Karnataka and Tamil Nadu had established the Mental Health Review Boards in India.

General Challenges

1. **ACCESS** - Mental health has been a major concern worldwide, where about 14% of the global burden of diseases is attributed to neuropsychiatric disorders. It was identified that especially in the middle income countries and most low income countries the progress of mental health care has been slow, but primary challenges as to the slow diffusion of mental healthcare into the public was because the delivery of mental health care is not considered as one of the primary care in the health sector, low number of trained professionals in mental health care often compromises the quality of the mental healthcare that is been rendered to the public, and lack of awareness in the public with regard to the mental health care or mental illness. Accessibility to a proper healthcare services is hindered as in the district mental health programme are not uniform with various provisions of 2017 act and also persons with disability act of 2016, The procedural aspect as to access and mental care services becomes a challenge accessibility to mental health services is also impeded by financial hurdles since only a few could afford private health care while all the government-sponsored mental health care facilities offered the services for free and subsidized still has to avail such services it requires regular visits to the government facilities where often medications are not adequately sufficient or else dispensed in small doses so there is a lot of time and transportation cost also involved as to obtain medication refills for the patient especially patient was suffering with chronic mental illness. Also the implementation of covering mental illness in the insurance policies is delayed.

2. **AFFORDABILITY** - Healthcare is considered a luxury, where a study by Oxfam India has noted that 63 million people due to the health care cost are pushed into poverty - two every second. Mental health is even more so far for the country, the national mental health survey in the year 2016 has reportedly stated that lifetime prevalence of 13.7% and even the global burden of disease survey of 2010 have noted that the mental illness of the country has contributed to 31% of years lived with disability. With a major share of the mental health care in India that is 80% is rendered by the private sector hence affordability of mental healthcare is a challenge especially less accessible to people who have a low income, low educational levels and women since income has been identified as the cause of inequity in health care. Even the Supreme Court has questioned the insurance regulatory and development authority of India as to why the insurance

companies were not covering the cost of mental illness in the cover as there has been a PIL filed stating the companies were violating the provisions of 2017 act which has ensured for treatment of mentally ill to be covered in the **medical insurance** in the same way as the physical illness is covered. The cost and the policies have been in a way which makes affordability of mental health care a challenge[lvi]

3. **AWARENESS** - Research on mental health and mental illness was accounting only 4.5% of all published Indian research between the years 1990 and 2016 since Health literacy and awareness about mental health are the two important aspects where stigma or disparity with respect to mental illness would result in ignorance and misinformation. One of the studies concluded that mental literacy in India, especially among adolescents, was very low i.e 29.04% have identified depression and stress of Mania or psychosis was only identified by 1.31 percent. This study has also shown that stigma among the people has been one of the hindering aspects for seeking the help and early detection. However, the bulk of awareness contributed from the following platforms is conventional media where in recent times it was observed that mental health was addressed by celebrities sharing their own experience of depression, usage of taglines and content which narration, documentaries are media driven so far. Imparting awareness and de-stigmatisation of mental illness in education is necessary as to remove discrimination so that in the very young age any mental illness could be detected earlier and intervention could be sorted out, this could help young people or children were suffering from or going through any mental illness could come up and was out about their problems. It was also identified especially in the working industry there was a loss of workforce or absence of workforce who go through mental illness which is not addressed in all **the corporate's so mental illness** has to become a part of corporate social responsibility as to maintain the productivity and also make sure that the companies are concerned about the well-being of the workforce.[lvii]
4. **COLLABORATIONS & REHABILITATIONS ARE MINIMAL** - Collaborative care may include case management or coordination, patient education, provider education, systematic follow-up of the patient, use of guidelines and algorithms, psychological interventions, and shared decision-making with patients.[lviii]

5. **POOR MONITORING & EVALUATION OF HEALTH PROGRAMMES**- Evaluations in India are predominantly used to validate the successes of programmes, rather than for policy and budgetary planning, and this needs to change. Currently, at the national level the Development Monitoring and Evaluation Office (DMEO), which is an office attached to NITI Aayog, is responsible for driving evidence-based policymaking by monitoring and evaluating government policies and programmes. Management Information Systems (MIS) for monitoring programmes and evaluations have remained a need-based exercise only.[lix]

6. **TREATMENT GAP:**
Primary challenges associated with mental illness such as lack of access, affordability, and awareness lead to significantly high gaps in treatment. Despite the efforts taken as to improve and enhance the mental health system across the country study conducted by NMH survey in the year 2015 to 16 revealed that there exist a huge treatment gap ranging from 28% to 83% where is mental disorders like psychotic disorders, MDD, neurosis,

BPAD while only 86% treatment gap exist for alcohol use disorders except for epilepsy all mental disorders displayed a treatment gap more than 60% and highest was further alcohol use disorders.

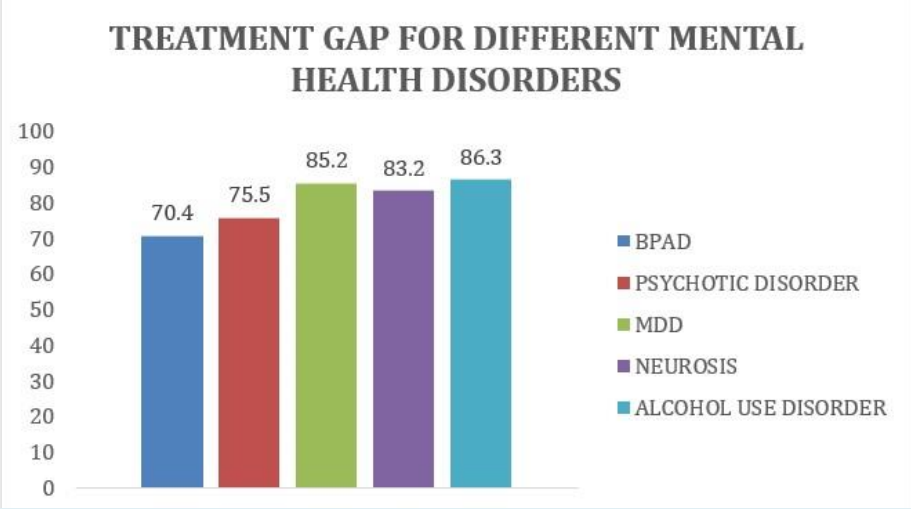


Fig. Treatment gap between various disorders, Source: NHMS 2016 Summary report[lx]

7. INSENSITIVITY TOWARDS MENTALLY ILL:

Mental health disorder in India is looked with a sense of judgement and there's a lot of stigma surrounded around those who suffer from mental illness. The results showcase how mentally ill are judged and perceived alike and the study also suggests that nearly creating awareness about mentally ill or mental health care isn't just sufficient in order to address the judgemental perception of the society towards the mentally ill strong holistic program has to be adopted which mainly addresses the stigma and also involves community-based support would be helpful in the de-stigmatisation.

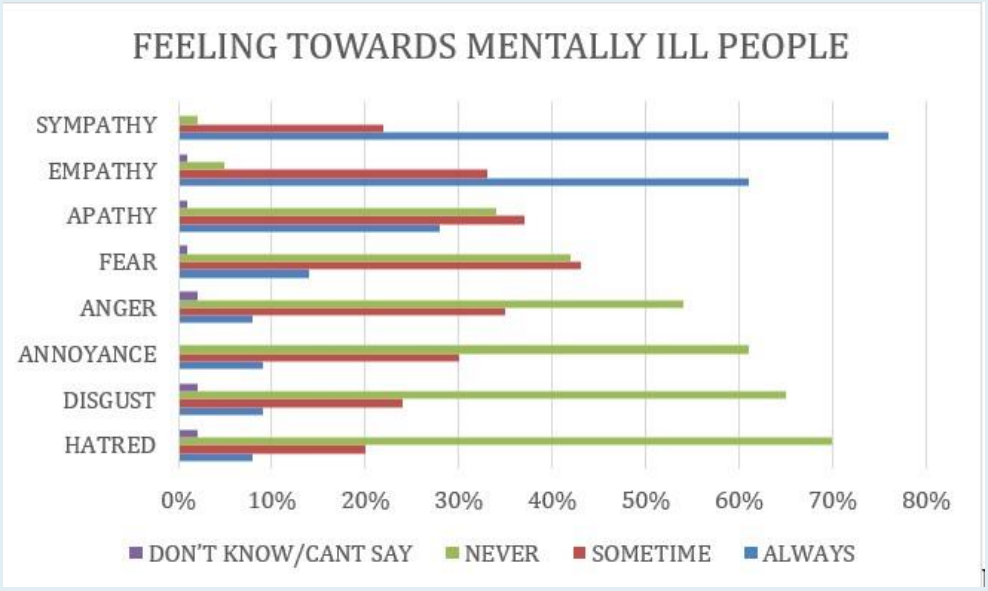


Fig. Public feeling towards mentally ill, Source: live love laugh foundation survey, 2018

8. INADEQUATE BUDGET ALLOCATION:

When presenting the national budget in February 2022, Indian finance Minister Nirmala Sitharaman has referred that there has been a tremendous increase in mental distress in the country especially during the pandemic which would lead into mental health issues in people of all the ages a plan was introduced to set up a national daily mental health programme in India as to enhance the accessibility to a quality mental health care, counselling and care services. Anxiety and depression are the common mental illnesses that could be the result of a financial or an economic burden, since in the midst of Covid-19 pandemic unemployment and isolation resulting from the lock down and also phobia surrounding contracting the virus has resulted in mental health crisis in the country. Budget allocation of Rs.5 97.14 crore was a direct allocation towards mental health under the Ministry of health and family welfare but it was less than 1% of the total health budget. Even within the budget read 557.44 was for two central funded institutions.

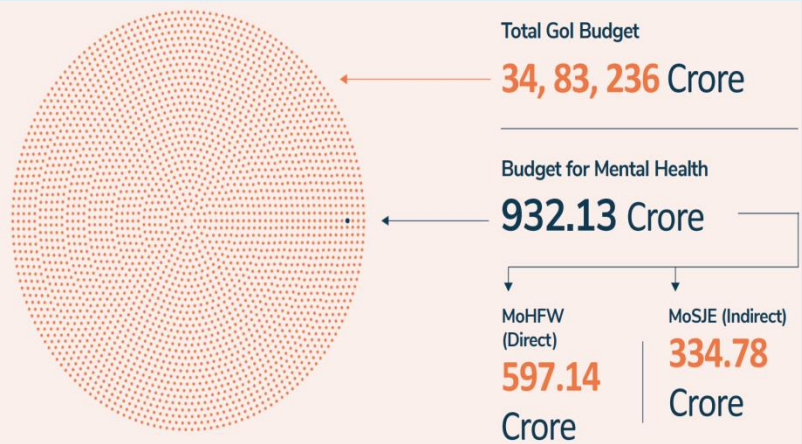


Fig. Budget allocation for mental health breakdown, Source: India mental health observatory for Budget or mental health, Analysis of union budget 2021-22

The current direct allocations made for mental health care are grossly insufficient when it is to be considered that 14% of the population lives with some form of mental illness and there exists a huge treatment gap ranging 72 to 92%. Also there have been some funds allocated for mental health under the scheme for implementation of rights of persons with disability act 2016 and Deendayal disabilities rehabilitation scheme but still there is a challenge as to what proportions these funds are for the person with mental illness. It was only 0.81% of expenditure budget allocated directly to mental health, only 7% was allocated for the national mental health programme. There also exists the problem of underutilization of the funds especially observed interaction level activities and district level activities while implementation of mental health programmes.

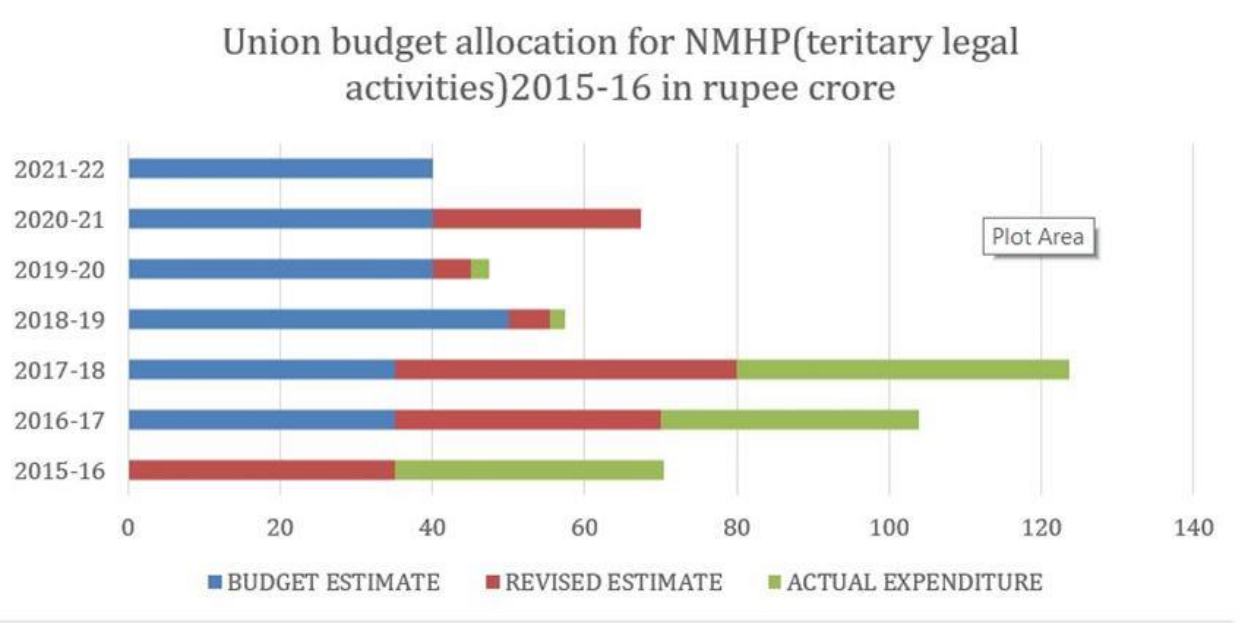


Fig. Union Budget allocation for mental health programmes, Source: India mental health observatory for Budget or mental health, Analysis of union budget 2021-22

The reasons for underutilization and poor formation between the Center, state, district in demarcation of funds which was impeded by administrative delay. Another problem identified was lack of data as to determine the proportion of funds for budgeting the DMHP since DMHP functioning is important as to cover a wider population and improve the accessibility to mental health care. Kerala was only the one state which is considered to have hundred percent coverage with respect to DMHP.[lxi]

9. HUMAN RESOURCE SHORTAGE:

India projects second position in terms of population which clearly indicates a challenge in rendering mental health care and catering the same to 1.3 billion people spread across. The greatest challenge is resourcing for mental health services.

MAGNITUDE OF MENTAL ILLNESS AND AVAILABLE RESOURCES IN INDIA	
VARIABLE	**NUMBERS**
POPULATION OF INDIA	**130 crores**
Number of people suffering from diagnosable psychiatric conditions(current)	**10% or 13 crores**
Number of people suffering from severe mental disorders(current)	**0.8% or one crores**
Number of beds for patients with psychiatric disorders (approximately)	**60000**
Number of psychiatrists	**9000**
Number of psychiatric nurses (mental health nurses)	**2000**

Number of psychiatric social workers	**1000**
Number of clinical psychologists	**1000**

Fig.Magnitude of mental illness and available resources in India, Source: Indian J Psychiatry

Psychologists and psychiatric workers are very low, play psychologists, social workers and working nurses are 0.03, 0.03 and 0.05 by 1,00,00 population. The Indian psychiatric Society accounts to 7000 registered psychiatrists in the country; this indicates that there is a gross deficit with respect to human resources that would even affect the quality of the care that will be rendered in India.[lxii] The estimated number of psychiatrists available in India in 2018 was approximately 9000. In low and middle income countries very few mentally ill people receive standard health care and the treatment gap exists because of scarcity specialist resources and insufficiency in resource allocation. A comprehensive Indian mental health workforce has to be achieved where currently there is a deficit in the workforce addition to this only about six of 640 districts have implemented the district mental health programme which was one of the nation effort to decentralize the mental health care to promote early detection and stigma reduction but despite the efforts within these implementing districts they have been PC doctors that remain untrained.[lxiii]

VULNERABLE GROUPS AFFECTED FROM MENTAL HEALTH:

a) STIGMATIZATION OF LGBTQIA COMMUNITY:

Stigma is related to the Mental Health Conditions. LGBTQIA individuals may be at risk for suicidal behavior due to perceived stigma and psychopathology. Both quantitative and qualitative analyses revealed external attributions for discomfort, calling into question this diagnosis and suggesting that the discomfort that homosexual individuals may have related to their sexuality is largely because of societal factors that are related to stigma and discrimination. Sexual minorities experience internalized homophobia, felt stigma, and actual stigma which contribute to higher stress that increase vulnerability to mental health conditions. There is a need of more epidemiological studies with larger and non-inclusive populations are recommended from different parts of the country, including more semi urban and rural areas. [lxiv]

b) DEPRESSION AND PRISONERS IN INDIA:

Depression is a clinical condition that, contrary to popular opinion, cannot simply be overcome with time and it needs to be treated. Imprisonment can often lead to feelings of isolation, anxiety, low mood and prisoner depression in prisoners. Prisoners are under huge stress mentally and physically, leading to psychological changes that can lead to depression. Researchers consider prison as a “powerhouse of mental problems”.

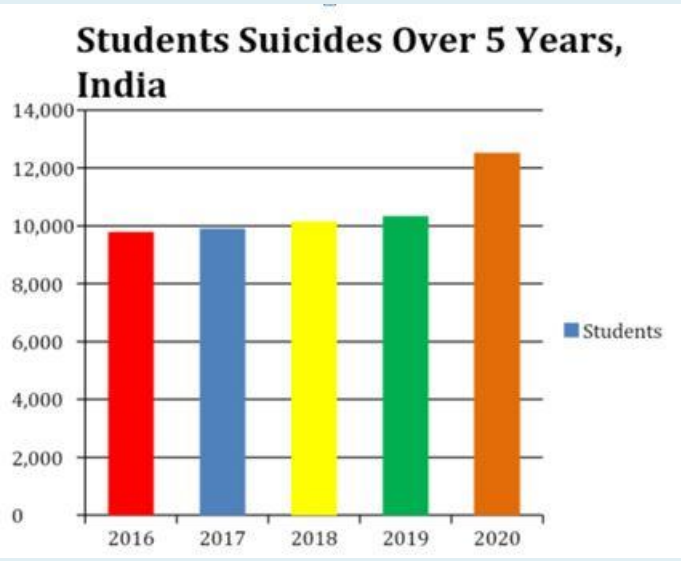
c) FARMERS SUICIDE IN INDIA:

India has the highest suicide rates in the world. 5,579 Indian farmers died by suicide in 2020 according to Crime Records Bureau (NCRB). Records Bureau 3.7 Lakh farmer suicides from 1995, there is under- reporting and data manipulation. About 2000 farmers leave their profession every day, there is financial risk of high cost of credit, debt trap, external dependency, no assured incomes, climate change and other environmental stress. As per census 2011, 73.3% of Rural Workers in Agriculture. With the impact of Covid-19 it is believed farmers have suffered a huge loss due to bankruptcy , the measures economist say, are forcing millions of households into poverty and contributing to long run tragedy of farmer suicides. Distress among farmers in the state pushed 2,498 of them to end their lives in 2021 in Maharashtra .Data from the state revenue department shows that despite loan schemes of the government, farmers would continue to commit suicide because of their inability to repay loans. In Maharashtra the suicide rates of farmers in 2020 is 2,547 while in 2021, 2,498 ended their lives. There is no major reduction in the suicide rate of Farmers. "The young whistle-blowers Foundation" are of the view that ignoring the mental aspect of farmers and just giving loan waivers will never address the problem .A bankruptcy scheme with cost effective mental health support specifically for farmers facing the issue would help resolve their problems.

d) INCREASED EDUCATIONAL COMPETITION IN INDIA:

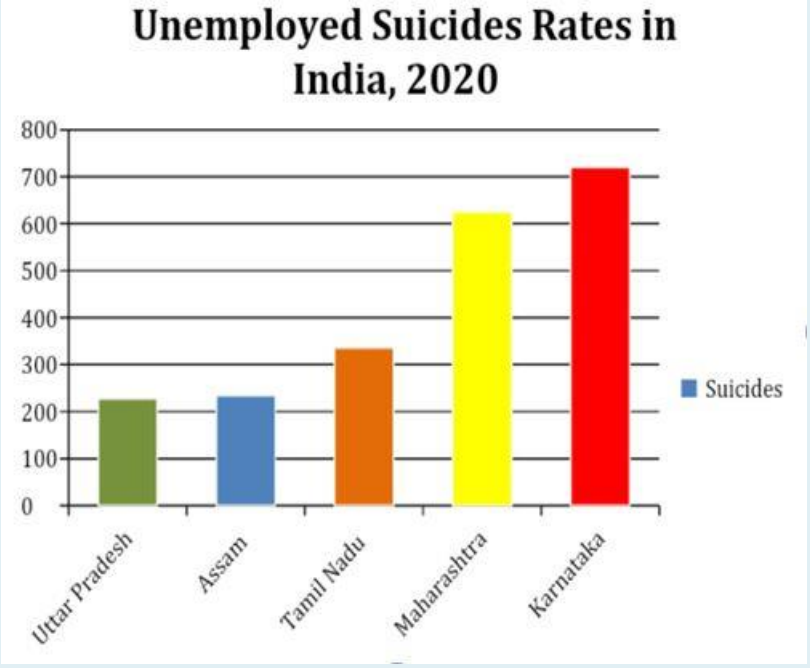
Among the specified cases of suicide, failure in examinations is the most predominant (NCRB, 2002) According to reports from the Child and Adolescent Psychiatry Clinic, AIIMS diagnosis of adolescent depression in India has gone up from 0.4% in 1980 to 6.5% in 2005.

With the impact of COVID-19, more students ended their lives in 2020 than 2019, according to data compiled by the National Crime Records Bureau (NCRB). Student Suicides spiked to a new high of 12,526 in 2020 contributing 8.2% deaths. The biggest spike in deaths was recorded in Odisha, where the number of student suicides reached 1,469 a jump of 287% over 2019.Maharashtra recorded more student suicides than Odisha with 1,648 young people ending their lives.



e) UNEMPLOYMENT IN INDIA:

In India suicides due to unemployment was highest in COVID-19 hit 2020 among the unemployed in the recent past. Over 16,000 people committed suicide due to bankruptcy or indebtedness while 9,140 people ended their lives due to unemployment between 2018 and 2020.A total of 3,548 people committed suicide in 2020 due to unemployment on data collected by National Crime Records Bureau (NCRB). Citing NCRB Minister of State for Home Nityanand Rai inform that number of suicides in 2020 on account of unemployment was almost 24% higher than those recorded in the same category in 2019 (2851). 2014-2019 Suicides due to unemployment has been increasing over the last few years:



RECOMMENDATIONS

After going through intensive research on various policies and institutions in India, we came across various challenges at different levels. Therefore, Following are the recommendations suggested by us for better implementation of policies and providing better health care to mentally ill persons:

1. **Policies**

Laws should address not only curative but also preventive, promotive and rehabilitative aspects. We have found certain lacunas in various legislations dealing with mentally ill persons.

1.1. Mental Health Act, 2017

1.1.1. **Psychiatry units in general hospitals are kept out of the purview of these act- Common mental disorders** like anxiety and depression, which do not come under the purview of this act, are effectively treated in these settings. Therefore, this legislation needs to have some provisions for Psychiatry units to deal with minor mental disorders.

1.1.2. **In the MHA, definitions of 'convalescent home' and 'psychiatric hospital' and 'psychiatric nursing home' are clubbed together and both the terms are equated for legal purposes.** This has led to an outcry among private convalescent homes and rehabilitation centres operated mainly in the non-governmental sectors whose aims and functions are distinct from psychiatric hospitals. It is proposed to bring their monitoring under any alternative Acts like the Rehabilitation Council Act.

1.1.3. **Active Public-Private linkage** - Ensuring adequate standards of care both in institutions and in the community requires active public-private linkages, as only governmental agencies cannot comprehensively shoulder the responsibility of the care of the mentally ill.

1.1.4. **Choice of treatment** - The Act is silent regarding the choice of treatment, consent for treatment, and the method to be adopted when a severely ill patient refuses well established treatments like medication or modified electroconvulsive therapy (ECT) (under anesthesia) or unmodified ECT (without anesthesia). Some psychiatric hospitals continue to use unmodified ECT, without the consent of the patients or the legal guardian. One method has been to obtain the opinion of two independent psychiatrists and the consent of the hospital RMO or superintendent who acts as a surrogate guardian. Considering the well-established efficacy of modified ECTs and from a human rights perspective, modified ECT's should be mandated.

1.1.5. **De-institutionalisation,**ie., minimising custodial care and encouraging treatment of the patient in the community is a wonderful concept, but can only occur if community outreach services and resources are strengthened.

1.1.6. **Emergency ambulance/escort services** - Many helpless families requesting emergency ambulance services to escort or shift a violent patient to psychiatric hospital. Unfortunately, there are no guidelines or provisions under this act for crisis intervention to help these families

1.1.7. **Rehabilitation/aftercare of the mentally ill persons** – This act has elaborated on the admission and discharge procedures; there are no provisions available for

rehabilitation/aftercare of the mentally ill persons under this Act. They require social and vocational rehabilitation.

1.1.8. **Social welfare institutions**[lxv] - There are no provisions in the Act for placing these treated and stable persons in other social welfare institutions. This issue calls for inter-sectoral coordination between the Departments of Health, Women and Child Development, and Social Welfare.

1.1.9. **Judiciary intervention and NHRC to conduct inquiry** - The issue of death during custodial care of a mentally ill person is not addressed by this act. In case of any custodial death of any prisoner there is provision in CRPC for enquiry and even NHRC have played a proactive role by investigation in any such death but in the case of custodial death of mentally ill person in a mental institution there are no specific provisions in this act.

1.1.10. **Provisions for persons with substance dependence** – This act remains silent on the issue of admission and treating persons with substance dependence without any behavioural changes who refuse consent for treatment. It is important to understand that such persons have different needs than any other mentally ill person. Moreover, there are high chances of their recovery if given proper rehabilitation opportunities.

1.1.11. **Mandatory psychiatrists in prisons** - No provisions have been made for a baseline assessment (during induction into prison) and periodic examination of all the prisoners for mental illness. Many international studies have shown a high prevalence of mental disorders among prisoners. There are many public interest litigations regarding the issue of detaining mentally ill persons in jails. Unfortunately, only a few prisons in India have attending psychiatrists. There should be provisions in this act for mandatory psychiatrists in prisons.

1.1.12. **Pre-trial assessment** – There should be provisions under this act and CRPC to have a pre-trial assessment of the accused person against whom the entire trial is going to proceed ahead. It is a very important principle of natural justice that 'fitness to stand trial'. If an accused is suffering from mental illness at the time of trial, the presiding judge will not be able to proceed with the case until the accused becomes mentally fit to stand trial.

1.1.13. **Judiciary and executive should be adequately sensitised**– Implementation of this act and human rights for the mentally ill will remain a distant dream if the judiciary and executive are not adequately sensitised.

1.1.14. **Media/Cinema and mentally ill persons** – Media trials also play an important role in bringing a lot of stigma and ill feeling to the person who is mentally ill. Media should be prevented from displaying footage of any such person. Also, the media should be restrained from using terms like Lunatic or disabled persons.

1.1.15. **Natural guardians should be given priority over legal guardians or decisions should be taken from the common consent of both** – This act is rigid and cumbersome on the right of a legal guardian to dispose or deal with the property of mentally ill person. This aspect requires simplification at least for the natural guardian on the lines of the procedure outlined in the National Trust Act 1999.

1.2. Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation), 1995

1.2.1. **Differentlyabledperson** - The Disability Act of 1995 defines 'disability' as (i) blindness; (ii) low vision; (iii) leprosy-cured; (iv) hearing impairment; (v) locomotor

disability; (vi) mental retardation, and (vii) mental illness. There was much ignorance among policy makers and administrators about mental illness as a disability. Terms such as disability shall not be used. They can be replaced by softer terms like 'differently abled persons'.

1.2.2. **Representation for mentally ill persons -** There has been no representatives or representation for persons with mental illness in the Central Coordination Committee. To understand the challenges and policies for the benefit of such persons. The Central Coordination Committee shall have their representation.

1.2.3. **Development of halfway homes**, vocational training centres, social-skill training centres, cognitive retraining centres, day-care centres and long-stay centres requires advocating and initiating at regional levels.

1.2.4. **Indian Disability Evaluation and Assessment Scale (IDEAS)** - five dimensions, namely, 'Self-Care'; 'Work', 'Interpersonal Activities', 'Communication and Understanding'; and 'Duration'.

1.2.5. **Awareness programs about Temporary Disability certificate** - This information is not widely known, and in several instances such certificates have not been honoured by concerned administrators, and patients have been denied their rights.

1.2.6. **Awareness programs about Travel concessions** - Concessions are little known. This concession will greatly help people who often have to travel long distances for consultation.

1.2.7. **To have a strong monitoring & implementation system** - Despite having a strong legislation, its implementation lacks due to absence of a strong monitoring and implementing system.

1.3. **National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999** – This act provides for the constitution of a national body for the welfare of people with autism, cerebral palsy, mental retardation, and multiple disabilities. The Act mandates: a) promotion of measures for their care, b) protection of persons with these disabilities

1.3.1. **Combination of Guardians and patients consent** - It should rather be a 'shared decision' making or 'assisted decision' making or 'informed decision' making. The combination of ownership (patients) and responsibility (guardians) is most empowering.

1.4. **The Protection of Women from Domestic Violence Act, 2005 -** Domestic violence is defined in terms of mental, physical, sexual, verbal, emotional and economic abuse.

1.4.1. **Male members unprotected** in circumstances of a woman mounting an attack on men or files a false complaint against men.

1.5. **Narcotic Drugs and Psychotropic Substances Act, 1985** - The NDPS Act focuses on three different categories of persons liable for prosecution.

They are:

a) Drug manufacturers / Cultivators

b) Dealers / Traffickers /Transporters

c) Consumers (Substance users / addicts)

1.5.1. **Only once immunity** - The Act has partially addressed this issue by providing once in a life-time immunity against conviction for undergoing de-addiction treatment if he/she is willing to execute necessary bonds prescribed under the Act. It

is peculiar to note that in case of substance users there are chances of relapse, therefore, it is advised to have a rehabilitation approach against such users rather than having a deterrence based system. Substance dependence syndrome is a life-long illness like diabetes and hypertension. In substance dependence, relapse is a rule rather than an exception. Hence, provision like once in a life-time immunity for treatment is simply not practical.

1.5.2. **Differentiate between the offendergroups** - This Act does not differentiate between the offender groups. The first two groups (manufacturers and traffickers) have monetary motives, whereas the third group (consumers) is a drug dependent group, which does not have any profit-making motive but requires treatment. Research has proven beyond doubt that substance dependence is an illness and requires treatment for a long duration.

1.5.3. **Action group based** - The NDPS Act should act as a facilitator for treatment for persons with substance use. This Act's emphasis should be on stringent action against people involved in manufacturing and trafficking of drugs.

1.6. The Juvenile Justice (Care and Protection of Children) Act, 2000

1.6.1. **Investigation on established institutions to protect juveniles against any kind of human rights violation** - There should have been more emphasis on investing in the establishments of institutions governed under the Juvenile Justice Act. This ultimately defeats the very purpose of the Act to protect and promote the rights of children by providing safe, protective, rehabilitative and social reintegration for full participation.

2. Education policy-

2.1. **Integrated approach to treatment, training, teaching and research** – Mental illness is an area which has very less training and research in India. This needs to be boosted by having an integrated system in which mental health colleges are present along with mentally ill patients in institutions. Therefore, the students can have training under supervision in these institutions.

2.2. **De-stigmatization of mentally ill persons for acceptability and reintegration into the mainstream of society** - Even after treatment mentally ill persons face a lot of stigma in society. They need to be infused back into society by creating awareness among society members of their suffering in the past and their special need for care and love.

2.3. **Increase in undergraduate education in mental health** – There are very less students enrolling for the undergraduate study in the field of psychology this is leading to the main cause which is less number of staff in mental institutions.

2.4. **More Diploma courses to be started**[lxvi] – Minor psychology disorder demands for psychologists which have done a bit of study in this field. Therefore, diploma courses can be started to create more professionals in psychology.

2.5. **Post-graduate training courses** with adequate emphasis on prophylaxis and prevention in line with the principles of modern preventive medicine.

2.6. **Teachers / researchers to have a stint of training abroad:** It is very important for teachers and researchers to understand the international perspective of mental health and how various countries across the globe are dealing with mental health issues.

2.7. **Well-trained staff and mental health nurses required:** Only trained doctors won't suffice the need of mentally ill person. Because such persons need a lot of attention and

love which is devoted by trained staff and nurses therefore, their training is of utter importance.

2.8. **Schools and hospitals need to have Psychologists** to whom students can freely talk about their mental health. Even seminars and awareness programmes need to be conducted for awareness among students of their mental health. Hospitals are also required to have psychologists so that any person suffering from any mental disorder can visit them.

3. **Community outreach programmes** - Community Based Rehabilitation (CBR) has been advocated by WHO and by many international agencies for more than two decades. CBR improves self-esteem, empowerment, self-reliance and social inclusion, which improves the quality of life of persons with disabilities. A paradigm shift from custodial care to community care has occurred because of the following reasons:
a) Proactive legislation;
b) advances in medical technology in assessment and treatment of mental disorders;
c) human rights movement;
d) WHO's definition of 'health' and
e) promotive, preventive, curative, rehabilitative approaches and mitigation of disability. This shift has given a new perspective to the care of mental disorders and has led to the review of mental health legislation.

3.1. **Para Professionals** - Treatment of mentally ill persons in mental hospitals has its severe limitations and can be very expensive. The concept of Paraprofessionals with short and simple orientation and training could deliver reasonably satisfactory mental health care.

3.2. **Need to introduce social workers in mental hospitals**– Social workers should periodically visit mental hospitals to provide love and care to these differently abled persons. This will bring a sense of being linked with the outer world and interacting with people. Care and treatment for the significant proportion of people with mental illness who have never been admitted to a psychiatric facility and who may never need to be if they are provided with appropriate care, support and treatment in their own environment.

3.3. **Arrangement for the care and support of families** – Family plays a vital role in extending love, support and care. They need to have regular visits and provide them a sense of belonging.

3.4. Consumer participation and involvement in the organisation and management of mental health care services.

4. At hospital level

4.1. Need for a mental health service, with improvement in the status, pay and conditions of service of the **medical staff**, with increased opportunities for purely professional work;

4.2. Establishment of a Department of Mental Health in the proposed All-India Medical Institute.

4.3. Creation of **mental health organization** as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services

4.4. Need for **outdoor clinics** in mental hospitals;

4.5. Need to create **goodwill**about mental hospitals by letting the community know that the mental hospital has a real service to be given; convincing people that they need what it

has to offer; making it easily obtainable; making people glad they can have what the institution has to offer.

5. **At home/ schools**
   5.1. **Accepting the fact of their disorder gracefully** without shame and taking the ill person to a mental health facility for evaluation and admission.
   5.2. **Provide Services addressing mental health issues** in schools, child guidance clinics, juvenile homes and remand homes;

   5.3. Create awareness to students (the person in distress) and parents.
6. **During admission –**
   6.1. Every case should be **seen by a magistrate** before and after admission for detention.
   6.2. **Certification for detention should be limited to experts** with recognised qualifications.
   6.3. **Visiting Committees** needed to be set up.
7. **During stay in hospital**
   7.1. Living condition
   7.2. Out-patient Services
   7.3. Bed strength
   7.4. Admissionvia courts
   7.5. Long/short term patients
   7.6. **Electroconvulsive therapy** - There are two kinds of ECT: Modified ECT (under anesthesia) or unmodified ECT (without anesthesia), Unmodified ECT should be abolished and made illegal. Modified ECT shall only be done in the rarest case with prior magistrate consent in writing specifying the reasons for allowing ECT.
   7.7. Recreation and rehabilitation facilities in hospital
   7.8. Community programmes by hospitals
   7.9. **Mental hospital professionals** – Sanctioned and vacancies
   7.10. A largely closed set-up with little networking with academic institutions on the one hand and social organisations on the other;
   7.11. Immediate downsizing of the large hospitals
   7.12. Immediate attention to replacement of old and unsafe structures
   7.13. Conversion of most closed ward facilities to open wards
   7.14. **Interim measures to address human resource shortage** – Short term training courses for mental health professionals, contractual employment of mental health professionals from the private sector;
8. **After discharge** [lxvii]
   8.1. Taking a person to hospital for regular follow-ups whenever prescribed by doctors. **Follow-up home visit by psychiatric** and social workers after discharge.
   8.2. **Rehabilitation Centres** - Preventive, promotive and rehabilitative
9. **Miscellaneous recommendations**

   9.1. **Pro-bono duty on psychologist** and Psychiatrist to provide mental health care for certain persons.
   9.2. **Watchdog**– NHRC has played a vital role of promoter, facilitator and catalytic agent. Hence, it is recommended to establish more body/ department for regular monitoring of such institutions and persons with special needs.

9.3. **Curative treatment** - The majority of mental hospitals in India are out of date, and are designed for detention and safe custody without regard to curative treatment. The conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal

9.4. **Do away with orthodoxy** - It mentioned that chronic starvation or undernutrition, tropical fevers, anaemia and frequent childbirth in women who are unfit for motherhood are responsible for the large numbers of mental breakdown in India.

9.5. **Alternative services** - Need for development of alternative services and linkage in the community for mental health care.

9.6. **Psychological or psychiatric counselling should be provided to prisoners**[lxviii] : for early detection and to prevent mental illness. To prevent people from becoming mentally ill after entering jail, each jail and detention centre should ensure that it provides

i) a conducive environment with physical and mental activities for prisoners that reduce stress and depression;
ii) a humane staff that is not unduly harsh;
iii) effective grievance redressal mechanisms;
iv) encouragement to receive visitors and maintain correspondence;
v) Overseeing bodies should have members from civil society to ensure the absence of corruption and abuse of power in jails.

9.7. **Budget** - Insufficient involvement of the state government in matters relating to release of funds, filling of vacancies and lack of support to facilitate change;

9.8. **Vulnerable groups prior attention**[lxix]– Certain groups such as teenagers, LGBTQ+ and women are vulnerable groups which can fall easily at any point of time in depression. If they are given attention at the very beginning of this mental illness then they can be cured in the initial phase.

9.9. **Corporate Social Responsibility**– To have a psychologist department in companies shall be made a CSR because of the fact that many employees these days are mentally disturbed due to overburden or workplace harassment.

9.10. **Increase timely data collection and research to identify and respond to mental health needs more rapidly**[lxx]- The country needs an integrated, real-time data infrastructure for understanding youth mental health trends. More research is also needed on the relationship between technology and mental health, and technology companies should be more transparent with their data and algorithmic processes to enable this research. We also need to better understand the needs of at-risk youth, including youth facing multiple risk factors. Governments and other stakeholders should engage directly with young people to understand trends and design effective solutions.

9.11. **Rehabilitation to person who attempts to suicide**– It is also important to analyse that attempt to suicide have been made punishable offence under section 309 of IPC whereas, Sec. 115 mental health act provides that notwithstanding anything in section 309 of IPC, any person who attempts to commit suicide shall be presumed to have severe stress and shall not be punished. There is a controversy among two acts. It is also recommended to provide rehabilitation facilities to such people rather than deter them from being mentally suffering.

9.12. **#SPEAKUP** - Be a safe person to talk to. Many mental disorders of acute nature can be addressed by speaking up with your colleagues and fellow mates. We all shall be

a safe person with whom they can have their sufferings. Certain training needs to be conducted by students from time to time to develop these ethics.

9.13. **Use of technology** – In this century where everything is available at our doorstep and most of the things are going online. It would be appropriate to suggest having qualified psychologists online at a semi-government platform, which have private and government both organisations into it. App based counselling is advisable in acute mental illness cases.

10. General Standards recommended[lxxi]

10.1. **Availability, accessibility, acceptability and quality** – Mental ill people are in need of special care, love and attention therefore, they need caregivers at home and hospital levels both.

10.2. **Infusing hope, faith and confidence in the mind of the recovering person** all the time that he/she can be effectively treated, cured and resume their normal life in public domain.

10.3. Need to have a motivated team and effective leadership.

10.4. Active liaison with governmental and non-governmental organisations.

CONCLUSION

Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world. Therefore, it can be concluded that any policy can only be implemented when it fulfils the 7 mantras which are as follows:

- Politically acceptable
- Financially viable
- Socially desirable
- Technologically feasible
- Emotionally relatable
- Judicially tenable
- Administratively durable

In this era of technology to deal with mental ills, it is very important to have technology along with community care service, with support to ministries. In this research paper we have analysed various government policies and initiatives however, we are of the opinion that there are not much policies in early detection and prevention of mental illness in India. There are number of policies nationally and internationally for mental healthcare workforce to provide adequate mental health services in India. But there is a gap between these legislations and their effective implementation due to certain factors such as budget insufficiency, lack of manpower, lack of primary research and many more which have been discussed under chapter challenges.

Further, we have also gone into depth analyses of research present in this sphere. After research we are of the opinion that community awareness and community outreach programmes can in short span of time solve many issues related to mental health. Although we have noticed a positive change in the society about mental health awareness and their efforts to support persons affected it. Certain recommendations suggested are to have a pre-trial mental status assessment of prisoners, to create rehabilitation centres/ social welfare homes for persons recovering from mental illness, and also, we suggest having private and public both sectors to collectively work for the welfare of persons suffering from any mental illness.

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