National Mental Health Policy, India (2014): Where Have We Reached?

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The World Health Organization (WHO), in its world health assembly (WHA), 2012, resolved that "there is need of a comprehensive, coordinated response from the health and social sectors at the community level to address the issue of burden of the mental illness."[1] India being a signatory to it, launched her national mental health policy (NMHPolicy) in 2014.[2] The policy was in concordance with WHO's mental health (MH) policy, plan, and program (2005), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007). Further, it aligned with and was supported by contemporary laws such as the Rights of Persons with Disabilities Act (RPWD, 2016),[3] Mental Healthcare Act (MHCA, 2017),[4] etc. Before NMHPolicy, India attempted to address the MH needs of the people of the country through National Mental Health Program (NMHP, 1982), and subsequently, through the District Mental Health Program (DMHP, 1996) with the purported objectives of ensuring the availability and accessibility of minimum MH care for all, encouraging MH knowledge and skills in general healthcare, and promoting community participation in MH service development.[5,6] NMHP has been the main MH service framework of the country till the launch of NMHPolicy. Since the NMHPolicy is an ambitious and idealistic policy with wide-ranging implications (including rights-based treatment, provision for community rehabilitation, etc.), its progress, to a large extent, is also determined by the constitution and performances of the supporting MH and allied (health and social welfare) plans/policies/laws. Consequently, NMHPolicy has not been free from criticism from different sections of society, especially regarding its ground-level implementation and performance.[7–9]

Despite the significance of this policy in the lives of persons with mental illness (PWMI) and having spanned six years since its launch, little has been discussed about it in the Indian psychiatric parlance. Moreover, the available literature, mostly from public health, has primarily focused on challenges with its implementation. There is a dearth of literature comprehensively discussing the evolution, important issues, and future course of the policy. As the ongoing COVID-19 pandemic has brought public MH issues to the forefront, a relook at the NMHPolicy and its public health implications would be prudent. Hence, this article aims at highlighting the (a) background of NMHpolicy and the implications of the policy, (b) important issues of the policy, including the possible roadblocks in its effective implementation, and (c) inherent potentialities of the policy, future course, and recommendations for its effective implementation.

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

Mental Health Policy, Plan, and Program, WHO (2005)

It is one of the 13 documents released by the WHO for the policymakers and planners to develop MH policy and comprehensive strategies for improving the MH of populations.[10] It is the central module that provides detailed information about the process of developing policy and implementing

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TABLE 1.

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

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

it through various plans and programs. Further, it guides on the need of and the roadmap for parallelly developing related legislations, policies, plans, and programs to realize the goals of the MH policy of the countries.[11]

UNCRPD (2007)

Another major development in the field of disabilities (both physical and mental) and global MH unfolded in the form of the UNCRPD.[12] It obligated the member states to undertake appropriate measures, including legislative ones, to promote and ensure the human rights and fundamental freedoms for all Persons with Disability (PWD) without any discrimination based on their disability. The NMHPolicy of India (2014) is in concordance with the convention and has provisioned equity-, justice-, quality-, participatory-, right-based care for PWMI. It also ensures that MH care be provided in a destigmatizing manner to PWMI and their social integration be promoted (discussed later).

WHO Mental Health Action Plan (MHAP, 2013–2020)

Following the WHA 65.4 (2012) resolution, WHO prepared a comprehensive MHAP and set up some global targets and objectives (**Table 2**). It had close conceptual and strategic links with other global action plans and strategies (e.g., global strategy on the reduction of harmful use of alcohol, prevention, and control of noncommunicable diseases [NCD, 2008–2013 and 2013–2020], etc.).[13] MHAP built upon mhGAP but did not duplicate the action plans of the latter. Furthermore, it focused on expanding services in low-resource settings.

Rights of Persons with Disabilities Act (RPWD, 2016)

The enactment of RPWD has given impetus to the NMHPolicy in realizing its goals.[3] The provisions of the NMHPolicy are in concordance with the country's RPWD (2016): ensuring the rights of PWMI, including the vulnerable groups (children and adolescents, intellectually disabled, etc.), by providing affordable, accessible, and quality MH services and rehabilitation and disability benefits.

Mental Healthcare Act (2017)

The NMHPolicy was framed in concurrence with the draft MHCA (2017). The NMHPolicy group was also entrusted with the responsibility to recommend changes, if any, pertaining to the draft MHCA.[4] Some of the relevant aspects of the MHCA concerning NMHPolicy include the rights to access MH care, community living, confidentiality, access medical records, personal contacts and communication, legal aid, and make complaints against the MH establishment (MHE) for any deficiencies; capacity to make decisions; advance directive; nominated representative; suicide decriminalization; ensuring funds for the implementation of the provisions of the bill; and insurance for mental illnesses.[14]

National Health Policy of India (NHP, 2017)

The Government of India (GoI) launched NHP in 2017, aiming to inform, clarify, strengthen, and prioritize the role of the government in shaping health systems in all its dimensions.[15] NHP (2017) made certain provisions that support NMHPolicy: (a) to increase the creation of specialists through public financing, (b) to create a network of community members to provide psychosocial support to strengthen MH services at primary level facilities, and (c) to leverage digital technology in a context where access to qualified psychiatrists is difficult.[16]

As highlighted in the NMHPolicy, India (2014) has its root in the above-mentioned documents or have been supported

TABLE 2.

Global Targets for the Comprehensive Mental Health (MH) Action Plan 2013–2020, WHO

Objective 1: To strengthen effective leadership and governance for MH	*Target 1.1:* 80% of countries will have developed or updated their policies/plans for MH in line with international and regional human rights instruments. *Target 1.2:* 50% of countries will have developed or updated their laws for MH in line with international and regional human rights instruments.
Objective 2: To provide comprehensive, integrated, and responsive MH and social care services in community-based settings	*Target 2:* Service coverage for severe mental disorders will have increased by 20%.
Objective 3: To implement strategies for promotion and prevention in MH	*Target 3.1:* 80% of countries will have at least two functioning national, multisectoral MH promotion and prevention programs. *Target 3.2:* The rate of suicide in countries will be reduced by 10%.
Objective 4: To strengthen information systems, evidence, and research for MH	*Target 4:* 80% of countries will be routinely collecting and reporting at least a core set of MH indicators every two years through their national health and social information systems

The action plan has been extended from 2020 to 2030.

Source: Comprehensive Mental Health (MH) Action Plan 2013–2020, World Health Organization (2013).

by them. The salient features of the NMHPolicy and National Mental Health plan-365 (2013) have been elaborated further.

National Mental Health Policy, India (2014)

To draft the NMHPolicy, in April 2011, the GoI constituted a policy group, which gave rise to NMHPolicy in 2014. It is an inclusive policy where MH issues were addressed both in medical and nonmedical terms. Salient features of the policy are enumerated further.[2]

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

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

Goals

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

Objectives

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

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

National Mental Health Plan-365 (2013)

The launch of the NMHPolicy co-occurred with the release of the MHAP-365 to succinctly describe the roles and responsibilities of each stakeholder for a particular action. The major stakeholders of the MHAP-365 are the union GoI, the governments of states/union territories, local bodies including municipalities and Panchayati raj institutions, civil society organizations, PWMI, medical and health-care providers, medical colleges, academic and research institutes, schools, and colleges, private corporate sectors, and finally, media. MHAP-365 pointed out that although the complete attainment of the complex objectives may not be feasible in the short or medium term, it is nevertheless necessary to have directed and coordinated action plans.[17,18]

Issues with the National Mental Health Policy (2014)

The policy envisaged the delivery of MH services through an integrated care

model. However, in reality, the training of general practitioners at the community level in this regard is meager.[19] Although policymakers have envisaged providing holistic health care, including MH care, at the level of the primary health center, by setting up "health and wellness center" under the Ayushmaan Bharat Scheme (NHP, 2017) and collaborating with the private sectors/nongovernment organizations (NGOs), its implementation and outcome are yet to be evaluated.[20]

NMHPolicy outlines important aspects of justice for the vulnerable groups (homeless, orphaned children, children in conflict with the law [CICL], etc.). However, it requires a concerted effort from different stakeholders (legal experts, social-welfare organizations, educationists, etc.) who might, at times, have different mandates.[21] For instance, MH needs of the CICL can only be achieved when the legal system and civil society, who may not acknowledge the bio-psycho-social model of mental illness (and associated behaviors, including legal offenses), thereby endorse punitive measures, work in collaboration with the social-welfare agencies and MH professionals (MHPs) for improving the lives of CICL and preventing recidivism. Similarly, community rehabilitation and social inclusion of the PWMI can only be achieved if the executory bodies (educational institutes, employment sectors, and social-welfare groups) are ready to comply with the legislation in its true spirit (providing reservations to PWD in education and employment, thereby promoting their social inclusion). Hence, a national-level coordination committee needs to become functional at the earliest to address this issue.

Although NMHPolicy is provisioned for community rehabilitation of PWMI, its ground-level implementation is still abysmally low. This is attributable to the poor MH resources; sub-optimal linkage among MH services, allied health facilities, and social welfare schemes; and lack of involvement of the community leaders, NGOs, and private sector.[22–24] There is an urgent need to infuse more financial and human resources that can be utilized in organizing awareness campaigns; mobilize community resources by training the community health workers, laypersons, and community members in rehabilitative services; provide rehabilitative services at multiple levels (daycare and residential care, routine psychosocial activities, outreach activities, livelihood activities, etc.); and set up integrated CBR programs by involving various stakeholders.[25,26]

The NMHPolicy proposes evidence-based care for PWMI. However, the evaluation of MH care services of the country, including the latest national MH survey (2016), highlighted the scarcity of MHPs and medical officers (medical graduates who are trained in providing routine psychiatric care) at the community level, thereby limiting the full realization of the NMHPolicy.[27–29]

Furthermore, there are several hurdles in realizing the right-based and participatory MH care for PWMI. For instance, under MHCA (2017), the facilitatory institution to ensure these rights (standard of care to be provided by the MHE, disability benefits, and complaining against the MHE in case of any deficiencies) is Mental Health Review Board (MHRB). Unfortunately, many states still lack a functional MHRB.[30,31] Much of this is attributed to the financial crunch at the state level; support from GoI and civic bodies could be instrumental in overcoming it. Likewise, MHCA (2017) provisioned for participatory care, considering the poor MH literacy among the patients and their caregivers (about the illness model; treatment decision-making, including emergency treatment; etc.).[24] To what extent patients and their caregivers can be burdened with these responsibilities, especially when the MH awareness in the community is still low and patchy, is yet to be assessed.[23]

Similarly, despite the fact that suicide has been decriminalized (MHCA, 2017) to reduce the stigma against those who attempted suicide and PWMI, the public still lacks awareness about it. Moreover, there is still ambiguity about it in the legal as well as health systems.[32]

The NMHPolicy proposes support to the families of PWMI. Despite the existence of various health and social welfare schemes, their reach and utilization are far from satisfactory.[33,34] This is attributable to several factors: attitudinal barrier (stigma and discrimination), dynamic nature of the mental illness (e.g., episodic illness such as bipolar affective disorders), cumbersome process of obtaining disability certificates, and lack of awareness among the patients/caregivers about these schemes.[34–36] Hence, a nationwide awareness campaign, single-window issuance of the disability certificates, and decentralization of such services (provision of disability certificate at the PHC or community health centers level) are urgently required.[34,35] Although MHAP-365 demarcates the roles and responsibilities of different stakeholders concerning this, the implementation and tangible change at the ground level are yet to be seen.[18]

Also, the MHAP-365 needs to be evaluated on outcome indicators that evaluate the extent to which we have achieved the goals led down by UN (sustainable development goals) and WHO: reduction of suicide (10% reduction by 2020), improvement in community-based service coverage for severe mental disorders (20% increase by 2020), number of people covered by health insurance,[37] etc.

Lastly, no policy can be effectively implemented without an adequate allocation of budget and a timely financial flow. Literature suggests that NMHPolicy is still under-implemented because of the lack of the earmarked funds and mechanism to ensure their regular flow.[7]

Importantly, for the policy to progress and being pragmatic, we need to learn from the experiences of other countries, particularly in terms of utilizing innovative approaches to service delivery, including the use of digital technology, nonspecialized MH services, culture-specific interventions, awareness programs, interventions targeting the vulnerable population, etc. Some of the potential look after examples are the development of culture-specific, and acceptable psychological interventions to be delivered by non-specialized health workers (task-sharing: e.g., improving access to psychotherapy program, UK; Dutch Depression Initiative primary MH collaborative care model)[38,39]; utilizing digital technology in providing MH services[40]; and a balanced care model for mental disorders depending upon the income-setting of the country[40] (interventions to prevent mental illness and early management and facilitate help-seeking: e.g., an anti-stigma campaign in an educational institute, UK[41,42]; involvement of family members and service users and proactive community case finding in Nepal[43]; MH initiatives as peace initiatives to address the psychological well-being of children affected by armed conflict, Sri Lanka[44]; the surveillance and care system of Thailand to address the burden of depression and suicide in the country).

The Road Ahead

Although NMHPolicy has been a well-conceptualized and planned policy, its objectives can only be achieved through increased synergy among the parallel health (including the MH and social welfare) policies and strategies. For instance, universal access to MH care can be realized through effective implementation of the provisions of MHCA (2017), particularly early setting-up of the MHRB across the country (requiring a collaborative effort from both the state and center), which will ensure right-based MH services. Coverage of the MH services can be expanded by ensuring medical insurance for treatment of mental illnesses—that needs coordination with the insurance regulatory authority of India and effective implementation of Ayushman Bharat schemes. Safeguarding the rights (community rehabilitation, social inclusion, etc.) of PWMI requires collaboration among the government, private sector, NGOs, community support groups, etc. The proposed "health and wellness center" (NHP, 2017) should function by incorporating the MH services and liaising with the ongoing DMHP as a form of a to-and-fro referral system. Similarly, right- and participatory-based MH care, including the vulnerable population such as children and adolescents, could be achieved through effective implementation of the RPWD Act (2016), MHCA (2017), Juvenile Justice Act (2014), and Protection of Children from Sexual Offences (POCSO) Act (2012).[3,14,45,46]

Although the NHP (2017) has highlighted the growing concern of MH problems and the need for a holistic and pluralistic treatment approach, MH largely gets obscured under the broader category of NCDs (diabetes, cardiovascular diseases, cancer, etc.). Therefore, the NHP needs to address the MH issues more specifically and directly with an earmarked budget (than subsuming it under the broader category of NCDs), outlining a clear-cut procedure for fund utilization in developing MH infrastructure, including skill training for medical officers and other community health workers, at par with other NCDs.

Similarly, MH and allied laws (Juvenile Justice Act, POCSO, RPWD Act, etc.) should be effectively implemented through the earmarked budget and human resources. This would not only facilitate the implementation of the NMHPolicy but also strengthen it.

It cannot be overemphasized that any policy and program with such wide-intended goals cannot be completely achieved on a short- or medium-term basis, particularly when concerted effort and coordination from multiple stakeholders are required. This also warrants that the policy is periodically evaluated and revised, maybe on a five-yearly or decade basis; this would ensure that ever-evolving MH issues get incorporated in to the policy and effectively get addressed, thereby making the policy relevant across times.

The ongoing COVID-19 pandemic brought MH issues to the forefront more than ever before. Although it has alarmed and sensitized the policymakers about the MH issues of the general population, the government also has responded by launching some public-health-related preventive measures. It is yet to be seen how much and far this momentum gets channelized in the context of the NMHPolicy.[47] No doubt, the current pandemic offers an opportunity for all the stakeholders, particularly the MHP, to display leadership and put forward a concerted effort to achieve the goals of the NMHPolicy.

Conclusion

NMHPolicy is a path-breaking policy with wide-ranging objectives and implications. It needs to be provided with adequate time to bring about a tangible change in society. Enactment of laws such as MHCA (2017), RPWD Act (2016), and the latest NHP (2017) covering MH issues of the population and the government's recent response to MH challenges posed by COVID-19 are some of the positive moves. We need to capitalize on them to realize the objectives of the NMHPolicy. Although its progress has been marred by delays in implementing supportive laws and action plans, a policy of such a magnitude mandates concerted efforts from various stakeholders, and MHPs have a major role to play. Lastly, policy-implementation-related research from different sectors of academia, particularly from MH, is also warranted.

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