Mental health is an integral part of an individual’s overall health (Prince et al. 2007). The World Health Organisation (WHO) defines mental health as ‘a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO 2001). Mental health problems are the result of an interaction between genetic, biological, psychological, and adverse social and environmental factors that shape an individual’s personal make-up and lead to poor quality of life, disability and even death (WHO 2005). Mental health problems can be broadly categorised into common mental disorders, severe mental disorders, substance use disorders, and childhood mental disorders (see Table 18.1). These problems affect a large number of people across all age groups in India, and hence constitute a significant public health burden. In this chapter, we will discuss the public health significance of mental health problems, barriers to access to care, and recent opportunities and innovations for improving access to mental healthcare in India.

**Significance of Mental Health Problems on Public Health**

Mental health problems have great significance for public health, the key reasons for which are discussed in this chapter.

They Affect People of all Ages

Mental health problems can affect people at different stages of the lifecycle. These mental disorders, based on their burden in the population, could be in the nature of: neuro-developmental disabilities, and emotional and behavioural disorders in childhood; anxiety and depression, self-harm, substance-use disorders, and psychotic disorders in adults; and dementia, depression and self-harm in older people.

Various studies in India have reported widely varying prevalence rates of mental health problems from 9.54 to 370 per 1,000 population. A meta-analyses of these studies have estimated that the prevalence of any mental health problem ranges from 5.8 to 7.3 per cent of the population (Gururaj et al. 2004). This translates to 70.2 to 88.3 million people in India based on the Census 2011 population.

**Leading Contributor to the Burden of Disease**

Mental health problems constitute around 7.5 per cent of the global burden of disease (Murray et al. 2012). They are the leading causes of Disability Adjusted Life Years (DALYs; a metric which combines the impact of a disorder on life expectancy and disability) in men and women in the prime of their lives, i.e. between the ages
### Table 18.1 Brief Overview of Mental Health Problems

<table>
<thead>
<tr>
<th>Category</th>
<th>Disorders</th>
<th>Key Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Mental Disorders</td>
<td>Depression, anxiety disorders (phobia, obsessive compulsive disorder, post-traumatic stress disorder), somatoform disorders</td>
<td>Is 'hidden', usually not recognised as a 'disorder'; Typically present in primary care with medically unexplained symptoms (multiple aches and pains); sleep and appetite problems; strong association with social disadvantage (poverty, gender).</td>
</tr>
<tr>
<td>Severe Mental Disorders</td>
<td>Schizophrenia, bipolar disorder, brief psychosis, dementia</td>
<td>Recognised as a 'disorder' in most of the cultures; runs chronic course and is associated with severe disability; Strong association with genetic factors.</td>
</tr>
<tr>
<td>Substance-use Disorders</td>
<td>Alcohol-use disorder, other substance-use disorders (opium, cannabis, cocaine, inhalants)</td>
<td>More common in men; Strong association with poverty; Rarely present in clinical settings, except in case of secondary complications such as liver failure or injuries during intoxicated stage.</td>
</tr>
<tr>
<td>Childhood Mental Disorders</td>
<td>Neuro-developmental disabilities such as autism, attention deficit hyperactivity disorders, depression and anxiety disorders, conduct disorder</td>
<td>Long delays in recognition; Far-reaching consequences on individual development.</td>
</tr>
</tbody>
</table>

*Source: Patel (2003).*

### Figure 18.1 Contribution by Different Mental Health Problems to Disability-Adjusted Life-Years in All Age Groups in India in 2010

*Source: Based on the data downloaded from IHME (2013). The authors would like to thank Dr Sandesh Samudre for helping with the analysis of India GBD 2010 data to produce Figures 18.1 and 18.2 in this chapter.*
of 15–39 years (ibid.). The mental health problems which contribute the most to DALYs are depression, bipolar affective disorder, substance-use and alcohol-use disorders, schizophrenia, and dementia (ibid.). The number of global DALYs attributable to mental health problems increased by 38 per cent from 1990 to 2010 (ibid.).

In India, the contribution of mental health problems to the overall burden of disease in 2010 was estimated to be 5.6 per cent (IHME 2013). This represents an increase of 65 per cent in the past 20 years and this burden is projected to increase during the next 25 years as a consequence of the epidemiological and demographic transition (Patel et al. 2011). Self-harm contributes to 3.4 per cent of Years of Life Lost (YLLs) and depression is one of the top five leading causes of Years Lived with Disability (YLDs) (IHME 2013). There has been a 150 per cent increase in DALYs contributed by self-harm and 50 per cent increase in DALYs contributed by depression in the last two decades (Murray et al. 2012).

**Association with Premature Mortality**

Mental health problems are independently associated with increased risk of early death and their overall contribution to causes which lead to death (all-cause mortality) is also very high (Prince et al. 2007). Schizophrenia and dementia increase the risk of all-cause mortality by two-and-half times (relative risk for schizophrenia is 2.59 (95 per cent Confidence Interval: 2.55-2.63) and for dementia it is 2.63 (95 per cent Confidence Interval: 2.17-3.21) (Heila et al. 2005), while depression increases the risk by one-and-half times [relative risk: 1.7 (95 per cent Confidence Interval: 1.5-2.0)] (Prince et al. 2007). In statistical analysis, confidence interval provides the ‘interval’ bounded by lower and upper estimate. There is a 95 per cent chance that this interval covers the true relationship between

![Figure 18.2 Contribution by Different Health Problems to Disability-Adjusted Life-Years in Age Group 15–29 Years in India in 2010](https://example.com/figure18.2.png)

*Source: Based on the data downloaded from IHME (2013).*
exposure and outcome (schizophrenia/dementia and all-cause mortality in this case respectively) at the population level. Patients with schizophrenia have a 10–25 year reduction in life expectancy as compared to the general population. This increase in the all-cause mortality risk is excluding the risk for suicides (ibid.). Although the mortality rate from suicide is high, natural causes of death and differential access to care due to their mental health problem account for a greater part of the reduction in life expectancy (Heila et al. 2005).

Mental health problems are also an important proximal risk factor for suicide. Amongst the individuals who commit suicide, around 47–74 per cent of them suffer from a mental health problem (Patel et al. 2007). The recently published findings of the Million Death Study (2012) observed that 3 per cent of the surveyed deaths in individuals aged 15 years or older were due to suicide, corresponding to about 187,000 suicide deaths in India in 2010 (Patel et al. 2012). Suicide mostly kills individuals in their youth, 40 per cent of suicide deaths in men and 56 per cent of suicide deaths in women occurred at ages 15–29 years, thus making suicide a leading cause of death in this age group (ibid.). There is around 1.3 per cent chance that a 15-year-old individual in India would commit suicide in his/her lifetime; men having around one-and-half times higher risk than women (ibid.).

**Strong Linkages with Poverty and Social Disadvantage**

There is strong evidence linking mental health problems with factors related to social disadvantages such as poverty, illiteracy and gender. In low and middle income countries, low levels of education, food insecurity, poor housing, and financial stress exhibit a relatively consistent and strong association with the risk for depression and anxiety disorders (Lund et al. 2010). Mental health problems and poverty interact in a vicious negative cycle. Thus, conditions of poverty increase the risk of mental health problem through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence and trauma (Lund et al. 2011). Conversely, people with mental health problems are at increased risk of drifting into or remaining in poverty through increased health expenditure, reduced productivity, stigma, and loss of employment and associated earnings (ibid.) (these are further elaborated below). Gender further compounds the problem as it plays a major role in determining socioeconomic position and access to resources and social status (Shidhaye and Patel 2010). Women are one-and-half to two times more likely to suffer from depression and anxiety disorders as compared with men (Kessler et al. 2003). Low education, low standard of living, intimate partner violence (IPV), dowry harassment and husband’s alcohol use have been found to be independently associated with depression and suicide among women in India (Shidhaye and Patel 2010).

**Violation of Human Rights**

Stigmatisation of and discrimination against people with mental health problems is common in all sections of society, from the community to schools, work-place and even healthcare settings. Stigma and discrimination present formidable barriers both to social inclusion for affected people and their families, and to access to appropriate healthcare (Shidhaye et al. 2013). In the worst cases, there are profound violations of human rights in the form of restrictions to their freedom (e.g. by being chained) in their homes, in mental hospitals and in traditional healing centres. Some persons are subjected to inhuman and violent practices, sometimes as a way to ‘treat’ their disorders. Many homeless persons in India suffer from a mental health problem; homelessness is not only often the result of a mental health problem but it can itself worsen the course of the disorder.

**Negative Impact on Physical Health**

Mental health problems are intimately connected with other health conditions such as cardiovascular diseases, diabetes, chronic infections such as HIV and tuberculosis (TB), and injuries (Prince et al. 2007). There is a bi-directional association between mental health problems and these health conditions in which mental health problem can act as a risk factor and could also be a consequence due to these health conditions (ibid.). Mental health problems are associated with risk factors for chronic disease such as smoking, reduced activity, poor diet, obesity, and hypertension (ibid.). Mental health problem such as depression could be a consequence of chronic physical conditions by creating a psychological burden, which arises from factors such as the acute trauma of the diagnosis; the difficulty of living with the illness; the long-term threat of shortened life expectancy; necessary lifestyle changes; complicated therapeutic regimens; distressing symptoms such as pain; and stigma, which can lead to guilt, loss of social support, or breakdown of key relationships (ibid.). If an individual suffers from schizophrenia, dementia or substance-use disorders, and also has physical health
problems such as diabetes, cardiovascular disease or cancer, then these individuals receive poor general medical care simply because they suffer from mental health problem. Mental health problems can delay help-seeking, reduce the likelihood of detection and diagnosis, and adversely affect adherence to medication, behavioural modification and health promotion-related activities (Lawrence et al. 2003, Desai et al. 2002, Cradock-O’Leary et al. 2002). In addition to this, specific mental health problems such as depression in a specific sub-population such as mothers can potentially have far more detrimental effects which could be inter-generational. There is an independent association between perinatal depression and low birth weight, and infant under-nutrition at six months and reduction in adherence to child-health promotion and disease-prevention interventions (Prince et al. 2007) for example immunisation (Rahman et al. 2004, Patel et al. 2004).

**Economic Impact**

Mental health problems not only affect the health of an individual, but also the economic outcomes at the individual and household level. Studies from India show that people with depression spend more days being unable to work as usual due to their illness (Patel et al. 1998). The total cost of a single episode of depression, due to lost productivity and healthcare costs, is equivalent to three weeks' wages for agricultural workers (Chisholm et al. 2000). A population-based study conducted in Goa in 2007, assessed the healthcare costs of three common conditions affecting women (reproductive tract infections, anaemia and depression) and reported that only depression was associated with increased healthcare costs and markedly increased the risk of catastrophic health expenditure (Patel et al. 2007). In the case of severe and enduring disorders like schizophrenia or dementia, around a third of caregivers need to spend significant time at home- caring for the person, which results in cutting back or giving up their work (Fineberg et al. 2013). Alcohol Use Disorders have significant costs related to healthcare and lost productivity as well as social costs related to law-enforcement, property damage and loss, and other direct administrative costs and economic loss due to the fact that caregivers miss on their work. It is estimated that the costs associated with alcohol, amounts to more than 1 per cent of the gross domestic product (GDP) of the high and middle income countries (Rehm et al. 2009). There is little data on the long-term economic costs of childhood mental health problems and psychoses, but these are likely to be significant given their impact on lost educational and employment opportunities and caregiver burden.

**Most People Affected do not have Access to Affordable, Evidence-based, Quality Care**

There are a wide range of drug, psychological and social interventions which have been shown to be cost-effective and which can transform the lives of people affected by mental health problems (Patel et al. 2007). Despite this evidence, there is a huge disparity between the burden of mental health problems and availability of mental health services. It is estimated that only 10 per cent of those with mental health problems are receiving evidence-based interventions (Murthy 2011). Both demand and supply factors contribute to this large treatment gap. Low demand for services is due to the historic lack of availability of services and the poor awareness about these conditions and their treatments. Supply barriers are mostly due to the great shortage of qualified mental health specialists in India; e.g., estimates in 2011 suggest only about 4,000 psychiatrists in the country, most of whom work in the urban areas and in the private sector (WHO 2011). Inadequate training and support to non-specialist health workers and the lack of a reliable drug supply limits the delivery of mental healthcare through the primary care system. Moreover, this unmet need for care is even larger in the rural areas as most specialist services are concentrated in the urban areas (Murthy et al. 2011).

Thus, mental health problems constitute a significant burden of disease in India; they affect people across all age groups, especially those with social vulnerabilities, reduce life expectancy and kills individuals in their youth, result in social isolation and in extreme cases human rights violations, ultimately leading to huge suffering and unmet needs in the population.

**Policy Context for Improving Access to Mental Healthcare**

While the challenges for reducing the treatment gap for mental health problems in India are many, several recent developments at the global and national level offer a conducive policy environment for strengthening the mental health system in the country and improve the delivery of mental health services. The major policy initiatives are outlined in this chapter.
WHO Comprehensive Mental Health Action Plan

The Sixty-sixth World Health Assembly, held in May 2013, adopted the Comprehensive Mental Health Action Plan for the period 2013–20 and urged the member states to implement the proposed actions mentioned in this Plan. The vision of this Action Plan is a world in which mental health is valued and promoted, mental health problems are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatisation and discrimination (WHO 2013). The Action Plan relies on six cross-cutting principles of Universal Health Coverage (UHC), Human Rights, Evidence-based Practice, Life-Course and Multi-sectoral approach, and Empowerment of persons with mental health problems and psychosocial disabilities (ibid.).

Mental Health Care Bill

The draft Mental Healthcare Bill was tabled in Parliament in August 2013. It has been cleared by the Parliamentary Standing Committee and is currently in the Rajya Sabha (Upper House of Parliament). The Bill enshrines access to healthcare as a right and an entitlement, ensuring that the vast majority of people with mental health problems have the right to receive care close to their homes, through the established district-level healthcare system (MoHFW 2013). The Bill mandates the provision of a range of facilities (including supported homes and community-based rehabilitation) and support to people in their own homes to help them achieve full and effective participation in the community. Beyond the narrow domain of treatment, the Bill makes the state responsible for the implementation of the programme for promotion of mental health and prevention of mental health problems and suicide. The state also has to ensure that adequate numbers of mental health professionals are available and international norms are achieved in 10 years. These provisions in the new Bill could well serve as a key legal foundation for the proposed expansion of the District Mental Health Programme (DMHP) in the Twelfth Five Year Plan. The Bill proposes to de-criminalise suicide attempts and encourage those in need of counselling and related support to access it without fear or shame. The person with a mental health problem will have the right to advance directives (AD), a legal document drawn up when the person is well, on the treatment protocols that s/he would like to be followed, and to a nominated representative (NR) to facilitate her/him in supported decision-making during periods of ill-health or crisis. All involuntary commitments in an extraordinary situation have to be requested by an NR. In the case of homeless persons, the state or a state-appointed party would serve as the NR. There is also a landmark proposal in this draft Mental Healthcare Bill to establish Mental Health Review Commission that will regulate admission and discharge, deal with violation of rights, and thus prohibit the pervasive culture of exploitation, neglect and abuse of human rights. The Bill also provides for stringent regulations for all mental healthcare facilities, irrespective of the sector (public or private). Unlike in the past, the process of drafting the Bill has involved extensive consultations, over two years, with a broad range of stakeholders, including civil society organisations representing people affected by mental health problems. The provisions on access to care for homeless persons were included based on this feedback.

National Mental Health Policy and Plan

During the consultations on the Mental Healthcare Bill, the need for a National Mental Health Policy was highlighted by several stakeholders, as a result of which the Ministry of Health and Family Welfare (MoHFW) created a Policy Group in April 2011 to prepare a National Mental Health Policy and Plan. The policy group was entrusted with the task of re-designing the DMHP as a matter of priority to be ready for the Twelfth Five Year Plan period (MoHFW 2012).

Based on the document reviews, consultations with key stakeholders and field visits, the Policy Group concluded that the DMHP required substantial changes and planned a complete overhaul of the DMHP in the Twelfth Five Year Plan. The revised DMHP is available on the website of mental health policy group (ibid.). The primary objective of the new DMHP is to reduce distress, disability and premature mortality related to mental health problems and enhance recovery from mental health problem by ensuring the availability of and accessibility to mental healthcare for all in the Twelfth Five Year Plan period,
particularly the most vulnerable and underprivileged sections of the population.

As per the recommendations of the Policy Group, the new DMHP will be based on following principles:

i) A life course perspective with attention to the unique needs of children, adolescents and adults.

ii) A recovery perspective, through provision of services across the continuum of care and empowerment of persons with mental health problems and their care-givers.

iii) An equity perspective through specific attention to vulnerable groups and to ensure geographical access to mental health services.

iv) An evidence-based perspective by following established guidelines and experiences on treatments and delivery models.

v) A health systems perspective with clearly defined roles and responsibilities for each sector from community to district hospital and including a cascading model of capacity building and supervision.

vi) A rights-based perspective to ensure rights of persons with mental health problems are protected and respected by mental health services.

Shortage of trained human resources across all the levels of care has been one of the major challenges for implementation of DMHP in the past. To address this challenge, one of the major recommendations in the new Plan is to recruit a new cadre of community mental health workers based at the primary health centres (PHCs) level to help in identification of persons with mental health problems, help people access necessary treatment, provide basic counselling and help in accessing social benefits. There is also a recommendation to increase the number of specialists (psychiatrists, psychologists, and psychiatric social workers), by relaxing the stringent educational requirements for their recruitment. The Plan lays down a clear designated structure with adequate funding and trained staff for programme management at central, state and district level to ensure efficient, timely and full implementation of DMHP. Adequate supply of psychotropic medications will be ensured by establishing a close linkage with state-level centralised drug procurement and distribution systems based on the Tamil Nadu model. Key indicators for programme implementation have been identified and the staff in the PHCs and sub-district hospitals will be trained to report on these indicators as part of the Health Management Information Systems (HMIS) to ensure continuous monitoring of the programme and enable mid-course correction. There is also suggestion for independent programme audit and formal outcome evaluation.

Partnerships with academic institutions and voluntary organisations at district and state level and collaboration with other government departments such as education and social justice is encouraged. There is a strong emphasis on community participation to promote local ownership and accountability of the DMHP and to utilise the existing mechanisms such as the Village Health and Sanitation Committees (VHSCs); Gram Swasthya Samitis; Accredited Social Health Activists (ASHAs); Rogi Kalyan Samitis (RKSs) or Patient Welfare Committees (PWCs). There is also a provision for continuing care services in the community which includes home-based continuing care and institutional continuing care services to address the needs of persons with severe and chronic mental health problems, including the homeless population (ibid.). This process led by MoHFW was participatory and the Policy Group consisted of members from diverse backgrounds such as mental health professionals, user and care-giver representatives, public health experts and senior officials of the MoHFW.

National Mental Health Survey

In June 2013, the MoHFW commissioned a national survey for mental health problems to inform policy and to provide a reference for future surveys to evaluate the impact of national initiatives outlined above. The National Institute of Mental Health and Neurosciences (NIMHANS) will lead this survey and it aims to cover all states and union territories (UTs). This survey will take at least a year to be completed and rather than just ‘head-counting’ it will try to capture all the information required to plan mental health services and ensure their optimal utilisation and impact.

Mental Health Capacity Building Initiatives

Recognising the need for qualified mental health professionals, the MoHFW launched a Manpower Development Scheme in the Eleventh Five Year Plan which proposed to develop 11 Centres of Excellence in Mental Health as well as establish/strengthen 30 Departments of Psychiatry, Clinical Psychology, Psychiatric Social Work and Psychiatric Nursing each in the country. The grant consists of financial support
for developing infrastructure and employment of the faculty. Another major development has been in the field of building the capacity of Primary Care Physicians in providing basic mental health services. A new collaboration in 2013, between the MoHFW, Indian Psychiatric Society and Public Health Foundation of India is being established to develop and implement a competency-based nation-wide training programme for primary care and family physicians.

**Innovations in Improving Access to Mental Healthcare**

Innovative approaches to service delivery are gradually picking up, which include task-sharing approach, providing continuing care in the community, technological innovations and new developments in implementation science.

**Task-sharing with Lay and Community Workers**

‘Task-sharing’ is a human resource innovation in which the skills to deliver specific mental healthcare tasks are transferred to appropriately trained and supervised community and lay health workers as has been done in other national health programmes. This helps in improving access to evidence-based interventions in the context of great shortages of specialised staff and leads to more efficient use of these limited resources. In last few years, this approach has been evaluated for mental health service delivery in India and its efficacy established using rigorous evaluation methodology. Task-sharing is implemented through a collaborative care framework with four key human resources: the front-line lay or community health worker; the person with a mental health problem and her/him family; the primary or general healthcare physician; and the mental health professional. Three examples of such task-sharing interventions have now been evaluated through randomised controlled trials, two of which were led by the NGO Sangath (MANAS and COPSI), and one by the Dementia Society of Goa (Dementia Home Care Programme).

MANAS is the largest mental healthcare trial in India and showed that a lay counsellor-led collaborative stepped care intervention for depression and anxiety disorders in primary healthcare led to substantial reductions in the prevalence of these disorders, suicidal behaviours and days out of work compared with usual care (Patel et al. 2010). MANAS study was led by Sangath and was carried out in the state of Goa. The trial also evaluated the economic impact of the intervention and found that the overall health system costs were lower in the intervention arm, despite the intervention costs, because patients recovered sooner and had lower overall healthcare costs. Home Care Programme led by Dementia Society of Goa, for the elderly affected by dementia, evaluated a lay health counsellor-led community-based collaborative care model and showed the benefits in reducing caregiver burden and improving care-giver mental health (Dias et al. 2008). The recently completed Community Care for People with Schizophrenia in India (COPSI) evaluated a community-based worker delivery home-based psychosocial rehabilitation interventions for people with chronic schizophrenia (Chatterjee et al. 2011), which observed significant reductions in levels of disability. There are several other trials, all led by Sangath, which are further evaluating the effectiveness of task-sharing in progress in India, examples include: using community-based workers to support parents to deliver interventions for children with autism (PASS); using peers to deliver psychological treatments for depressed mothers (SHARE-THPP); lay counsellors based in primary health care to deliver psychological treatments for drinking problems and severe depression (PREMIUM); and school health promotion interventions which include a mental health component (SEHER).

**Providing Continuing Care in the Community**

A major gap in the current services for mental health problems is the lack of continuing care in the community which is often needed to provide psychosocial interventions over the long-term, and to address the needs of vulnerable and homeless persons. A series of studies in rural Madhya Pradesh, led by the NGO Ashagram, evaluated a lay mental health worker delivered community-based rehabilitation intervention for people with chronic schizophrenia and demonstrated impressive benefits in terms of disability reduction and symptom management (Chatterjee et al. 2003, Chatterjee et al. 2009). This intervention was the basis of the COPSI trial mentioned earlier and provides a model for home-based care for people with chronic psychoses (Chatterjee et al. 2011). Banyan, an NGO in Chennai has been in the forefront for providing care for homeless mentally ill women for the last 20 years. They
have established a transit-care centre, ‘Adaikalam’ for homeless women with mental health problems, living on the streets and nowhere to go. The primary needs of rescued individuals are met in this centre, and then they are enrolled into the programme for rehabilitation and recovery with the help of medicines, psychological therapy, occupational therapy and vocational training. The latest figures available show that Adaikalam has successfully rehabilitated 1,066 women in their families and communities (Adaikalam undated). Similar programmes with focus on rehabilitation of individuals with mental health problems are run by Ashadeep in Assam (Ashadeep undated), Richmond Fellowship which provides a range of day and residential care facilities (Richmond Fellowship Society undated) and ACMI which is a family care-giver support organisation (Action for Mental Illness undated). Other NGOs, such as Iswar Sankalpa, provide community-based care for the homeless persons with mental health problems.

Using Appropriate Technologies

In the aftermath of tsunami which struck the eastern coast of India in December 2004, a community psychiatry programme was launched by the NGO SCARF in two coastal districts of Cuddalore and Nagapattinam in Tamil Nadu. The end of the funding endangered the continuity of care for many individuals with chronic mental health problems receiving treatment in this programme. SCARF decided to apply tele-medicine for psychiatric consultations (Thara et al. 2008). Based on a thorough review of technology options, they decided to use Integrated Services Digital Network (ISDN) as it was a cheaper, reliable and compliant with the guidelines issued by the Government of India. A tele-psychiatry network was established with seven peripheral units in four districts of Tamil Nadu, setup either by SCARF or in collaboration with local NGOs, and these were linked to the central unit at Chennai. In each of the peripheral units, tele-consultations were held on specific days with the frequency ranging from once a week to once a month depending upon the case load. In these tele-consultations, a psychiatrist in Chennai reviewed the patients along with their family members. SCARF’s experience suggests that with a clearly outlined process and realistic goal setting, it is now possible to deliver quality mental healthcare through tele-psychiatry (ibid.).

Sangath, is combining the task-sharing approach with mHealth platform to address the care gap for Neuro-Developmental Disorders (NDDs) through its recently launched programme INFORM (a mHealth platform for Improving Functional Outcomes foR children with iMpairments through community health workers). Through improving access to affordable, quality assured, parent-delivered strategies, INFORM’s goals are to enable children with diverse NDDs to function to their maximum ability, improving their overall health, development and Independence, as well as social well-being and social participation thereby reducing the care and financial burden for their families and improving the quality of life for all (WHO 2001).

Implementation Research to Develop and Evaluate Mental Healthcare Plans

There is a huge knowledge gap at the national as well as global level in terms of how the evidence-based packages of care are delivered on various platforms or delivery channels for service provision. There is a strong need to invest in the health policy and systems research to provide guidance on how to increase access to cost-effective treatments to reduce the burden of mental health problems. The mental health systems research could be strengthened by focusing on some of the key research questions related to quantifying the treatment gap for realistic goal setting, capacity building approaches for achieving and maintaining key skills and competencies by health workers to provide mental health care, development and evaluation of mental health interventions delivered using ‘task-sharing’ approach, and effectiveness of different approaches to improve awareness about mental health problems and reduce stigma against people suffering with mental health problems, ultimately leading to improved help-seeking behaviour.

Two programmes launched in the last two years involving partnerships between Ministries of Health, NGOs (led by Sangath) and the Public Health Foundation of India are aiming to implement evidence-based interventions in the ‘real-world setting’ with an ultimate goal of scaling-up mental health programmes. PRIME (Program for Improving Mental Health Care) is a multi-country consortium of research institutions and ministries of health in five countries in South Asia and Africa, with partners in the United Kingdom (UK) and the WHO. In India, PRIME has been implemented in Sehore district of Madhya Pradesh (Lund et al. 2012).

VISHRAM (VI Darbhaj Health ProgRAM) is a four-year community-based mental
health programme being implemented in the Amravati district in collaboration with Prakriti and in Wardha district in collaboration with WOTR (Watershed Organisation Trust). The primary objective of VISHRAM is to implement and evaluate a comprehensive, population-based, psychosocial intervention to reduce the psycho-social distress and suicide risk, through targeted interventions for the prevention and management of depression and anxiety disorders and alcohol abuse in agricultural communities in Vidarbha region of Maharashtra. Based on a systematic series of participatory research methods, these two programmes have developed mental healthcare plan (MHCP) for implementation and evaluation of mental health services.

The MHCP is broadly divided into core packages and enabling packages. The core packages are related to the delivery of mental health services for three priority disorders—depression, psychosis and Alcohol-Use Disorders (AUDs). The mental healthcare plan for these disorders could be seen as an intervention matrix (see Table 18.2). The columns in this matrix represent the key process or 'WHAT' will be delivered while the rows represent the platform of care or 'WHERE' and 'WHO' will deliver the services. Thus, each cell is an 'intervention' which is defined by 'WHAT' type of health activity will be conducted, by 'WHO', i.e. the service provider and in which setting or 'WHERE'. The services will be delivered at three different levels of health system or platforms; community level, facility

<table>
<thead>
<tr>
<th>District Hospital/ Specialist</th>
<th>Awareness and anti-stigma interventions for other specialists</th>
<th>Specialist diagnosis by psychiatrist</th>
<th>mhGAP-based Pharmacological interventions by psychiatrist</th>
<th>Relapse prevention for AUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC/PHC</td>
<td>Awareness and anti-stigma interventions for medical officers</td>
<td>Diagnosis by medical officer</td>
<td>mhGAP-based pharmacological interventions by medical officers</td>
<td>Follow-up and adherence management</td>
</tr>
<tr>
<td>Community</td>
<td>Awareness and anti-stigma interventions for community members through mass media channels</td>
<td>Identification by front-line workers</td>
<td>Mental Health First Aid by front-line workers</td>
<td>Follow-up and adherence management</td>
</tr>
</tbody>
</table>


table 18.2 Intervention Matrix for Priority Mental Health Problems (Depression, Psychosis and AUDs)

Source: Authors’ compilation based on their research on PRIME and VISHRAM projects.
level (PHCs and community health centres [CHCs]) and district level (specialist setting).

Enabling packages consist of cross-cutting interventions which will ensure smooth implementation of core mental health service delivery packages. There are three enabling packages:

- **The programme management package** comprises of human and financial resource management, procurement and supply-chain management of essential psychotropic drugs, well-functioning Mental Health Information System, routine monitoring of the programme and evaluation.
- **The capacity building package** is aimed to ensure that the medical officers and front-line workers are trained in evidence-based interventions and a continuous supportive supervision is provided to maintain and enhance the skills and competencies acquired during initial training.
- **The third enabling package** aims to promote engagement with the community and mobilising people affected by mental health problems, caregivers and other community members to demand for services and advocate for a rights-based delivery of mental health services.

The implementation of PRIME and VISHRAM will be rigorously evaluated using a suite of methods comprising repeated community cross-sectional surveys to assess the change in coverage of mental health services, prospective cohort studies of patients treated under these programmes to assess the improvement in individual level health, economic and social outcomes and routine monitoring of indicators for assessment of health system level outcomes.

**Conclusion**

The burden of mental health problems in India, the huge treatment gap for these problems, and violation of human rights of individuals living with these disorders make a compelling case for investing more resources and strengthening mental health services. WHO’s Comprehensive Mental Healthcare Action Plan, and the renewed policy attention to mental health in India through the draft Mental Healthcare Bill and a radically redesigned District Mental Healthcare Plan offer a robust policy framework to invest in, expand the coverage and improve the quality of mental health services in this country. We have summarised some of the recent innovative initiatives in task-sharing, continuing care in the community, use of appropriate technology and implementation science which have the potential to achieve the goals of improving access of evidence-based care for people with mental health problems in India. It is now essential to scale-up these innovations by progressively strengthening existing mental health systems.

**References**

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