

Chapter VII

Discussion

The Burden of mental illness is huge in India as well as the unmet need of services for it. This need is the result of two factors- ‘supply gap’ (inadequacy of resources) and ‘demand gap’ (failure to demand mental health services by households). In India, the burden of mental illness and rising DALYs lost due to it is a matter of concern. Hence, there is a need to make active efforts to reduce these two gaps. Various measures have been suggested globally as well as in India to address this problem. This study reviews literature on the extent of supply gap and steps to reduce it and at the same time calculates the extent of demand gap, i.e., RD and MNPT on the basis of collection of primary data of 249 patients from YMH. The study also collected data from sample households about reasons for the demand gap. Following recommendations are made which are based on the review of literature on the one hand and the analysis of primary data on the other.

Measures to address Supply Gap in resources for mental health

1. Greater financial resources through budget

Increase in the budget for mental health commensurate with BOD of mental health issues is extremely necessary. For reducing the burden of mental illness, treatment (both prevention and cure) facilities should be adequately available. This means that there is a need for greater human resources, more beds and other infrastructure, well-placed legislation, policy and planning - all of which need more resources. It is argued that it is necessary to ensure parity to mental health with physical illnesses in terms of access to treatment and care and persons with mental health problems also need to have full access to universal health coverage (Movement for Global Mental Health, 2015). Hence, it is necessary to increase the budgetary resources substantially. The current share of mental health in the health budget of the Government of India is 1 per cent. It needs to be increased to 5 to 10 per cent in order to make it commensurate with the burden of mental health (WFMH, MGMH, 2013). Increase in state and local level budget on mental health is also required (However, disaggregated data at state or local level is not easily available.). However, it is not feasible to increase it to such a level in a single step. Therefore, a step-

by-step enhancement is necessary. In the meantime, there is a need to utilise the existing resources in an efficient way.

2. *Greater share of other resources through other ministries: social justice and women's empowerment, human resource development, law, rural development, and labour*

Mental health issues have interface with several other health and non-health issues and hence with their respective ministries. In order to address the problems of mental illness effectively, there is a need for dedicated legislation and mechanism to monitor it, social welfare schemes, training and employment opportunities. For all this to happen, there is a need for greater allocation of resources not only from health ministry alone but also from other related ministries like ministry of human resources, social justice and women's empowerment, law, social welfare and rural development and labour.

3. *Effective governance: policy, plan and legislation*

In India where socio economic status of majority of population is low and out of pocket expenditure is the primary source of health financing provision of services in the public domain is necessary. However, having adequate funds for mental health is a necessary but not a sufficient condition. For mental health services to reach the people, well articulated a policy, well designed plans and programmes are necessary. Funding for mental health will have meaning, direction, focus and desired results only when it is accompanied with policy, plan and programmes. It is essential to have comprehensive legislation as well as to implement. Moreover, there is also urgent need for social insurance (Kalyansundaram, 2008); Saxena, Sharan, & Saraceno, 2003a).

4. *Awareness among policy makers: planners/ministries/departments/health officials*

Mental health is a health issue which has been neglected in the past. Policy makers, planners, ministries and concerned departments are not adequately informed about mental health issues. Besides, a stigma is attached to it. Hence, they are not likely to take decisions in the interest of mental health. There is an urgent need to increase awareness among policy-makers, planners, ministries, departments and health officials.

5. *Suggestions by Shiffman and Smith*

Shiffman and Smith (2007) have studied the allocation of funds by international health networks and allocations between the governments. They ask why some health issues receive less attention and global funding than other health issues that cause a relatively lower burden or mortality on the society. The study concludes that such an anomaly in the matching between the resources and their burden could be explained with the help of 18 factors which are grouped into four broad categories, viz.,

1. Strength of the actors involved in the initiative.
2. Power of the ideas they use to portray the issue.
3. Nature of the political context in which they operate.
4. Characteristics of the issue.

In order to obtain more funding, it is necessary to act and bring about changes in all these factors (Shiffman & Smith, 2007). For generating additional resources, mental health lobby needs to work on all the above categories. Tomlinson and Lund (2012) provide following suggestions using this framework: there is a need for greater mental health community cohesion to ensure unified voice, providing evidence-based and scalable interventions in order to create impact on policy makers, innovative strategies for treatment, stigma reduction and a social and human rights approach. Broadly, for generating greater resources, mental health issues have to be positioned and showcased in a way that policy makers understand their importance, severity and outcome.

6. Advocacy by users and family organisations

For promoting any health issue, advocacy of stakeholders is important. It consists of various actions aimed at changing the major structural and attitudinal barriers for achieving positive mental health outcomes in population (WHO, 2003). It can be of people who are directly involved with the issue or of outsiders. Among the stakeholders of mental health problems, consumers and family organizations hold the key. In USA, National Alliance for Mentally Ill (NAMI) is one of the biggest organizations of caregivers of persons with mental illness in terms of coverage, membership, number of advocacy initiatives and rapport it has with politicians and policy makers. Through their advocacy efforts, NAMI has helped to maintain the share of mental health at eight per cent of the

national health care budget in USA (HU, 2003), which is one of the highest mental health budget shares in the world.

Besides, non-profit organizations through their efforts of three decades have succeeded in many different ways- 1) Become a powerful voice for having community based rehabilitation services, 2) Successfully pressed for federal legislation for family participation in mental health planning boards, 3) Successfully lobbied for congressional legislation for parity in mental health services, 4) Ensured training of mental health professionals, 5) Provided psycho education-specific information for family members, and 6) lobbied for increased funding for research (Department of Health and Human Resources, 1999).

Sustained efforts of these organizations have led to increased budgetary and other resources, forced government to pass 'Parity laws' for bringing parity in insurance coverage for mental health with other physical disorders, improve quality of services and reduce discrimination (in the allocation of resources both public and private) for mental health problems. At the other level, by educating people, family members and users and by imparting problem management skills, they ensure early detection and treatment on the one side and better care at home on the other.

But all over the world, except in high income countries, family and patient movement is weak or almost absent, especially in low income countries (WHO Atlas, 2011). There is a need for strong and focused users and family organizations to ensure increased resources and improved quality of care. Very few low and low middle income countries have such organizations. However, with an increase in awareness, aspirations and spread of information among users and family members, the necessary changes are not far away (Hu, 2003; Department of Health and Human Resources, 1999; Saxena, Thornicroft, Knapp, 2007).

7. Research in economics of mental health and its dissemination for policy making and treatment

Unlike physical disorders, limited research has been done in the economics of mental illness (Hu, 2003). This required research needs to be conducted on three fronts:

economic consequences of mental disorders, cost-effectiveness of alternative treatments for them and their financing. This is necessary to convince the government and legislative bodies to allocate additional funding for mental health services. Moreover, research findings have to be disseminated to policy makers and others for further interpretation and action (Hu, 2003).

8. Making mental health a development issue

A person with a mental illness certainly meets the criterion of vulnerability due to the disability, stigma, prejudice and discrimination he/she has to suffer. Due to this vulnerability, the patient faces stigma, prejudice and discrimination in education and employment. However, unlike other vulnerable groups, persons with mental illness are not a part of a developmental strategy. A WHO report titled ‘Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group’ strongly advocates the need for inclusion of persons with mental illness in the development strategies and policies. It argues that development stakeholders like governments at national and international levels, international financial institutions and NGOs should consider and target persons with mental illness while giving subsidies, loans, affirmative action and developing access for them in employment and education (WHO, 2010).

Measures to address ‘Demand gap’ in utilization of mental health services

1. Awareness and de-stigmatisation campaigns

Lack of information and attachment of stigma are the biggest obstacles in accessing treatment for mental health. They not only create delay in seeking treatment but also lead to inadequate and interrupted treatment. There is a need to increase awareness about mental illness, its symptoms, outcome of such symptoms, types of treatment and people to be contacted. Awareness and de-stigmatisation activities can be taken at various levels: an all-community campaign to increase awareness of public in general or activities for target groups like school-based activity or for young people or people in a mental health crisis (Murthy, 2012; Jorm, 2000; Kelly, Jorm & Wright, 2007). Moreover, there is a need for

targeting people not only those developing illness but a range of people in their network (Pavitra KS, 2013).

There is a need that professionals shift to an active mode of empowerment while disseminating information and educating people about mental illness, i.e., they should not only focus on asking people to get rid of their beliefs about mental illness, but should take active interest in disseminating information about it at various levels – individuals, families and community (Murthy, 2012). However, precaution should be taken not to oversell treatment of mental illness. For effectively dealing with the problem of mental illness, participation of a variety of community agents such as teachers, clergy, nurses, hairdressers or any other culturally sanctioned sources of emotional and spiritual support is necessary (Abramovitz, 2008). Dialogue with other systems of care is also essential (Murthy, 2012). Instead of seeing NPT as an opposite or contradictory treatment to psychiatric treatment, some forms of it can be treated as complementary to psychiatric treatment.

2. Early detection and intervention services

Even modest period of untreated mental illness (psychosis) causes distress and disruption to individuals and families. Hence, there is a need to prioritize early detection (Pavitra KS, 2013). Initiatives aimed at reducing untreated illness will not succeed merely by providing more services or swift response, but they also need to target delays in initial help seeking (Pavitra KS, 2013).

This study finds that RD or failure to recognize symptoms as that of mental illness is very large, i.e., about 36 months. This gap is greater for patients in the young age group, i.e., up to 25 years. The 16-25 age group is important in which psycho-social development of a young person takes place and delayed treatment leads to a significant burden on the patient, caregiver and society as a whole in terms of the loss of DALYs. Hence, efforts should be made to detect and initiate treatment as early as possible, especially for people in the young age group. Apart from training of ASHA workers, regular screening camps could be organized for early detection.

3. Reducing demand gap due to discontinuation of treatment

Often primary demand gap, i.e., failure to recognize the symptoms of mental illness and initiate treatment early for the same, is given importance in research and policy initiatives. Secondary demand gap, i.e., failure to continue the treatment is overlooked either due to the assumption of its limited occurrence or its small contribution in the total demand gap. However, this study finds that more than 50 per cent of the total respondents (128 respondents) had at least one discontinuation. The average period of discontinuation was 25 months.

This means that discontinuation is a common feature for a sizable proportion of patients with a significant mean period. Limited research work is available on discontinuation. Hence, there is an urgent need to study its occurrence and duration, and the socio-demographic and other determinants governing it. Second, efforts should be made to disseminate information about mental illness, its treatment and necessity of its continuation, along with the advantages and side effects of treatment. Programmes should be planned and implemented like discharge planning of patients from hospital, their regular follow-ups (on a landline phone, mobile phone or app called What's-up or mobile), creating and circulating material, a highlighting the importance of continuous treatment, counselling and training or awareness-raising among others.

4. Integrating mental health services into primary care

The extent of under-treatment and undetected cases of mental illness are extensive. This is the main reason of a huge burden due to mental illness relatively as well as in absolute terms. For reducing the burden of mental illness, it is necessary to reduce its present state of non-detection and under-treatment. Various studies have shown that treatment for mental health can be provided efficiently at the primary care level, i.e., it can be easily integrated into the general health system (WHO, 2001; WHO, 2008; WHO, 2013; Patel & Thornicroft, 2009). Primary care comprises services of government health centres as well as private general practitioners. It has been found that with training, primary care providers can effectively deliver service of diagnosis, treatment, management, promotion and prevention of mental illness. Such an arrangement has additional advantages. Primary care is also closer to people. Therefore, it is accessible and

affordable. It has fewer stigmas. It is holistic. Moreover, it promotes respect for human rights. From the economic point of view, it is affordable and cost-effective. It requires much less investment and generates good health outcomes (WHO and WONCA, 2008; Patel, 2002; Patel & Thornicroft, 2009; NHRC and NIMHANS, 2008).

The principle of providing mental health care at the primary level is accepted the world over but little has been done in reality. There is an urgent need to introduce this change in India too. But it is not possible in a single step. Therefore, efforts should be made to introduce it in phases.

5. Use of non-government organisations (NGOs) for awareness and prevention of mental ill health

In India, NGOs play an important role in many walks of life. Their presence is particularly significant in education and health. Although in the last decade or two, some organisations have taken up mental health as their focus of work, very few of them work in the area of mental health which is a sensitive area requiring socio-cultural and psychological knowledge of the population. Due to their inherent advantages, NGOs can play an important role for awareness, promotion and prevention of mental health. The government should encourage them by giving financial and legal concessions (Thara & Patel, 2010; Patel & Thara, 2003) at least on grounds similar to other disability programmes.

6. Training traditional healers

Traditional healers or non-medical providers like religious healers, faith healers and spiritual healers are the first point of contact for a majority of the patients in India. This situation has hardly changed in the last three decades (Trivedi & Jilani, 2011). Often these providers do not refer their patients for mental health care which leads to long delays and subsequently poor prognosis. These providers should be trained to refer such patients to mental health care providers. ‘Dava and dua’ project at Ahmadabad in which religious healers refer psychiatric cases to mental health care providers has received a remarkable success.

Success of this measure is limited world-wide. However, considering the important role of these traditional healers in India at present and in the future various ways should be considered to involve them in the problem of mental health (Trivedi & Jilani, 2011). They should be trained to detect cases which they cannot handle and refer them to psychiatrists.

7. Effective solutions of other barriers

Apart from social and cultural factors, other factors like distance, financial expenses, inconvenience with respect to time and place, etc., pose as significant barriers either for the first treatment or for its discontinuation. Hence, efforts should be made to reduce their influence by provision of services in the primary health centres and subsidise travelling to mental health centres.

8. Availability of medicines and psychiatric services at inexpensive rate

Availability of inexpensive psychiatric services and medicines in the vicinity of the patients is essential for uptake of mental health services (Kohn, Saxena, Levav et. al., 2004). However, such services and experts are not easily available in rural and other inaccessible areas. This deprives people of modern psychiatric services and does not leave any option for them but to contact NPT providers. Besides, it does not allow information about psychiatric practices to spread among them. Many researchers have suggested that basic psychiatric skills – diagnosis, identification, treatment and referral - should be provided to health workers and even to non-health workers. Primary health centres should be supplied with basic psychiatric drugs (Kohn, Saxena, Levav et. al., 2004; WHO and WONCA, 2008).

9. Task sharing and shifting

Task sharing and shifting are the approaches developed by WHO and World Bank in order to deal with acute shortage of psychiatrists. Treatment for mental health problem does not need much equipment but more of human resources (WHO, 2001). Professional resources for mental health include psychiatrists, psychologists, psychiatric social workers, counsellors, etc., which are in short supply, more so in low and middle income countries. This gap cannot be bridged even in the long term (NHRC and NIMHANS, 2008). The

solution is training of health and even non-health workers to identify and treat such cases at the primary health centres or at the general practitioner's level. These health workers can refer more complicated cases to a psychiatrist whose main role is to train and supervise health workers (WHO, 2003; WHO, 2008; Patel V., 2009; Saxena et. al., 2007; Patel, Maj, & Flisher et. al., 2010).

Task sharing is a situation in which diagnosis, treatment and management of psychiatric cases are addressed by lay health workers and even by non-specialist health workers. In task shifting, expert psychiatrists are expected to get involved in training, supervision, monitoring of health and non-specialist health workers. Besides, they are expected to handle emergency cases, if necessary (Saxena et. al., 2007; Patel V. , 2009).

Summary

Mental illness imposes a huge BOD which is detrimental for the development of society. However, there exists a huge treatment gap and treatment lag in the treatment of mental illness. This is because mental health sector suffers from both the sides, (i) supply gap, i.e., inadequacy in supply of resources for mental health, and (ii) demand gap, i.e., inability to demand and utilise mental health services by households due to several barriers.

In India resources available for the treatment of mental health with the central, state and local governments are grossly inadequate as compared with the incidence of mental ill-health. This inadequacy exists not only in terms of finance but also other respects like skilled manpower, infrastructure, legislation, policy, plans and programmes. The inadequacy has existed historically and now has become chronic. This situation continues even though effective and cost efficient treatments are available which can be implemented through the public distribution system.

In order to reduce this imbalance, there is an urgent need for greater resources to be made available by the governments at central, state and local levels. In order to make resources commensurate with BOD, five to ten per cent of them have to be provided to mental health sector from current one per cent of the budget for mental health in the total health budget of the Central Government (WFMH & MGMH, 2013). Substantial increase

in resources is required in related fields also. However, a steep increase in them may not be possible in one go as it will lead to a reduction of resources for other health issues (NHRC and NIMHANS, 2008,). Hence, a step by step increase in resources is recommended along with changes in other respects -non-fund resources (policy/plans/programmes/awareness/advocacy). It will also be necessary to undertake innovative and human rights oriented steps like establishing community rehabilitation centres, mass awareness campaigns, improving conditions at mental hospitals and selling infrastructure and land to current mental hospitals.

Even though a reduction in supply gap or increase in the supply of resources is a necessary condition, it alone cannot be effective in reducing the BOD due to mental illness. As seen in Chapters V and VI, there exists a huge demand gap or TD, i.e., people do not demand and utilise mental health services due to various reasons. This study finds that this gap exists across all the social, economic and demographic sectors. Use of alternative treatments or non-medical treatment is usually blamed for delay in psychiatric treatment. However, it was found that households with low use of NPT have also a significant demand gap, i.e., TD. It means that other factors are important for demand gap. Lack of awareness about the illness, peculiar nature of illness, social stigma, ignorance and financial difficulties are some of them. Lack of awareness about mental illness is the most important reason for demand gap or TD. A majority of the sample households had discontinuation in treatment and its period is also significant. Discontinuation, usually studied from medical point of view, is sizable and needs to be reduced in order to bring down BOD. Even though free of charge services were available in the vicinity, people did not demand and utilise them which highlights the importance of awareness about mental illness.

Need for two way efforts for improving services

Summing up, efforts are necessary to reduce the gap in supply of resources for mental health. However, considering huge deficit in resources, a steep increase in resources is not possible in the near future. Moreover, changes in the supply side alone are not adequate. There is a need to address the demand gap, i.e., delays in recognising and treating symptoms of mental illness which are significant. These demand side barriers are often historical, chronic and rooted in the culture and peculiarities of mental health issues

and cannot be overcome easily. Creative and well articulated programmes should be designed and implemented which will reach people who have not sought help or whose needs are not recognised (Abramovitz, 2008).

Burden of mental illness is huge and rising. However, unmet need due to supply and demand gap is also huge. Various measures are suggested to reduce supply and demand gap. This study, on the basis of review of literature and primary data, suggests measures to reduce supply and demand gap.

For reducing the supply gap, there is an urgent need to reallocate greater financial, human and infrastructural resources. This will need greater resources from ministry of finance as well as ministries of labour, law, human resource development, etc. For ensuring and sustaining higher resources for mental health at the national and international levels mental health lobby needs to be strong. Primary stakeholders, i.e., families and patients need to form strong lobbies for advocacy. Research on economics of mental health and its dissemination is required to convince the policy makers about the need for it. Additionally, mental health should be regarded as a development issue which will ensure greater resources.

In order to reduce the demand gap, there is a need to spread scientific information about mental illness through awareness and de-stigmatisation campaigns, assertive ways to detect early presence of mental illness, use of NGOs for supplementing mental health services and training of traditional and religious providers. What is urgently required is that mental health services should be integrated with primary health care. For this to happen, existing role of the mental health professionals especially psychiatrists needs to be redefined in terms of task sharing and task shifting.

In all, for reducing unmet need for mental health, not only supply gap should be addressed, but efforts should be addressed to reduce demand gap also.