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# Mental Health Care in India: Prescribing the Right Policy

*By KIMBERLY MELTZER*

## I. Introduction

Mental health is a vital aspect of health and essential to human development. Mental illness is prevalent throughout the world, and with many disorders left untreated due to inadequate services, mental health care needs to be improved. The problem is most severe in developing countries, posing a burden for global development (Kaplan, “World”). India is one such country in the developing world with a fragmented mental health system in need of improvement. Tailoring mental health care to local conditions and demographics is the most effective way to improve care, because different problems among countries require different solutions. Mental health care is not a widely recognized priority on the global health care agenda, and the differences in quality of mental health services can be attributed to varying global perspectives on the importance of mental health. Certain historical factors have influenced the progression of mental health issues, and, subsequently, policies that affect mental health care. Attitudes about mental health and its impact on well-being have been shaped by various factors such as how mental health is defined, its role in overall health, its relation to human rights, and a combination of economic, political, and social factors. All of these factors have contributed to greater recognition of mental health and its higher priority in health care in the more developed Western world as compared to the non-Western world.

India’s perspectives on mental health and standards of care have been complicated by developmental factors, resulting in recognition not upheld in practice. India is a country of particular interest due to this disparity between its rhetoric and reality, and looking at the history of mental health and the impact of these factors will help shape recommendations for improving mental health care. Mental health policy efforts and traditions of care continue to fall short of the country’s mental health care needs. Policy recommendations proposed in this paper center on community mental health care, which should and can be expanded by maximizing existing resources in the community. Increased training and education, in addition to research, should also be included in this effort. These recommendations are provided because they are cost-effective, beneficial for health, and take into account country-specific demographics to improve the state of mental health care in India.

## II. Perspectives on Mental Health

Mental health is regarded differently across cultures. Due to varying global perspectives, mental health services throughout the world do not conform to the same standards because mental health care is not a universal priority. Generally speaking, the West holds a higher regard for mental health and has more adequate mental health services than in the non-Western world. Differences between the West and Asia can be attributed to each region’s unique history and to developmental factors that have determined the priority of mental

health care.

### ***Mental Health Defined***

Since mental health is a socially and culturally defined concept, perspectives on its importance vary. Different cultures conceptualize the nature of mental health in various manners according to social norms and values. In *Reasoning about Madness*, J.K. Wing asserts that the difficulty of defining health stems from its context—health, disease, and disability are all socially defined concepts, as the social contexts in which they evolve determine how certain characteristics are regarded (29). Disorders have different meanings in different cultures and are regarded according to societal values (Fabrega, Jr., “Culture” 391). With regard to cultural context, Roland Littlewood says the “language of medicine makes sense within our particular context, because we are embedded in that context” (509). On discussing mental disorders in China, Sing Lee says “Psychiatric disease constructs represent social constructs and genuine states of distress that have biopsychosocial sources [. . .] they have social uses peculiar to social groups in which they are created and legitimized. This is as true in the U.S. as in the rest of the world” (428). All cultures are afflicted with the burden of mental illness, but different cultural definitions and interpretations determine outcomes in health care. The way in which mental health is regarded depends on regional context, and so variations exist between Asia and the West. Conceptualizing mental health and disorders in India is specific to Indian culture and societal values, and therefore mental health policy should be country-specific.

### ***Role in Overall Health***

The importance afforded to mental health affects its perceived role in overall health and health care. Health is typically associated with conditions pertaining to the body. Kumar argues that we tend to focus on physical ailments in health and ignore mental health:

In the past and in the present also, in the field of health, our mind has been preoccupied with communicable diseases because they are the biggest causes of death in the population. These diseases have partly been conquered. We have been looking at health in terms of physical health, while neglecting mental health. Over the years, mental illness has increased manifold. (“India”)

Not all cultures recognize the same connection, if any, between the body and the mind. If too much consideration is given to physical health, psychological health may be underemphasized or not valued at all. Consequently, people may assume that mental health has a minimal effect on overall health and a limited role or no role in health care. Regarding the ‘body-mind problem,’ Wing says “there is no logical reason why physical and mental events should not interact” (30). Since cultures recognize the connection between mind and body differently, care for the mind comes in different forms. Viewing the body as a system, rather than separate parts such as the distinction between body and mind, constitutes the basis of Chinese medicinal care (Kirmayer and Groleau 470). This systemic concept may explain the lack of specific focus on mental health care in China, which would emphasize the mind rather than caring for the body as a whole, complex system. Such an ancient view in Chinese culture may lower the importance of mental health care if that traditional view continues to be salient. In India, the view that the mind can affect the body is becoming more common. The mind and body were thought to be separate components, but over the past few decades, researchers have found that psychological factors can bring about not only mental illness but physical illness as well (Kumar, “Understanding”).

A triad view of overall health has evolved, comprised of the interaction among physical, social, and mental well-being, which has increased the importance of mental health. This more complex view has most likely emerged to affirm the connection between mental health and physical health, because a sole focus on the latter ignores the impact of mental health on well-being, an idea that has become more pronounced with increased education and advocacy efforts. The World Health Organization (WHO) defines health according to this triad model, as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (“Constitution”). Such a well-known international institution declaring the importance of mental health in overall health has been significant. A.V. Shah also defines health according to this model of well-being and proclaims mental health to be “the most essential and inseparable component of health” (qtd. in Kumar “Understanding”).

### ***Human Rights***

The place mental health has in human rights has also been a determinant of the importance of mental health care. The priority for mental health stems from an evolving concept of human rights that includes the right to health. According to Shridhar Sharma, the modern idea of human rights is rooted in equal creation, which evolved into the concept of certain natural, individual rights, and finally a “transition from individual liberty to social entitlement” in which society is responsible for citizens’ well-being, including the right to health (“Evolving”).

The United Nations helped to promote international regard for the right to health and the societal obligation to provide it with the formation of the WHO and a multitude of resolutions, including those that expanded on the concept of the right to mental health. Shridhar Sharma contends that “health as a right took on a higher value” with the formation of the WHO, whose goal is to make it possible for all people to obtain the highest possible level of health, according to the definition of health in its Constitution (“Evolution”). The Constitution of the WHO indicates that the right to health is a fundamental right (WHO “Constitution”). The “Universal Declaration of Human Rights” declared health as a human right (United Nations, “Universal”), and Article 12 of the UN General Assembly’s “International Covenant on Economic, Social and Cultural Rights” further defined the right of health to include mental health (United Nations, “International”). Mental health and human rights became more valued with the 1978 Declaration of Alma Ata, which promoted the integration of mental health services with primary health care in order for everyone to be healthy by the year 2000, and the UN General Assembly’s “The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care” in 1991 (Shridhar Sharma, “Evolution”).

Although the concept of human rights has evolved to include mental health as a fundamental and universal right, there are disparities about how this right is viewed in regards to the state of mental health care throughout the world. Shridhar Sharma attributes “the foundations of the modern concepts of universal human rights” as having “evolved out of centuries of economic, political, and ideological conflicts in the West” (“Evolving”). In Asia, human rights awareness and implementation vary, but there has been a change in government perspective about human rights and, in turn, psychiatric care (Shridhar Sharma, “Asian”). People claim that the human rights of patients with mental illnesses align with the standards of developed countries and that inadequate care is due to the lack of facilities, trained personnel, and psychosocial support systems, especially in growing urban populations (Shridhar Sharma, “Asian”). A major contributing factor to poor human rights records is stigma associated with mental illness, which differs between Asia and the West. Although stigma may always be attached to some extent, mental illness is less stigmatized in the West than in Asia, a fact that has contributed to better mental health care and human rights in the West. The effect of

stigma, which is associated with awareness about mental disorders, can be attributed to the historical development of both the Western and Asian regions.

India's view on the right to health aligns with the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights, but there is debate on the extent of India's attention to human rights. Increased awareness about human rights and mental illness led to progressive legislation to protect the human rights of people with mental illness, such as the Indian Mental Health Act of 1987 and the establishment of the National Human Rights Commission, which is aided by non-governmental organizations to investigate cases of abuse towards people with mental illness (Shridhar Sharma, "Human"- "Asian"). Amnesty International contends that India's human rights record is poor, with human rights violations and attacks on human rights defenders and activists ("Asia-Pacific"). In light of the contentions as to where India stands, it still seems plausible that India's view on human rights contributes to more adequate mental health care and alignment with developed countries than other Asian nations such as China which has no human rights commission. The reality of human rights in India may not match its rhetoric, but the fact that the rhetoric is established makes it more progressive in terms of human rights awareness.

### III. Historical Development: The West vs. Asia

Economic, political, and social factors have determined regional rates of development and contributed to the state of mental health care in the Western and non-Western worlds. Mental health care is generally more recognized and of higher quality in the West, because countries are not experiencing rapid economic transitions that are bringing about significant developmental changes as in other parts of the world (Desjarlais et al. 4). Less developed countries are transitioning into the infrastructure and institutions that the more developed Western states have already had in place for quite some time. Along with this progress and development come adverse consequences to society in terms of survival and functioning, evidenced by mental health problems in these improving countries:

[. . .] economic progress and gains in overall longevity have been accompanied by an increase in the social, psychiatric, and behavioral pathologies that have become a part of daily life in North America and Western Europe [. . .] along with the increase in life expectancy has come an increase in depression, schizophrenia, dementia, and other forms of chronic mental illness, primarily because more people are living into the age of risk. (Desjarlais et al. 3-4)

Because the Western world developed much faster than Asia, the mental health field and relevant care was able to progress unlike in India, which is currently experiencing the great economic transitions that have already occurred in the West.

Though regional rates of development may partly explain differences in mental health care between the West and Asia, lengthier periods of economic development do not necessarily equate with better care. A more complete explanation for the disparities in mental health care should include the historical roots of the regions, which relate to rates of development. For example, Fabrega, Jr. discusses the evolution of the psychiatric profession as part of the histories of the regions. He asserts that all societies deal with problems of mental illness and hence develop knowledge and practices to combat such illness. The second half of the 18<sup>th</sup> century experienced demographic, social, and political economic changes that affected Anglo-European societies, such as changes in population sizes, migration and urbanization, industrialization, the growth of a capitalist economy, and the growth and evolution of the medical profession, which contributed to the history of the psychiatric profession ("Culture" 392-3). Other societies,

including ancient China and the Indian subcontinent, were influenced by “non-Western but equally major traditions of medicine” and “met some of the conditions that gave rise to psychiatry in Anglo European societies during the early modern period . . . [but] did not all share the exact mix of demographic and political economic conditions of early modern and modern Western societies”; instead, they were influenced by diverse social and cultural traditions and had integrated religious values (Fabrega, Jr., “Culture” 398). Although medical traditions do exist in Asia, they are not the same as those of the Western world. Asia is diverse due to its range of political ideologies, and influences from ancient Chinese and Indian traditions have contributed to views on health and health practices (Shridhar Sharma, “Asian”).

In non-Western countries, traditional medical systems such as Chinese medicine are still common amid the “worldwide ascendancy of modern Western medicine” (Lin, Smith, and Ortiz 531). Historical factors and cultural values have therefore contributed to a different system of medical care in Asia than in the West.

India has traditionally afforded importance to mental health, although it has approached mental illness differently than in Western societies. This can be attributed to differences in the evolution of psychiatry and medicine as mentioned by Fabrega, Jr. Cultural and religious values influenced the nature of the psychiatric profession and the approach to mental illness. According to Fabrega, Jr.’s discussion on traditional India, “ancient India’s cultural psychology, encompassing philosophical, religious, and moral/ethical dimensions” influenced how mental health and illness were viewed and served as the basis for the healing system, which included a “local system of support” in which family and villages were responsible for caring for the mentally ill (“Mental” 556). He also says that “Indian approaches to mental illness were not limited to discrete, separately defined conditions” but that there was a “broadly conceptualized model of mental health and illness” (“Mental” 557). India’s tradition is different from the West because of the integration of its culture and religious values, particularly in village settings, in the care given to people with mental illness. The notion of responsibility in traditional Indian culture may be a determinant of India’s health policy rhetoric as evidenced by its signing of the Declaration of Alma Ata, which corresponds with the idea of society’s obligation to ensure health for the population. India’s tradition of mental health care conforms to the concept of societal well-being including the right to health.

Shridhar Sharma characterizes Asia’s political and health systems, demographics, and economic strategies as transitional following European imperialism. As a result, the economic, political, and social systems are growing in diverse ways across and within Asian countries. In a general sense, the health systems in Asia mirrored those of Europe, specifically Britain, France, and Holland. The Asian health systems are becoming more influential in national policy due to a growing private sector. The idea that governments should provide health security for all citizens is becoming more common, but mental health care accessibility and availability varies throughout the region (“Asian”).

Transplanting a European health care structure to Asia seems to have contributed to the Asian region’s ineffective health infrastructure. Because of Asia’s diversity, a health care system analogous to the more homogenous European region yields a fragmented system in Asia. Michael Yahuda describes the new diplomatic order in Asia as “one that reflects the special characteristics of Asian states” (348). The European trend of integration, with its “pooling sovereignty” to establish a political order such as the European Union, does not apply to Asia where states wish to retain their sovereignty (Yahuda 348-9). In this sense, not only is it a poor idea to transplant a Western system to a diverse Asian region, but the sovereignty of the Asian states may make it necessary to tailor systems to individual countries.

### ***Economic Factors***

Developing economies and impoverished states have produced an inadequate state of mental health care in Asia. Low-income countries cannot support mental health services as well as more developed countries, and if services are available, they are typically of poor quality or people of low socioeconomic status cannot afford them. Although Asia is currently experiencing economic expansion, the region is still afflicted with much more poverty than the West. In the 1980s, global poverty increased, with economically disadvantaged countries experiencing a significant deterioration in living conditions, and in the 1990s, poor living conditions and an increasing global population “led to unprecedented poverty” (Desjarlais et al. 16). East and Southeast Asia saw strong economic growth later on as countries in the region were “growing economically at the fastest rate in the world,” which led to enhanced health care services, such as the growth of Taiwan’s mental health care system (Desjarlais et al. 17). In the Asia-Pacific region, China and India are the two rising “economic superpowers,” yet many people still live in poverty and lack adequate health care (Amnesty International, “Regional”). This poverty is largely due to the prevalence of rural communities. The rural poor comprise more than 80 percent of poor people worldwide, with the largest number of these people living in Asia (Desjarlais et al. 19). In East Asia, “rapid economic growth” and “growing social and economic pressures” have resulted in many more people pursuing treatment for mental distress, but developing countries in the region have inadequate services compared to more developed economies, and people living in rural areas cannot afford treatment (Fan, “East”).

Despite rapid economic growth, much poverty remains in India, especially in the large rural populations, which leaves many people unable to afford mental health services. India’s economic growth rate has been credited with reducing poverty but, according to a 2002 estimate, 25 percent of the population lies below the poverty line (CIA, “Economy”). The major source of financing for mental health care in India is out-of-pocket expenditures incurred by patients or families (WHO, “Mental Health Atlas” 233). India’s poorer economic status yields poorer infrastructure, and its health care, including mental health care, is subsequently inadequate compared to other developed nations. Amount of funding may not necessarily be a source of discrepancy in quality of health care systems between India and more developed countries. Comparing India, a low-income country, to the United States, a high-income country, the proportion of health budget to GDP is 5.1 percent and 13.9 percent, respectively (WHO, “Mental Health Atlas” 232, 491). India allocates about 2.05 percent of its total health budget for financing mental health activities, while the United States allocates about 6 percent (WHO, “Mental Health Atlas” 233, 491). Although the United States spends more of its total budget on health care, including mental health, and has a much higher GDP and about one-third of India’s population, it is commonly argued that health care expenditure in the United States does not accurately represent the quality of health care.

### ***Political Factors***

Regional perspectives on mental health and care for the mentally ill have been shaped by varied political cultures, but Western politics have had a major influence on the progression of mental health in the non-Western world. Because mental health concepts are relative to the contexts in which they are constructed, different political contexts have produced variations in views on mental illness and mental health care. Defining mental health and illness becomes problematic “as soon as we start thinking of ‘not-health,’ defined according to the standards of some particular society or social group, as ‘disease’” (Wing 33). In the past, people questioned the legitimacy of treating mental illness because of accusations that some societies with “oppressive regimes” would use psychiatrists to ascribe medical conditions to social deviance in

order to “suppress political dissent” (Desjarlais et al. 35). For instance, according to Wing, the U.S. and Western Europe criticized the former Soviet Union for committing political dissenters to mental hospitals, and there was “much publicity about alleged abuse of psychiatry in the Soviet Union” (Wing 167). The Soviet and Western perspectives on political dissent produced differences in dealing with mental illness. Whereas the Soviet Union regarded publicly expressing views as political slander and responded punitively with institutional commitment, political dissent has become tolerated and even appreciated in the West, as public freedom of expression is “the foundation of political democracy in Great Britain and the U.S.A.” (Wing 168-9). It seems that democratic institutions are more apt to deal with mental health care in a humane manner due to the principles that shape democratic societies. Western political freedom and public attention to other nations seem to have influenced more humane mental health treatment in non-Western societies.

Political and moral ideologies have influenced the formation of health services for the mentally ill, with the West influencing progression to more humane treatment. Wing states that although both developed and developing countries have similar goals of promoting health and preventing disability, these goals take into account local contexts of economics and morality, and varying political philosophies determine the meanings of ‘need’ and ‘ability’ (194). The Western world experienced changes in mental health care due, in part, to political and moral ideologies. In the U.S. and Britain, the first mental hospitals were established “in reaction to intolerable conditions,” and the idea of more “moral” treatment for the mentally ill came about as there was a wave of new laws and provisions to protect their human rights (Wing 197). Political ideology influenced policy shifts toward community care and away from institutions in Western welfare regimes post-1945 (Carpenter). Western society began to make a shift away from mental institutions that were used to solve social problems. Different countries with such different political philosophies as the Soviet Union, Great Britain, and the United States have experienced this trend in different ways (Wing 198).

Some believe that political factors cause an increase in mental health problems. For example, Zhang, a teacher from the eastern Chinese province of Shandong, observes that political campaigns by China’s Communist Party that have continued ever since China’s “so-called liberation” have caused people to experience “years under intolerable pressure” and hence greater mental health problems (Fan, “East”). This situation is exacerbated by the overarching view of mental health care in China. In Bai Fan’s report on the psychology profession in China, one can see the political dissidence exemplified by the Communist Party:

China’s Communist Party has traditionally regarded the psychological profession as an imported form of Western-influenced bourgeois decadence. Even the medically-based psychiatric profession was virtually non-existent until well after the Cultural Revolution (1966-76) had ended, and psychologists were almost unheard of until about a decade ago. (“China”)

Since India has been under Western influence, its political system has been more aligned with the Western world. Mental health policy in India has seen a shift from asylums to community care over the past few centuries (Goel et al. 6). Prior to independence from British rule, institutions for mentally ill people were common throughout India. English and European ideas about mental illness influenced the first institutions that were established in the Indian subcontinent in the 17<sup>th</sup> century (S.D. Sharma 25). The purpose of mental asylums was mainly to “protect the community from the insane,” thus taking a more custodial demeanor rather than a curative approach for treating mental illness (S.D. Sharma 25). The development of mental hospitals related to political developments in India, evidenced by the fact that “the 18<sup>th</sup> century was a very unstable period in Indian history” and the “events [that] gave rise to politi-

cal instability [ . . . ] also contributed to psychological and social turmoil” (S.D. Sharma 25). Early in the 20<sup>th</sup> century, negative publicity about poor conditions of mental hospitals under British control resulted in a more humanistic approach, with the Directorate of Health Services becoming responsible for overseeing hospitals rather than the Inspector General of Prisons (S.D. Sharma 27). This shift from punitive authority to health management in caring for the mentally ill shows the progression from a custodial to therapeutic nature for treating mental illness.

British influence was also seen in Indian legislation, as in the Indian Lunacy Act of 1912, where Britain tried to parallel its own legislation and institutions in India so that British soldiers in India could receive the same type of care offered in their home country (Khan 62). The traditional Indian mental health care system was not institution-based though, and “asylums were seen as the last resort in severely disturbed cases” (Khan 62). Faith healers played an important role in care, which was an outdated practice in the West but one still prevalent in India (Khan 62). The European system tried to replace an ancient Indian healing tradition, which rendered quite fragmented health care.

In the two decades following India’s independence, there was a shift from custodial to more treatment-based mental health care. Reports assessing the status of mental health revealed that asylums were not conducive to therapy or rehabilitation, and recommendations were given that centered on restorative efforts, such as establishing in-patient and outpatient facilities in general hospitals, individual mental health care facilities, and mental health institutions (Kumar, “Mental”). The 1970s and 1980s brought more initiatives in mental health care (Kumar, “Mental”). India’s National Mental Health Programme (NMHP) was adopted in 1982; it was the foundation for public health efforts pertaining to mental health (WHO, “Mental Health Atlas” 233). The NMHP aimed to improve the delivery of mental health care by alternative means, including treating mental disorders at the community level by using existing resources such as primary and community health workers (Kumar, “National”; Agarwal v). Initially, the program made progress, but overall it was ineffective because expanding efforts at the district level proved difficult (Kumar, “India”). The Central Council of Health and Family Welfare stated that mental health should be included in India’s total health program and all national health policies and programs, and thus in an effort to broaden the scope of mental health services to the community and to primary care, the Central Council assessed the NMHP in 1995 and subsequently created the District Mental Health Programme (DMHP) (Kumar, “National”; WHO, “Mental Health Atlas” 233). This initiative was a more feasible “national” mental health program because it penetrated the districts, which allowed for further integration of mental health care at the community level.

It seems that India’s post-British government may have been the least restrictive factor in the progression of mental health care. India’s government and legal system more closely resemble those of a “Western” nation, as it is a federal republic with a legal system based on English common law (CIA, “Government”). Other political issues are salient with respect to mental health, including international conflicts, violence, human rights violations, and disparities across states. The fact that India is comprised of 28 states and seven union territories poses a challenge for implementing successful national policies (CIA, “Government”).

### ***Social Factors***

Mental health exists in a psychosocial context, as demographic and social conditions can exacerbate mental illness and act as barriers to treatment. Developing countries are at the highest risk of the burden of mental illness, not only because of poor infrastructure, but demographic factors such as socioeconomic status, urban-rural disparities, gender, environmental stressors, natural disasters, and violence also hinder the progression and treatment of dis-

eases. Mental health problems associated with natural disasters, environmental scarcities, urbanization, and physical illness generally affect poorer communities more because there are no programs or services to lessen the impact of such factors (Desjarlais et al. 19). Poverty is highly associated with mental distress and disorders, and women are particularly vulnerable due to the increasing incidence of poverty among them (Belle 385). Although there is urbanization in Asia and the Pacific, there is a high rate of urban poverty in major cities due to rapid migration to cities with no prosperity as a result of industrialization (Desjarlais et al. 22). The rapid economic expansions in countries like China and India are still leaving many people in poverty. Low-income countries also have the double burden of “continued infectious diseases” and “chronic medical, mental, and behavioral conditions” (Desjarlais et al. 4). In addition to physical weakness and illness of the diseased poor, a lack of assets, population pressures, and powerlessness contribute to the perpetual state of poverty and so “poor people, like poor countries, almost always stay poor” (Desjarlais et al. 19). Poverty is one of the most detrimental factors for mental health, because it can cause and/or result from mental illness.

In addition to myriad socio-demographic factors, India faces overpopulation and conflicts with neighboring nations (CIA, “Introduction”). India is a populous country, and “the huge and growing population is the fundamental social, economic, and environmental problem” (CIA, “Economy”). The country is not only plagued with natural hazards but environmental stressors such as air pollution from industrial activity, which are detrimental to health (CIA, “Geography”). Both the urban and rural areas are afflicted with poverty and, consequently, inadequate health care. India has a large rural population, and poor people in rural areas lack basic infrastructure and economic prosperity (CIA, “Economy”). Without basic infrastructure, the rural poor suffer from a lack of mental health care or limited access to care, with no means to travel to distant urban areas that may have mental health services. Urban areas are poverty-stricken as well, so even if services are available, they are not always affordable. According to WHO’s Country Health Profile on India, there are “ad hoc provisions for health care if any” in urban slums, which have grown due to the increase in urban migration (2).

#### **IV. Analysis of India**

India is taken as a case study because it is in much need of mental health services as a developing country. Although still far behind the developed world, India is one of the more progressive Asian nations in terms of its perspective on mental health and actions it has taken in mental health care. The history of mental health care in India has seen some dramatic changes, and the factors affecting Asia have been important determinants in shaping the state of its mental health care attitudes and services. M. Sarada Menon asserts that mental health professionals in the 15-year period following India’s independence had a major impact on how mental health services and policy are conceptualized today, although the current understanding of policies, programs, and services for the most effective mental health care throughout India is due to the evolution of knowledge, research, and experience of past mental health professionals, planners, and policy-makers over many years (30). India has experienced some progressive legislation and transitions in mental health care, yet there are still gaps between policy rhetoric regarding rights and access to care and the reality of a treatment gap between the need for and actual coverage of mental health services.

#### ***Policy Recommendations***

Recommendations for improving mental health care in India are based on India’s existing resources and take into account all factors that have shaped progression of mental health issues. The country’s demographics cannot be changed easily or quickly. Recommendations do

not try to eliminate issues such as poverty but instead take such conditions into consideration and maximize existing resources to improve services.

Investing in mental health care now will help prevent high economic, social, and treatment costs in the long-run that can result from continued inadequate mental health care. Untreated or inadequately treated mental illness detracts from national productivity and development. Mental health is gaining recognition for its importance to national development. According to Kumar, “it is undoubtedly a vital resource for a nation’s development and its absence represents a great burden to the economic, political and social functioning of the nation” (“Introduction”). Historically, it has been difficult to quantify the costs of mental illness because rather than being captured in death rate figures, mental illness induces significant economic and social costs, evidenced by lack of worker productivity and societal contribution (Desjarlais et al. 34). Economic costs due to impaired functioning and disability from mental illness affect human capital. 63.1 percent of the Indian population is between the ages of 15 and 64 (CIA, “People”). This age range constitutes the work force, and so the burden of mental illness affecting this population affects national productivity. Social costs including reduced social performance and contribution to society may have potential consequences for the mental, physical, and social well-being of family members, in addition to people with mental illness (Argandona and Kiev x). In general, mental illness is expected to increase in the next few decades since the number of people living to ages at risk for certain disorders is increasing, and this situation is projected for India (Desjarlais et al. 6; WHO, “Country Health” 15). Care for psychiatric disorders needs to be re-prioritized in India. D.S. Goel et al. affirm this by saying, “the enormous asymmetry between different domains of the mental healthcare delivery system and among various geographical regions illustrates the need for radical reordering of priorities” (13). As nations discover that mental illness affects not only individuals but also society at large, mental health care will assume a greater priority on the international agenda.

Mario Argandona and Ari Kiev say that traditional approaches of modern psychiatry are not uniformly appropriate for the developing world. In Western societies such as the United States, it is common to have a one-to-one doctor-patient model of care, but in developing countries where the number of patients highly surpasses the number of available psychiatrists, the traditional approach is ineffective and the developing world should use the public health model already in place, as it serves as an appropriate channel in which to incorporate psychiatric problems (x). Treatment would maximize the existing resources such as facilities and health care workers to ultimately treat more people in need, which will yield more preventative measures effective for reducing not only progression to chronic illness or undue suffering but also long-term costs to society (Argandona and Kiev xi). India attempted to improve treatment with the NMHP, but limitations in planning efforts rendered the program ineffective. Kumar says that “the absence of a central organization for mental health has been a serious constraint in post Independence planning in India” (“Need”). Planning is a key component of effective recommendations. A lack of mental health workers and misallocation of scarce resources limit adequate mental health care, but “fundamental flaws in perception and planning” are also significant deficiencies (Goel et al. 13). Planning and tailoring treatment approaches to local conditions responds to the cultural relativity that affects the perspective on mental health and illness.

Even though India has no mental health policy, it could still have more adequate mental health care. The United States has no unified mental health policy, and yet mental health care is much more developed (WHO, “Mental Health Atlas” 491). Some people might recommend that India establish a unified policy, but other recommendations that are smaller in scope and more fiscally, organizationally, and politically feasible would improve the state of mental health care. WHO argues that mental health policies are necessary because they guide programs and services aimed at preventing and treating mental disorders and promoting men-

tal health, without which such programs and services would be disorganized and ineffective (“Mental Health Policy Fact Sheet”). Having a policy is pragmatic, but it must take into account local conditions in India in order to be effective. This goes along with WHO’s idea that as a part of mental health policy and service development, programs help to afford basic treatment to people who suffer from mental disorders and even help to alleviate associated stigma and discrimination (“Mental Health Policy Fact Sheet”). The many disparities throughout and among India’s states would make implementing a national policy very difficult; therefore, programs at the community level are more appropriate.

India’s mental health system comprises mainly community care, with more curative services than in the past, as human rights receive more attention as well (Menon 30). Mental health care should be integrated further into communities, as community treatment is also a more cost-effective manner of care. Maintaining large, poorly staffed institutions with chronic patients produces a high cost to society (Argandona and Kiev x). Institutions are also quite ineffective, not only due to violations of human rights but poor care modeled after the European system. The mental health system inherited from the British was counterproductive to the traditional practice of mental health care which historically included community integration (Menon 31). Community care is most practical for India for various reasons. It is tailored to India’s historical tradition of mental health care, as it takes family and community structure into account, as well as cultural and religious values. Because the country is diverse, impoverished, and has large, remote rural populations, services would be more adequate since they would be more accessible and affordable to remote rural populations. Community mental health care is the most effective manner of care considering India’s economic, political, and demographic conditions.

Currently, mental health is incorporated into health care at the primary level, with primary care offering treatment services for severe mental disorders (WHO, “Mental Health Atlas” 233). S.P. Agarwal says that “India was perhaps the first country in the world, and certainly the first among developing countries to recognize the need to integrate mental health services with general health services at the primary care level” (v). This is evidence of India’s progressive nature. Care has involved and should involve more innovative mental health workers. Since there are a limited number of such workers in India, especially in rural areas, the role of mental health personnel can be taken over by various people. In addition to families, more innovative workers such as teachers and religious leaders are effective care providers. Faith healers in India have historically been involved in mental health care and continue to provide such treatment today, which shows the ineffectiveness of modeling care after the West where such a tradition vanished long ago, and such participative healers today are evidence of a “purely Indian approach to treating the mentally sick” (Khan 62). NGOs are also important resources, because they have been involved in care and should continue therapeutic work. One limitation with the community care model is distribution of medication. Although innovative mental health workers cannot prescribe medication, perhaps advocacy and education efforts can provide more medications at primary health care facilities. Increased availability and affordability of medication is quite feasible. India is home to a pharmaceutical industry large enough to guarantee the availability and low cost of most psychotropic drugs (WHO, “Mental Health Atlas” 233).

Increased training and education would improve service and policy development by increasing awareness and quality of services, reducing stigma and discrimination which are barriers to treatment, and improving human rights of people with mental illness. Qualified mental health professionals could train and educate people to become innovative mental health workers, who in turn may contribute to public education about mental illness and care. Education would increase awareness and aid in reducing stigma. Such workers could also help to educate and train other people to become innovative workers, which would reduce the demand

for qualified mental health professionals and increase the supply of workers with general mental health knowledge. Mental health teams comprised of innovative community workers should be formed for treatment in the case of disasters and emergencies which are quite common in India. A lack of education is one of India's demographic conditions, with uneducated rural poor at highest risk. Community workers and NGOs can help to educate the rural poor about mental health issues, which would ultimately improve services.

Research efforts should be expanded to increase evidence-based care. NGOs can assist with data collection for epidemiological research that will help improve future treatment. Epidemiological data is necessary for planning health services (Menon 31). Research is essential because it provides an assessment of needs and a basis for effective interventions, without which treatment could be ineffective or detrimental, as well as costly. Education and research would also help with proper use and allocation of medication.

## V. Conclusion: India and Mental Health in the Grand Scheme

India's economic status, diversity among states, and demographic conditions contribute to both the inadequacy and necessity of mental health care. Socioeconomic conditions exacerbate mental illness and subsequently the need for adequate care. Political factors such as a democratic government and previous legislation make it feasible to implement recommendations for improved mental health care. The recommendations are relatively low-cost, with no direct request for increased funds; they only maximize existing resources. In order to develop an effective mental health system, services and programs need to be sustainable. To achieve this, efforts should be concentrated locally and perhaps expanded to the national level in the future. In this way, the mental health care system is tailored uniquely to conditions characteristic of India.

Health is an essential marker of human development. Although it is becoming more common to view overall health as encompassing physical, social, and mental well-being, mental health care is not yet universally recognized. Mental health care should vary according to cultural context, but it should take priority on every country's agenda. The consequences of untreated mental illness are often unacknowledged or underestimated and, as a result, mental health has generally been neglected as a public priority. Discounting the value of mental health is highly unwarranted for it is an integral aspect of overall health. As mental health care gains importance in overall health care, people with mental disorders will be afforded better treatment. Unnecessary human suffering from untreated mental illness is a violation of human rights. The right to mental health is fundamental and universal, and all societies are under an obligation to provide it.

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