Treatment Gap in Mental Healthcare
Reflections from Policy and Research

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There is a wide treatment gap in Indian mental healthcare. This article discusses the treatment gap and the contributing factors, and suggests ways to reduce it. The political (policy perspective), social (stigma, discrimination, and gender), cultural (beliefs, explanations, and help-seeking behaviours), and economic (direct and indirect costs of treatment) factors addressed have long impeded mental healthcare. A policy and research review reflects that mental illness in India contributes significantly to the global occurrence of mental illness. The treatment gap causes substantial losses to individuals, families, society, and the nation. Innovation and capacity building are necessary to develop and implement locally relevant, feasible, and effective community-based mental healthcare models.

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1 Introduction

The article focuses on reducing the treatment gap in India and offers data specific to the country and its political, social, cultural, and economic context. The reports and published research reviewed are either available on the web or in print. It builds upon the knowledge generated by the Lancet Series on Global Mental Health. The series calls for the prioritising of mental health services, especially in low- and middle-income countries (LAMICs), to reduce the treatment gap. Jacob et al (2007) have highlighted several reasons for the treatment gap, including inefficiencies in practice, the scarcity and unequal distribution of mental health resources (Saxena et al 2007), and inadequate mental health policies and legislation.

Recognised as an integral and essential component of holistic health (Saxena et al 2007), mental health is an important global health concern. In India, the prevalence of mental illness is estimated at around 5.8% and 7.3% of the general population (Reddy and Chandrasekhar 1998), and at 26.7% among the elderly (Ganguli 2000). The prevalence of mental illness in rural and urban India is estimated at 70.5 and 73 per thousand respectively (Ganguli 2000). Neuropsychiatric illness in India accounts for 10.8% of the global occurrence of mental illness (Seby et al 2011). Unipolar depression was the cause for roughly 12 million

disability-adjusted life years (DALYs) in 2010 and 8,100 deaths in 2008; anxiety disorders accounted for nearly four million DALYs in 2010 (World Health Organization 2004). The prevalence of serious mental illnesses is estimated at around 6.5% (Institute of Health Metrics and Evaluation 2013).

One major problem that exists in Indian mental healthcare is the treatment gap, or the number of individuals (expressed as a percentage) with an illness who need treatment but do not receive it. Major barriers to mental health service utilisation include a scarcity of resources, unequal distribution, inefficient use (Saxena et al 2007), non-medical explanations, and a lack of awareness, accessibility, and availability of healthcare services and the potential benefits of seeking treatment (National Commission of Macroeconomics and Health 2005; Working Group on Disease Burden for 12th Five Year Plan 2011; VenkatashivaReddy et al 2013). Stigma and discrimination (Lal and Vashisht 2002; Working Group on Disease Burden for 12th Five Year Plan 2011; Shidhaye and Kermode 2013) also contribute to the treatment gap in India, as summarised in Table 1.

2 Mental Health and State Policy in India

Before Indian independence, mental healthcare was governed by colonial acts such as the Indian Lunatic Asylum Act (1883) and the Indian Lunacy Act

Table 1: Reasons for Treatment Gap in India

Reasons for the Treatment Gap	Factors
Mental healthcare and state policy	- Deficiencies and lack of implementation of policy initiatives
	- Biomedical approach
	- Lack of community participation
	- Lack of coordination at different levels
Lack of mental healthcare resources	- Lack of availability
	- Poor attitudes
	- Lack of knowledge
	- Lack of training for healthcare providers
Socio-economic burden of mental illness	- Stigma
	- Gender
	- Economic costs of treatment
Beliefs, explanations, and help-seeking behaviours	- Non-medical explanations of mental illness - Easy accessibility of traditional healing resources
Violation of human rights	- Role of public interest litigations (PIL) and judicial intervention

(1912). The Indian Psychiatric Society was founded after independence—the society drafted a bill and submitted it to the Government of India in 1950. The bill was adopted as the Mental Health Bill by the Rajya Sabha in 1986 and by the Lok Sabha in 1987. The Mental Health Act (1987) was enforced in 1993, thus replacing the Indian Lunacy Act (1912). Since then, a number of programmes, policies, and legislative initiatives have been undertaken; they are summarised in Table 2.

Five-year plan documents are important guidelines for the economic development in India. A careful reading of the sections on mental healthcare in the various five-year plan documents suggests that the focus is on framing new programmes and policies, but little attention is paid to reporting the successes or failures of previous initiatives. It is noteworthy that the allocation of grants for mental health rose from ₹280 million under Ninth Five Year Plan to ₹10,000 million under the Eleventh Five Year Plan. The summary of priority areas for mental health under the five-year plans are given in Table 3 (p 36).

India has attempted to integrate mental healthcare into its primary healthcare system. Due to its close link with communities, the Integrated Child Development Services scheme has been chosen to make mental healthcare services effective at the primary level. Healthcare providers are being trained at the district-level through various programmes. Their role is to identify individuals with mental illnesses at the initial stages, provide knowledge about the treatment and facilities available to them, and record treatment adherence. Despite these efforts, India faces a wide treatment gap. The World Health Organization–India Council of Medical Research (WHO–ICMR) multisite task force project reports that there is a 92% treatment gap in Delhi. Other cities such as Chennai and Lucknow have treatment gaps of 96% and 82%, respectively (Desai et al 2004).

Mental healthcare initiatives in India focus on a narrow biomedical approach that tends to ignore sociocultural explanations for the occurrence of mental illness. To provide adequate mental health services, it is important to understand the needs of individuals in their local contexts. Mental healthcare initiatives miss out on another important dimension of mental healthcare, that is, psychiatric pluralism, or the availability of various traditional and religious resources. Data from other countries suggest that a partnership between psychiatrists and traditional healers could prove beneficial for patients (Crawford and Lipsedge 2004; Campbell-Hall et al 2010). Therefore,

Table 2: Mental Health Policies, Programmes and Legislations in India

Initiatives	Priority Areas	Merits	Deficiencies
Mental Health Act, 1987	- Humane approach to individuals with mental illnesses - Safeguarding patients' interests	- Replaced the Indian Lunacy Act, 1912 and previously used terminology - Simplified procedures of admission and discharge	- Lack of manpower and funds - Private hospitals were out of its purview
National Mental Health Programme, 1982	- Early recognition, adequate treatment, and rehabilitation of patients - Community-based approach - Ensuring availability and accessibility of minimum mental healthcare for all	- Increased the allocation of funds in the Ninth, Tenth, and Eleventh Five Year Plans	- Inability to link mental healthcare with primary care
District Mental Healthcare Model	- Providing mental healthcare at the district level - Sustainable mental health services - Community education - Treatment and rehabilitation	- Pilot tested in Bellary district, Tamil Nadu. Subsequently, the model was adopted in other districts in various states after evaluation	-
District Mental Health Programme, 1995	- Integrating mental health into primary care	- 123 districts covered across India; the aim is to cover all districts by 2017	- Lack of qualified staff at the district and sub-district levels - Funding constraints
Persons with Disabilities Act, 1995	- Providing fundamental rights to all people with disabilities to ensure equal opportunity	- Provided preventive and promotional aspects of rehabilitation (education, employment, vocational training, research, manpower development, creation of a barrier-free environment, rehabilitation, reservation, unemployment allowance)	- Limited disability categories
Right to Persons with Disabilities Bill, 2012	- A human rights approach - An emphasis on community participation	- Included developmental, emancipatory, and protective components	-
Mental Healthcare Bill, 2013	- Rights-based approach to mental healthcare - Making the state accountable	- Protection of rights of individuals with mental illnesses - Decriminalised acts of suicide - Autonomy of patients - Rights to the patients	- Posed challenges to psychiatrists regarding "supported admission" - Did not address issues of religious healing or the integration of traditional healing with biomedicine
National Mental Health Policy, 2014	- Pro-poor, pro-rights	- Assessed needs and filled existing gaps - Uniform policy with all-India coverage	-
The Rights of Persons with Disabilities Act, 2016	- Legal provisions for people with disabilities - Rights-based approach	- More types of disabilities were included	-

without taking into account cultural explanations for mental illness and psychiatric pluralism, mental health initiatives cannot be successful in addressing the treatment gap. Moreover, the concept of a treatment gap must not be considered merely in biomedical terms, but also against the backdrop of psychiatric pluralism in India.

Currently, mental healthcare is considered and treated as any other public health issue in India, but policymakers must realise the inherent differences (Davar 2012). Issues related to mental healthcare are different and must be addressed differently. There have always been debates about whether India needs a combined health policy with subsections on mental health (as a national health policy) or a completely separate mental health policy. In 2014, the Government of India realised the need for a separate mental health policy and established the National Mental Health Policy (NMHP). Mental health is covered under other policies as well, including those that address disability, social security, and health and family welfare. There are separate acts on disability and mental health, and different departments in the government deal with policies on disability and mental health independently. It is crucial that the approach to

mental healthcare is holistic, taking into account the coordinated efforts of various departments of the Government of India (social security, social justice and empowerment, disability affairs, and health and family welfare). These departments need to work together to implement mental healthcare initiatives and need to be monitored to address policy deficits without delays. In India, policy documents vary in their definitions of mental illness. The Persons with Disabilities Act, 1995, defines mental illness as any mental disorder other than mental retardation. The Census of India, 2001, describes individuals with mental illnesses as "insane"—this term is subjective and inadequate in classifying all individuals with mental illnesses (World Bank 2009). The National Sample Survey (2002) describes the symptoms of mental illness as talking to oneself, laughing/crying, staring, and exhibiting violence, fear, or suspicion without reason. Evidently, it is crucial to reconsider these definitions of mental illness.

3 Mental Healthcare Resources

Mental healthcare depends primarily on trained personnel and infrastructure to ensure early diagnosis, treatment, and prevention of mental illness. The density of trained manpower, especially psychiatrists,

is a reliable indicator of the human resources available for mental healthcare and provides a crude approximation of the capacity of the mental healthcare system (World Health Organization 2014). Studies have highlighted the acute shortage of mental health resources in LAMICs (World Health Organization 2001, 2005, 2011). Mental healthcare resources available in India are summarised in Table 4.

Table 4: Mental Healthcare Resources in India

Healthcare Facility	2001	2005	2011
Psychiatric beds per 10,000	0.26	0.26	0.08
Psychiatrists per 10,000	0.4	0.20	0.03
Psychologists per 10,000	0.02	0.03	0.004
Psychiatric nurses per 10,000	0.04	0.05	0.016
Social workers per 10,000	0.02	0.03	0.004

Source: Various WHO Mental Health Atlases.

Inadequate infrastructure and the scarcity of healthcare professionals in India contribute to wide treatment gaps in mental healthcare (Thirunavukarasu 2011). Statistics suggest that there are fewer psychiatrists than the requirement for the Indian population. Two major questions arise: Why are there so few psychiatrists in India? Why is psychiatry as a profession not flourishing? A number of researchers have tried to answer these questions. Their findings suggest that the unpopularity of psychiatry stems from a limited curriculum in medical colleges (Lingeswaran 2010), and a view among

Table 3: Five Year Plans and Priority Areas of Mental Health

Five Year Plan	Priority Areas Related to Mental Health	Outcomes
Seventh Five Year Plan	- Strengthening existing psychiatry departments - Promoting community psychiatry by providing drugs and services through the primary healthcare system - Organising training programmes - Initiating a National Mental Health Programme with an emphasis on community-based approaches	- Did not make any headway due to funding constraints
Eighth Five Year Plan	- Community-based model utilising the existing primary healthcare and district hospital services - Developing infrastructure for the National Mental Health Programme - Integrating mental health services with primary healthcare - Developing National Institute for Mental Health and Neurosciences (NIMHANS) - Implementing the district mental healthcare model in Bellary district, Karnataka	- Encouraging results from the district mental healthcare model
Ninth Five Year Plan	- Adopting the District Mental Health Programme	- District mental healthcare model was expanded to 22 districts in 20 states
Tenth Five Year Plan	- Modernising hospitals - Upgrading psychiatry departments in various government hospitals - Training staff to improve treatment services - Improving access to mental health services	- Not mentioned in the Eleventh Five Year Plan
Eleventh Five Year Plan	- Implementing the Mental Health Programme with new strategies - Schemes for manpower development - Greater family and community participation - Integrating mental healthcare with the National Rural Health Mission - Community and family-based approach	- Not much success was achieved due to a lack of qualified professionals at the district- and sub-district-levels
Twelfth Five Year Plan	- Preventing and reducing the occurrence of mental illness - Educating community workers, the primary care team, and caregivers	-

Source: Various five-year plan documents.

medical students that psychiatry is a difficult and non-scientific discipline (Kumar et al 2001; Jugal et al 2007; Manohari et al 2013). Psychiatry consists of only 1.4% of total lecture hours and a two-week internship in a medical school. This limited knowledge provided to undergraduate medical students does not prepare them to handle mental illness in professional settings (Jugal et al 2007; Thirunavukarasu and Thirunavukarasu 2010). Some studies suggest that psychiatry is not popular among medical students as their first option for specialisation (Subba et al 2012; Gaikwad et al 2012). Therefore, it is important to impart knowledge and arouse interest, as well as to remove the stigmas associated with psychiatry as a discipline and psychiatrists (Manohari et al 2013). The need to reform undergraduate and postgraduate training in psychiatry has also been highlighted (Yerramilli and Murty 2012).

In India, healthcare providers involved in mental healthcare are not well informed of the objectives of various state programmes and believe that these programmes serve only to spread awareness. They also report dissatisfaction with training because of the extensive use of complex vocabulary and a lack of vernacular language use (Desai et al 2004). Training of trainers is also essential for ensuring that mental health programmes are a success. The health teams of various healthcare providers must be trained together to distribute responsibilities and to understand all the roles involved.

4 Socio-economic Burden

Indian studies suggest that individuals with mental illnesses suffer from social stigma (Lal and Vashisht 2002; Pradhan et al 2013). Associated stigma is reported more by women than men (Chowdhury et al 2000; Thara and Srinivasan 2000). Kulesza et al (2014) suggest that men and women seeking psychiatric services at psychiatric clinics in India report similar levels of depression, but women report more perceived stigma. This tendency to perceive and report distress in psychological or somatic terms is influenced by social and cultural factors,

including the degree of stigma associated with particular symptoms (Raguram et al 1996). The fear that it would affect one's prospects of marriage, fear of rejection, and the need to hide illnesses from others are some of the most prevalent experiences of stigma that Indian women report (Thara and Srinivasan 2000). Moreover, the diagnosis of a mental illness sometimes leads to separation from partners, especially among individuals with chronic illnesses (Weiss et al 2001; Thara et al 2003).

The economic burden of mental illness contributes significantly to the treatment gap in India (Bloom et al 2014). The costs of long-term treatment, including consultation and medication costs (Sharma et al 2006), travelling costs to treatment centres (Srinivasa et al 2005; Sahoo et al 2010), and the stay in hospital (Sahoo et al 2010; Narayan and Kumar 2012), all contribute substantially to the economic burden of mental illness. The total treatment costs are significantly higher among people who are unemployed, chronically ill, disabled, and those who visit the hospital often (Chisholm et al 2000). Further, the indirect costs of mental illness are significantly higher than the direct costs (Chisholm et al 2000; Grover et al 2005). Studies in mental health economics suggest that the expenditure of time in caregiving, the inability of the patient and caregiver to work, social isolation, psychological stress, stigma, and a poor quality of life contribute significantly to the indirect costs of mental illness in India (Sharma et al 2006; Math et al 2007; Math and Srinivasaraju 2010). In this scenario, community-based care could provide substantial benefits to patients and families by providing affordable healthcare services, thereby reducing the economic burden of mental illness (Srinivasa et al 2005).

5 Beliefs, Explanations, and Help-seeking Behaviours

Belief in supernatural, non-medical explanations of mental illness and the easy accessibility of traditional healing resources are important reasons for not seeking medical help for mental illnesses in India. Beliefs concerning the aetiology of an illness, its course, the timing of

symptoms, the meaning of the sickness, its diagnosis and methods of treatment, and the roles and expectations of the individuals involved in the process affect people's health-seeking behaviours. Notions about an episode of illness and its treatment are referred to as "explanatory models" (Kleinman 1980). Predominantly shaped by culture, these models project the personal and social meaning of the illness experience (Kleinman 1980), and affect coping (Chesla 1989; Saravanan et al 2007), treatment preferences (Saravanan et al 2007), compliance (Foulks et al 1986), therapeutic relationships (McCabe and Priebe 2004), and treatment satisfaction (Callan and Littlewood 1998).

Studies from various parts of the world suggest that individuals with mental illnesses seek non-medical explanatory models of the illness (Ying and Miller 1992; Okello and Neema 2007; Dejman et al 2008; Hammarstrom et al 2009; Waite and Killian 2009; Niemi et al 2010). In South Asian countries, only a handful of patients with mental illnesses receive psychiatric treatment, and the majority of them are forced to hide their ailments even though they cause substantial distress and role impairment. As a result, individuals who have mental illnesses approach easily accessible traditional healers (Pradhan et al 2013). Indian studies suggest that social causes, supernatural forces, spirit possession, and karma are popular explanations for mental illnesses. Traditional healing is a popular resource for individuals and their families due to the easy accessibility of healers and the prevailing trust in age-old methods (Banerjee and Roy 1998; Srinivasan and Thara 2001; Raguram et al 2002; Pinto 2004; Davar and Lohokare 2009; Chakraborty et al 2013). Traditional healing resources include faith healers, healers at temples and dargahs, religious

leaders, etc. Studies suggest that individuals with mental illnesses benefit from traditional healing (Davar and Lohokare 2009) and report pleasant experiences of healing procedures (Halliburton 2004).

6 Violation of Human Rights and Judicial Interventions

Violations of human rights have been reported in psychiatric hospitals as well as at places of traditional healing in India. Psychiatric hospitals still retain certain obscure practices (shaving the heads of patients and making them wear uniforms) and infrastructure (closed structures, a lack of maintenance, unclean toilets and sleeping areas, etc) that violate the basic human right to a life with dignity (National Human Rights Commission 2008). In 2001, 28 patients who were chained at a home for people with mental illnesses died because they were unable to escape a fire that engulfed the thatched shed in Erwadi village in the Ramanathapuram district. This tragedy is commonly referred to as the "Erwadi Tragedy"; it shook the nation and caught the attention of human rights activists all over the world and resulted in structural changes to mental healthcare in India in the form of Supreme Court judgments. The Court directed the state governments to close all shelter homes for the mentally ill that were not covered by the Mental Health Act, 1987. A petition by the voluntary organisation Saarthak triggered a debate on the living conditions and status of people with mental illnesses and how they are treated in India. The demands, including abolishing electroconvulsive therapy (ECT) and banning medical research on patients with mental illnesses, were described as an "assault on clinical autonomy" by psychiatrists. Psychiatrists argue that in the Indian context, modified ECT is an important treatment procedure and sometimes, direct ECT is administered either due to lack of anaesthesia facilities or to reduce the cost of treatment (Pathare 2003). Three public interest litigations (PILs) led to the development of mental healthcare in India.

(1) *Sheela Barse v Union of India* (decided on 13 August 1986) was a case contesting the detention of non-criminal persons with mental illnesses in the jails of West Bengal. The Supreme Court observed that the correct facilities for people with mental illnesses were "mental asylums," and not jails. Large numbers of people were shunted from prisons to asylums at this point; most of them were homeless or deserted, with no other place to go. The courts did not consult the inmates on what they wanted, nor did they grant liberty to those found in the prisons to walk free at their own risk and/or determination. They were instead moved to asylums without relevant jurisprudence, human rights safeguards, or reviews.

(2) *B R Kapoor and Anr v Union of India* (decided on 9 May 1989) was a writ petition to review the mismanagement of a hospital for people with mental illnesses at Shahdara (Delhi). The Court directed to model this hospital after NIMHANS in Bangalore and directed the Union of India to take over the hospital from the Delhi administration. Following the Court's directions, the Institute of Human Behaviour and Allied Sciences (IHBAS) was established in 1993.

(3) *Chandan Kumar Banik v State of West Bengal* (decided on 25 April 1990) was a PIL addressed to the Supreme Court after a photograph of a chained patient in a state hospital in West Bengal was published in the press. The Supreme Court ordered the hospital to discontinue chaining individuals with mental illnesses and instead directed them to prescribe drug treatments in order to address the issue of human rights violations.

These PILs generated debate about the conditions of individuals with mental illnesses in India and some landmark decisions were taken by the courts to protect their rights. The controversial Human Rights Watch Report 2015 highlighted the violation of human rights, especially among women with mental illnesses admitted into various Indian psychiatric hospitals. Over the years, India has shifted its policy perspective from the medical model to a rights-based approach.

7 Reducing the Treatment Gap

The World Health Organization makes 10 recommendations to reduce the treatment gap in mental healthcare (Campbell-Hall et al 2010):

(i) Make mental health treatment accessible in primary care.
(ii) Make psychotropic drugs readily available.
(iii) Shift care away from institutions and towards community care.
(iv) Educate the public.
(v) Involve family, communities, and consumers.
(vi) Establish national mental health programmes.
(vii) Increase and improve training of mental health professionals.
(viii) Increase links with other governmental and non-governmental institutions.
(ix) Provide monitoring of the mental health system with quality indicators.
(x) Support more research.

The World Health Organization's Mental Health Gap Action Programme (mhGAP) provides a clear and coherent strategy for closing the treatment gap between what is urgently needed, and what is currently available, to reduce the occurrence of mental illnesses worldwide (Gopikumar and Parasuraman 2013). It focuses on providing information for better decisions, integrating policies, developing services, advocating against stigma and discrimination, and enhacing research capacity. In order to overcome barriers to mental healthcare, political will, advocacy for people with mental illness, development of community mental health, and a more effective use of available formal and informal resources are important areas of concern (World Health Organization 2002). Becker and Kleinman (2012) asserted that there is a need for innovation and capacity building to develop and implement locally relevant, feasible, and effective mental healthcare.

Through this research paper, we have attempted to stimulate discussion on the treatment gap and the factors that contribute to the treatment gap; we have also suggested ways to reduce the treatment gap in India. The political, social, cultural, and economic factors that are addressed in this research paper have long impeded mental healthcare in India. In order to effectively address the treatment gap in mental healthcare, the following considerations need to be tackled: popularising psychiatry (inducting more

medical students to specialisation), providing culturally sensitive training to mental healthcare professionals (taking into account cultural, geographical, and demographic diversity), increasing telemedicine practices and links (to reduce the cost of travel and stay at referral hospitals), providing psychosocial support for patients and caregivers (to reduce the indirect costs of mental illness), involving governmental and non-governmental organisations (NGOs) for community-based care (to prevent delays in seeking treatment and to spread awareness at the grass-roots level), and reducing stigma and discrimination (to improve treatment-seeking and adherence). Policy and research reflect that mental illness in India contributes significantly to the global occurrence of mental illness, and the treatment gap leads to substantial losses to individuals and families in particular, and society and the nation at large. The treatment gap can be addressed by utilising locally available resources, combining biomedical resources with locally relevant and feasible resources, and targeting primary and secondary care. As a socioculturally diverse and populous nation, India must adopt the models that fit well with the local contexts, needs, and conceptualisations of mental health. A partnership between psychiatrists, local healers (especially religious healers), psychiatric social workers, anthropologists, NGOs, and local volunteers could play an important role in making mental health services effective and accessible to a larger population.

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