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Mental Health in Bihar: Are we listening?

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The Centre for Health Policy
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Abstract

The growing evidence on prevalence of mental disorders, high economic costs of mental morbidity and its relationship with other non-communicable diseases, has made mental health a matter of grave concern, around the globe. This public health risk has been identified by the Indian government which it hopes to tackle through its Mental Health Policy-Action Plan (2014) and Mental Healthcare Act (2017). In Bihar, the current mental healthcare services are inadequate to serve the current population size of 99.2 million. Human resource in the mental health sector is sparse and constitutes a major hurdle in the development of mental healthcare services in the state. Availability, access and utilization of psychotropic drugs is also limited, due to several barriers. Stigma and discrimination regarding mental health conditions is prevalent because of lack of mental health literacy among the general population. In this context, this paper aims to: offer a constructive critique of the existent mental healthcare framework in Bihar; argue that proper implementation of the 2017 Act in consonance with the District Mental Health Programme, will to some extent, address the prevalent treatment gap experienced by mentally-ill persons; and explore probable interventions for the development of a public health oriented Mental Healthcare system in the State.

Introduction

It is estimated that the global burden of mental illness accounts for 32.4% of years lived with disability (YLDs) and 13% of disability-adjusted life-years (DALYs).[1] The global community has responded to this phenomenon by recognizing mental health as a key global priority. To this end, the Sustainable Development Goals, 2030 Agenda has emphasized on the need to prioritize mental health and disability and has set goals to promote mental health and well-being.[2] This endeavor is complemented by UN Resolutions that have included references to mental health and the World Health Organizations (WHO) Mental Health Action Plan 2013-2020, to guide global, regional and national strategies.[3] New to this position is the significance granted to the inclusion of a human rights perspective into policies and services related to mental health.[4] In this

respect, International Human Rights Law offers a 'unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of different stakeholders'.[5] The first National Mental Health Policy of India, launched in 2014 highlighted the need for a participatory and a rights based approach to Mental Health with the enactment of the Mental Healthcare Act, 2017 (hereinafter 2017 Act) a human rights perspective has been incorporated within the national mental health framework.

The 2017 Act marks a paradigm shift in the approach towards mental illness, where persons with mental illness are required to be treated as 'subjects' with rights, as opposed to 'objects' of charity, medical treatment and social protection. This statute was preceded by the Mental Health Act, 1987 (hereinafter 1987 Act) which dealt with diluted provisions on self-determination and informed consent of mentally ill persons. Under the 1987 Act, relatives and medical officers could move the court for detention and treatment of a mentally ill person in 'involuntary' circumstances.[6] Police officers were empowered to take action in respect of the mentally ill and detain them if necessary, without the opinion of any medical professional. It did not adequately protect the rights of persons with mental illness and even the basic tenants of human rights of the mentally ill in respect of availability, accessibility, acceptability and quality of mental healthcare were absent.

The current law defines mental illness in broad terms, as 'a substantial disorder of thinking, mood, perception, orientation or memory, that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with alcohol and drugs, but does not include mental retardation, which is…..'. This is in consonance with the WHO's conceptualization of mental health defined as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is a contribution to his or her community'.[7] Mental health or psychological well-being forms an integral part of an individual's capacity to lead a fulfilling life which if compromised in anyway, adversely affects this capacity. It leads to diminished functioning at the individual level, reduced rates of labor participation and increased health and other welfare expenditure, resulting in broader welfare losses at the household and societal level.[8] Data from the WHO's Mental Health Atlas (2014) survey suggests that most low-income and middle-income countries spend less than US$2 per year per person on the treatment and prevention of mental disorders which leaves a substantial gap between the need for treatment and availability.[9] Global evidence indicates the enormous economic challenges posed due to this increasing gap.[10,11,12,13] Nonetheless, allocation of funds to the National Mental Health Programme under Government of India's Union budget has declined from Rs.35.42 (in crores) in 2014-2015 to Rs.35.00 (in crores) in 2015-2016 and 2017-2018.

The Mental Health Survey (2015-2016) led by the National Institute of Mental Health and Neurosciences (NIMHANS) estimates the prevalence of any mental morbidity in the country at 13.7% lifetime and 10.6% current, with nearly 150 million Indians in need of active intervention.[14] The evidence indicates that common mental disorders (CMD) including depression, anxiety disorders and substance use disorders are a huge burden, affecting nearly 10% of the population. Since CMD's are closely linked as precursor risks and outcomes of several non-communicable diseases, it contributes significantly to the increased health burden. The survey identified high prevalence of substance use disorders and high suicidal risk as areas of concern across the country with variance in prevalence at the regional and state levels.[15] In India, males within the age-group of 30-49 where found to be the most affected age cohort by any mental disorder but Depressive disorders and Neurosis and Stress related disorders where found to disproportionately affect the female gender.[16]

Bihar is the third most populous state in India. Located in the eastern region, it harbors negligent mental health provisions. Lack of awareness coupled with stigma pertaining to mental illness have led to a dismal condition of mental healthcare in the state. The territory with a rural population of 88.7% is prone to natural disasters such as floods and is currently marked by high poverty rate; food insecurity; sanitation deficiencies; shortage of accessible good quality health services; low educational attainment; high unmet need for family planning; greater exposure to violence particularly intimate partner violence; poor nutritional status of children (high prevalence of stunting and wasting); and child maltreatment. These are all known risk factors for mental disorders.[17] According to WHO, best evidence indicates that the relation between mental morbidity and poverty is cyclical, where poverty increases the risk of mental disorders and having mental illness can increase the likelihood of descending into poverty.[18] Evidence also indicates that the highest prevalence of mental disorders can be found among people with the lowest levels of education or for people who are unemployed.[19] In this context, a substantial portion of Bihar's total population is adolescents' and youth, that forms a critical segment of future demographic, social, economic and political development in the state. Addressing mental healthcare needs of this target population is crucial, especially, since they are vulnerable to factors such as unemployment, stressful living conditions, lack of financial resources for a basic standard of living and exposure to violence.

Against this background, the paper begins with an insight into the vulnerable populations who are posed with a higher risk of mental illness as well as the vulnerable status of persons with mental illness, in order to better understand the various determinants of mental health and the way they interact with other individual, household and environmental factors. This perspective forms an intrinsic part of the human rights-based approach to mental health. It is accompanied by a legal analysis of the international human

rights framework as applicable within the territory of India; examination of the understanding on 'health' incorporated in the Indian Constitution; and an appraisal of the present-day Mental Healthcare Act (2017). This exercise clarifies the present legal obligations on the state of Bihar and offers a legal framework for development of mental health strategies by the state. To discern the position of mental healthcare in Bihar, this paper scrutinizes the financial outlay of the State health budget and other provisions of the National Mental Health Programme while assessing its implementation status in the state. The paper concludes with recommendations on potential focus areas for the state government to counter the mental health concerns raised in the narrative.

Discussion

People with mental health conditions including severe mental disorders such as schizophrenia, bipolar disorder; common mental disorders such as depression, anxiety; and intellectual impairments or neurological development disorders, constitute a vulnerable group in themselves. From another perspective, certain vulnerable groups including people living in poverty, trafficked children and adults, commercial sex workers, homeless persons, and individuals with HIV/AIDS have been known to have high prevalence of mental illness.[20] Additionally, persons inside custodial institutions, orphaned persons with mental illness (OPMI), children of persons with mental health problems, elderly care-givers, internally displaced persons, persons affected by disasters and emergencies and other marginalized populations with their special conditions and needs, bear a disproportionate and higher burden of mental health problems.[21]

Vulnerable persons or groups share common challenges in the form of societal and economic conditions, and environmental factors. These challenges include but are not limited to: stigma and discrimination; violence and abuse; restrictions in exercising civil and political rights; exclusion from participating fully in society; reduced access to health, social and emergency relief services; lack of educational opportunities; exclusion from income generation and employment opportunities; and increased disability and premature death.[22] Stigma and discrimination generally stems from misconceptions around the nature and cause of mental illness, the consequences of which are substantial. For example, attribution of mental illness to possession by evil spirits or punishment for immoral behaviour lead to harmful treatment practices.[23]

Besides social, economic and environmental factors, individual characteristics such as genealogy and social intelligence also act as determinants of mental health. These factors which interact at different levels, can be a precursor risk(s), or the consequence of some mental health conditions. Over time, the interaction of these factors can lead to further

marginalization, diminished resources and even greater vulnerability.[24] Another crucial way in which risks to mental health interact is over age and time, as risks to psychological well-being can manifest during different life stages, being: pre-conception and pre-natal period, infancy and early childhood, childhood, adolescence, adulthood and older age. It has been well established that malnutrition, low birth-weight and certain micro-nutrient deficiencies significantly heighten the risk to brain development, as does separation of an infant from the primary care-giver.[25] Exposure to violence, negative live events and adverse socio-economic conditions during childhood and adolescence can cause a level of trauma that has immediate and long-term consequences for mental well-being of an individual. Similarly, tobacco/alcohol/drug abuse is a risk known to typically occur during adolescence with long-term outcomes into adulthood. Old age is the single most important predictor for cognitive decline and dementia. Social and family isolation are significant predictors of depression in old age.[26] In addition, there are risks that affect an individual, irrespective of their age, such as gender-based discrimination, natural disasters or a medical epidemic.

The human rights ecosystem gives due recognition to the various factors operating at different levels to influence an individual's mental health, thereby, necessitating public health response across these different levels and social groups- through actions that promote and protect mental health, and efforts that aim to restore or improve mental health conditions. Integrating other sectors such as education, employment, housing and social welfare with public health, provides a broad framework that may enhance mental health and even prevent the onset of mental illness.[27]

International Human Rights Law and Right to Health in India

Human Right are rights inherent to all human beings, irrespective of one's nationality, place of residence, sex, gender, national or ethnic origin, religion, caste, color, language or any other status. These rights are inalienable, interrelated, interdependent and indivisible; are non-discriminatory and apply equally to all individuals or groups; and entails both rights (for individuals) and obligations (for state). International human rights law is a branch of international law that guarantees these universal human rights in the form of treaties, customary international law, general principles and other sources of international law. The principle of universality and non-discrimination as encapsulated in the Universal Declaration of Human Rights, 1948 (UDHR) and thereafter reiterated in many conventions, including the International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social and Cultural Rights (ICESR), stipulates a duty on part of the States to promote and protect all human rights and fundamental freedoms within their jurisdiction. The exercise of human rights and the enjoyment of

health share a synergistic relationship.[28] This implies, that while a certain level of physical and mental health is required to exercise human rights and fundamental freedoms, at the same time the protection of these rights is essential to realize genuine physical and mental well-being. The failure to enforce or violation of these rights can adversely affect the physical, mental and social well-being of all people.

The WHOs principle 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition', as formulated for the first time in WHOs Constitution in 1946, finds its place in International Human Rights Law. UDHR, the first comprehensive international statement of human rights principles, includes health as part of the right to adequate living standard.[29] ICESCR explicitly protects the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[30] Convention on the Rights of Child (CRC) requires states to ensure that no child is deprived of his/her right to access health care services.[31] Parties to this Convention are entrusted with the function of promotion of social, spiritual and moral well-being, and physical and mental health of children through IEC (Information, Education and Communication) activities. Article 19 stipulates the duty of States to protect children from all forms of physical, sexual and mental violence, and identify, investigate and follow up instances of child maltreatment with judicial involvement, wherever necessary. In relation to rights of women, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obligates states to eliminate discrimination against women in the field of healthcare.[32]

Article 25 of the Convention on the Rights of Persons with Disability (CRPD) lays down the right to highest attainable standard of health without discrimination for persons with disability. It includes persons with long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.[33] CRPD recognizes the profound social disadvantage faced by all persons with disabilities and multiple discrimination faced by women and children with disabilities which may include mental health conditions. It seeks to redress the imbalance through protection of their civil, political, economic, social and cultural rights. In this context, epidemiological evidence shows that persons with common mental disorders and severe mental disorders suffer from disability in different spheres of their lives. It is further submitted that the international and domestic legal provisions include mental illness within the disability framework.

India has signed and ratified ICCPR, ICESCR, CRC, CEDAW and CRPD which makes these provisions legally binding on the country. However, India has not signed and ratified the Optional Protocols accompanying the aforementioned treaties which contains the enforcement/compliance measures in the form of individual complaints procedure.

Consequently, the Committees designated to monitor and evaluate the implementation of these treaties have no jurisdiction to receive communication and enquire violations of the treaty provisions. Along-with these treaties based bodies, charter based bodies such as the Human Rights Council (HRC) and Special Procedures constitute the International Human Rights framework. HRC is an inter-governmental body comprised of 47 elected UN member states empowered to receive and examine complaints of human rights violations from individuals, groups and non-governmental organizations that claim to be victims of human rights violation. Special Procedures is another mechanism under the HRC to deal with thematic issues such as 'right to highest and attainable standard of physical and mental health' or country specific issues. They report to the HRC and many times to the General Assembly with their findings and recommendations for states. Additionally, the Office of the High Commissioner for Human Rights supports the HRC and Special Procedures in its work.

At the national level the National Human Rights Commission (NHRC), constituted under the Protection of Human Rights Act, 1993 (hereinafter 1993 Act) has the power to inquire *suo moto* or on a petition, the violation of human rights and any negligence in the prevention of such a violation.[34,35] The 1993 Act defines 'human rights' as the rights relating to life, liberty, equality, and dignity of the individual guaranteed by the Constitution or embodied in international covenants and enforceable by courts in India.[36] Upon discovery of such violation or negligence, NHRC is empowered to take several actions including initiation of proceedings for prosecution.[37] The 1993 Act also provides for the constitution of State Human Rights Commissions (SHRC) at the state level with similar powers as the NHRC, to intervene, investigate, grant compensation and bring to prosecution, violations of human rights within the State.[38]

'Health' under the Indian Constitution and other national legislations

To make right to life under article 21 of the Indian Constitution meaningful and effective, the Apex Court has developed an expansive interpretation to include a plethora of rights essential for a dignified human existence,[39] including the right to get adequate and good healthcare.[40] The right to medical treatment is a basic human right and the obligation is on the state to guarantee that the health of its citizens is not adversely affected.[41] Recently, in the case of Independent Thought vs. U.O.I & Others, the Supreme Court of India highlighted the consistent holdings of the court in respect of right to life and liberty to mean a right to live with human dignity.[42] The Apex court further declared that 'good health is the raison d'etre of a good life' and that good health includes both, physical and mental health.[43]

Directive Principles of State Policy contained under Part IV of the Indian Constitution contains many tacit references to development of health of individuals. These principles are not justiciable but are often cited by the courts and provide a direction to the State for policy formulation. Article 39 underlines the role of health of workers, men, women and children in policy formulation. The duty of the state to raise the level of nutrition, standard of living and to improve public health has been articulated under article 47. The protection of right to education, work and public assistance to sick, disabled and old-age persons has also been laid down as the duty of the state.[44]

Special legislations such as the Protection of Women from Domestic Violence Act, the Protection of Children from Sexual Offences Act (2012), the Juvenile Justice (Care and Protection of Children Act (2015) refer to health and specifically mental health in some provisions. The Protection of Women from Domestic Violence Act (2005), defines domestic violence to include physical harms and harms of a psychological nature and requires the court to acknowledge the mental torture and emotional distress caused to the victim while formulating compensation orders.[45] The Protection of Children from Sexual Offences Act (2012) gives due recognition to the special needs of persons with mental health conditions by stipulating the requirement of a 'special educator or any person familiar with the manner of communication of the child or an expert in the field, having such qualifications and experience to record the statement of the child', as opposed to police officials.[46] The Juvenile Justice Act requires special homes and foster families to provide for mental health interventions including counselling as required by the child.[47] Further, children in conflict with the law with mental health conditions are required to be sent to psychiatric care facilities for their specialized needs.[48]

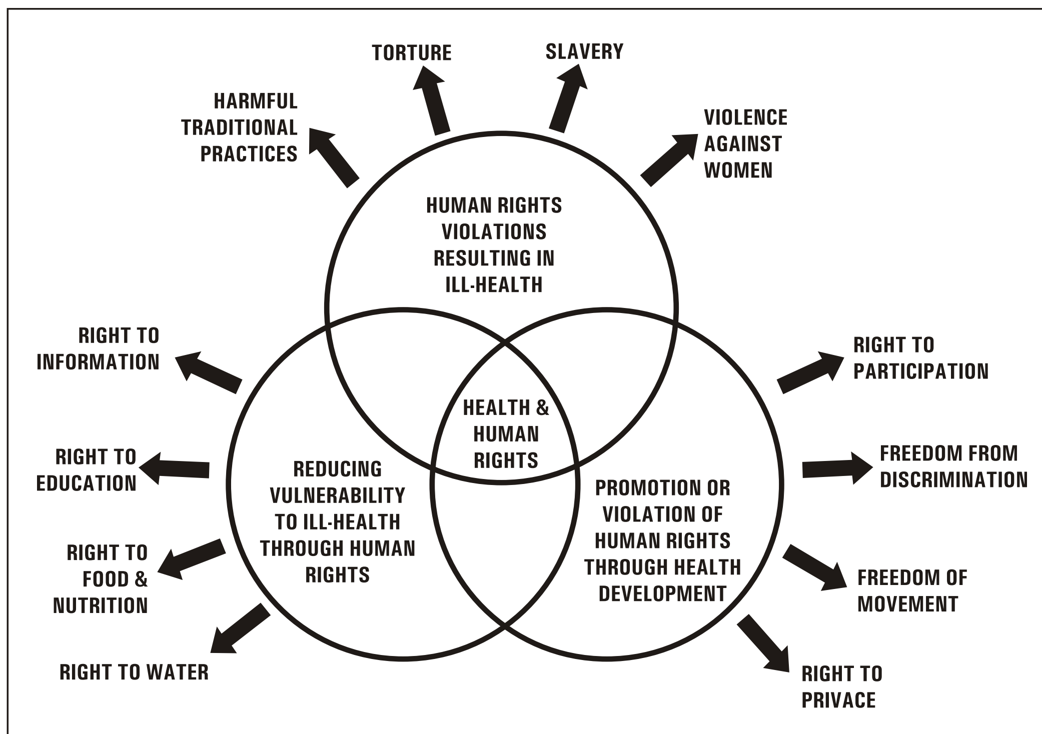
The Mental Healthcare Act (2017)

This Act adopts right to live with dignity, non-discrimination, community living and community healthcare as cross-cutting principles. Attempt to suicide has been de-criminalized through section 115 which provides for presumption of severe stress in respect of persons who attempt suicide and obligates the state to provide care, treatment and rehabilitation to the person as opposed to prosecution under the Indian Penal Code. For the first time, it assigns a mentally ill person the right to make an 'Advance Directive' in writing, to specify the way the person wishes to be cared and treated for, as well as care and treatment the person is opposed to.[49] However, the individual has to be above the age of eighteen years and should have the capacity to make mental healthcare and treatment decisions.[50] Electroconvulsive therapy has been listed as a prohibited procedure for treatment of mental illness, except in situations of emergency and only with the use of muscle relaxants and anesthesia.[51] The informed consent of the guardian and prior

permission of the Board is required for minors. Practices such as sterilization of men and women as part of mental illness treatment, subjection to seclusion, solitary confinement and use of chains have also been prohibited under the Act.[52]

This statute obligates State governments' to constitute a State Mental Health Authority (SMHA) within nine months of its enactment on (April 7th, 2017) comprising of officials from the Department of Health of the State government, psychiatrist, mental health professional, psychiatric social worker, clinical psychologist, mental health nurse, care-givers and family members of persons suffering from any mental illness.[53] The Chief Executive officer is designated as the legal representative of the SMHA and is responsible for the day to day administration and implementation of work programs and decisions adopted by SMHA. The function of SMHA includes registration of all mental health establishments in the State; development of quality and service provision norms for these establishments; registration and publication of the list of clinical psychologists, mental health nurses and psychiatric social workers to work as mental health professionals; and train law enforcement officials, mental health professionals and other health professionals in the implementation of this Act.[54]

Figure 1: Relationship between Health and Human rights.



It lays down a chapter of rights of the mentally ill with wide-ranging protections such as right to access mental healthcare, right to protection from cruel, inhumane and degrading treatment, right to equality and non-discrimination, right to community living, right to

confidentiality, right to information, right to legal aid and right to make complaints about deficiencies in provision of services. Right to access mental healthcare has been defined as mental health services of affordable costs, of good quality, available in sufficient quality, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers.[55] For persons below poverty line mental healthcare has to be provided free of cost at public health institutions. The right to make complaints where deficient services are available, provides a mechanism to mentally ill persons to exercise their right to access mental healthcare.

Numerous studies have established that mental illness related stigma within the community and the healthcare system, is a major barrier to access treatment and recovery, as well as poorer physical care for persons with mental illnesses.[56] Similarly, global evidence indicates the negative outcomes of division and prioritization of physical healthcare over mental healthcare.[57] To counter these barriers, the right to equality of persons with mental illness specifically in relation to persons with physical illness, finds place in the list of rights of the mentally ill.[58] Promotion of mental healthcare in turn, positively influences physical health outcomes. Promotion of mental health and preventive programmes; creating awareness about mental health and illness and reducing stigma associated with mental illness; human resource development and training for mental healthcare services; and coordination within the government, are the duties prescribed under the Act for the appropriate government.[59] These duties exist in addition to the aforementioned rights available against the state/government. It directly addresses the prevailing barriers of limited mental healthcare (public and private), especially paucity of specialist mental health human resources and lack of mental health literacy which contributes substantially to the current treatment gap in the country.[60] The existent mental health workforce (psychiatrist, clinical psychologist, psychiatric social worker and psychiatric nurses) in the public health system are mostly present in urban areas.[61] On the other hand, empirical evidence estimates mental health awareness in India to be minimal. For example, in a study conducted on mental health literacy among Hindu adolescents in Tamil Nadu, depression was identified by 29.04% and schizophrenia/psychosis was recognized by 1.31%.[62]India has witnessed some initiatives to increase mental health awareness in some states, however the efforts need to be revamped and expanded to efficaciously realizing the Human Rights of persons with mental illness. This Act requires it to be addressed by the government on a priority basis as it constitutes an essential roadblock in prevention and treatment of mental health conditions.

National Programmes in Mental Healthcare

In order to ensure availability and accessibility to minimum mental healthcare for all, to encourage dissemination of information and knowledge regarding mental health and to promote community participation in mental health service development, the National Mental Health Programme (NMHP) was launched by the Government of India in 1982. In 1996, the District Mental Health Programme (DMHP) was initiated as part of NMHP to expand mental healthcare services to the district level with the objective to provide Community Mental Health Services and integration of Mental health with Primary Health services. Over time, this program has been re-strategized by the Indian government. It seeks to address the need for human resource development in the field of mental health; provision of services for early detection and treatment at the community level; creating awareness and curbing stigma related to mental health problems; and enhancing research in mental health. The district level activities under DMHP are conducted by the DMHP team, consisting of psychiatrist, clinical psychologist, psychiatric nurse, psychiatric social worker and administrative personnel, stationed at the District Hospital. The implementation efforts of the DMHP team of eight members is complemented by a medical officer and a clinical psychologist/psychiatric social worker at the Community Health Centre (CHC) level and two community health workers at the Primary Health Centre level.

For the 12th Five Year Plan period NMHP has been brought under the umbrella of National Health Mission and financing has been approved from National Rural Health Mission-Non-communicable diseases flexi-pool from the year 2013-14.[63] For this Five Year Plan period Rs.1576.54 (in crores) was earmarked for activities under DMHP and Rs.753 (in crores) for tertiary/central level activities.[64] It sought to enhance tertiary care mental health facilities through availability of specialized human resources and upgradation of two central Mental Health Institutes. At the district level, financial support has been provided under DMHP for activities such as engagement of human resource, training, IEC, drugs, equipments, ambulance service and rehabilitation services. Outpatient services and inpatient treatment services, along with availability of all the essential psychotropic drugs, at the district hospitals, CHCs and PHCs and Sub-centres is also supported by DMHP. Furthermore, the psychiatrist at the district hospital along with one nurse is required to conduct outreach services at the CHC's at regular intervals. There is provision for Public-Private-Partnership with NGOs in areas such as Day-care, Residential/Long-term Residential Continuing Care centers and Innovative Mental Health services. Training of resource persons is not limited to the DMHP team, but extends to community health workers, para-medical officers and NGO members. Additionally, training of school teachers who can transfer information and skills around mental health to

children/adolescents as well as identify mental health needs of the children, is an important component of a comprehensive approach to mental healthcare under DMHP. Teachers at colleges are also required to undergo training as counsellors in order to provide referral and support to students any mental health condition/needs.

Status of Mental Healthcare in Bihar

Empirical evidence on mental disorder prevalence, predictors of mental illness and other quantitative and qualitative data on mental healthcare in Bihar, is scarce. As per Census (2011) data 37521 and 89251 persons were recorded to be suffering from mental illness and mental retardation, respectively.[65] An estimate of Bihar's mental illness burden can be drawn from the national estimates of mental morbidity according to the National Mental Health Survey. But, at the State level, UDAYA (2015-16) an adolescent survey conducted by Population Council provides evidence on mental morbidity caused due to depression and suicidality. According to it, 5% of younger girls (10-14), 14% of unmarried older girls (15-19), 17% of married older girls and 9% of older boys had signs of depression. Out of the total respondents with signs of depression, 55.2% of unmarried girls (15-19) years and 52% of married girls (15-19) did not reveal the reason for depression. This reflects a significant mental illness burden among adolescents in the state. Another study on prevalence of depression among school going adolescents in Bihar found depression to be statistically significantly associated with gender and religion, where it was found to be higher among females as well as students belonging to religious minorities.[66]

Persons rendered homeless due to poverty and natural disasters (floods); runaway children and adolescents; girls and women who are economically and socially deprived; older persons and persons with disability; and persons in custodial institutions, require special protection, care and medical services (including mental healthcare). Currently, this is not addressed adequately by the state. Status Report (2015) on Prisons in Bihar conducted by the Bihar State Legal Services Authority highlights the state's predicament where 476 persons claiming to be juveniles were found to be placed in jails instead of remand homes, due to severe shortage of these homes.[67] Moreover, in this study, 487 inmates were found to be of old age (visibly infirm) and 104 prisoners were found to be in need of medical attention for mental illness. Lack of mental healthcare services available in prisons and the need for mental health interventions and services is also accentuated by this report. The Supreme Court Commissioner's office's report (2014) on status of shelters in urban areas, reveals the despicable plight of homeless persons in Bihar with a complete absence of long-stay shelters and only a few night shelters, that too possessing bare minimum infrastructure and facilities and no medical services. Further high incidence of intimate partner violence,[68] child abuse[69](mental, physical and sexual) and child

marriages[70] have been consistently reported in the state which is worrisome from the perspective that these factors constitute risk factors for mental health conditions.

Over the years, due to political neglect, inaccessible funding and improper implementation of NMHP/DMHP across State's, the Supreme Court of India has intervened time and again through Writ Petitions and Public Interest Litigation (PILs), to ensure that the provisions of Article 21 of the Constitution are meaningfully made available to mentally ill persons. In the case of Dr. Upendra Baxi v. State of Uttar Pradesh and Others[71] the Supreme Court appointed the National Human Rights Commission (NHRC) to monitor the mental health system vis-à-vis the implementation of NMHP/DMHP in the State's.[72] The NHRC constituted the Technical Committee on Mental Health (TCMH) to 'appraise the Supreme Court regarding the deficiencies prevailing in the sphere of mental healthcare in the country with the objective to seek suitable directions for the concerned State Governments for taking suitable remedial action'.[73]The Report of the TCMH (2016) provides insight into the Mental Healthcare activities in the state of Bihar. According to this report the State Mental Health Authority has been constituted in Bihar, but the State Mental Health plan and rules have not been drafted. The summary of specialized human resources for mental healthcare portrays a distressing picture with availability of merely 28 psychiatrists, 2 clinical psychologists and 2 psychiatric social workers with the public health institutions and 3 psychiatrists in private health institutions for a population of 99.2 million in the state. The State Institute of Mental Health & Allied sciences, Bhojpur (BIMHANS) is the only exclusive mental health institution in Bihar where access and availability of psychotropic drugs has been ensured but it still lacks appropriate infrastructure for OPD services. Out of the 10 government medical colleges in the state, only 7 have a department of psychiatry, followed by 3 private medical colleges. A total of 3 seats for post-graduation in psychiatry is available in all these institutions combined. None of the district hospitals have a psychiatry department and do not even offer mental health services.

DMHP is active in eleven districts of Banka, Buxar, East Champaran, West Champaran, Gopalganj, Jamui, Kaimur, Muzaffarpur, Purnea, Rohtas and Vaishali.A nodal officer for Mental Health has been identified and his progress report indicates the constitution of DMHP team in these districts with eight sanctioned posts (psychiatrist, clinical psychologist, psychiatric social worker, psychiatric nurse, community nurse/case manager, monitoring & evaluation officer, case registry assistant and ward attendant orderly).[74] However, DMHP Human resource status report (2017) provided by the nodal officer, reveals thirty-six vacant posts out of the eighty-eight sanctioned posts, where scarcity of psychiatrist, followed by psychiatric social worker and psychiatric nurse is pronounced.[75]To address this human resource gap, training of twenty-one general medical officers was undertaken by the state government in collaboration with NIMHANS and

these officials are currently operative at the various DMHP centers. According to nodal officer's progress report, OPD services, day care activities and availability of psychotropic drugs has been ensured at DMHP centers and IEC/mental health awareness activities are being implemented at the community level by the DMHP teams.

The Essential Drug List for Bihar includes certain psychotropic medication; however, availability, distance and cost remain the main barriers to access and utilization of psychotropic medicines in Bihar.[76] The cycle between lack of demand for treatment for mental illness at the PHC and district level by doctors and patients, also constitutes a critical barrier to access and use.[77] Research further indicates that within the private sector, including NGOs, the evident distance and cost constraints can lead to non-adherence to treatment, thereby reducing the effectiveness of such treatment. Further, care and rehabilitation facilities are severely lacking in the state, with only one NGO run residential/long-stay rehabilitation facility. Other custodial institutions in the state include, a few shelter homes, observation homes, special homes and children homes out of which three are state-owned facilities and the rest are operated by NGOs.[78] Counsellors trained in mental healthcare are not available in all these institutions, and there is minimum provision of mental healthcare service delivery in a few homes.

Conclusion

Mental health comes across as a low priority for the State. This becomes evident from the lack of governance/state action in this sector. Mental health does not feature on the health budget of government of Bihar, other than the revenue allocation under centrally sponsored scheme of NMHP-DMHP, which has a limited reach in only eleven districts of the state. A few unilateral schemes under the Department of Social Welfare provide aid, including mental healthcare to persons who are socially and economically deprived, older persons and persons with disabilities which are executed through the State Society for Ultra Poor and Social Welfare (SSUPSW). This is not adequate to cater to the current population of beggars, persons with disabilities and persons dealing with extreme poverty, in both urban and rural areas. Large number of homeless persons and persons affected by natural disasters such as floods, have high support needs and they encounter various risk factors of mental illness, requiring particular attention of the government. The mental health issues of juvenile in conflict with law and juvenile in need of care needs to be tackled with utmost precaution and care, and their rights should be respected and enforced. Further, if mental illness remains untreated it results in disability, loss of productivity, economic depravity, stigma, marginalization and discrimination; often exacerbating the problem by adversely affecting the individual, associated persons and the society at large. The obligation of the state in light of the rights of the mentally ill and the

duties owed as a welfare state under the Constitution of India, the Mental Healthcare Act (2017) and other social welfare legislations, as well as international obligations under International Human Rights law, becomes pertinent in this regard.

The available global, national and state level evidence on prevalence of mental disorders suggests, that in Bihar persons belonging to different age-groups and genders, especially the vulnerable populations maybe at risk of/suffer from mental disorder conditions. The up to date inspection and analysis by the National Human Rights Commission, suggests that the existing mental healthcare system is not equipped to effectively address the mental health needs of the people. Minimal public mental healthcare provisions in the state, maybe indicative of existent private mental healthcare sector or alternative forms of medical care and cultural practices being used to treat current mental illness burden.[79] Private mental healthcare system has not been mapped in the state and limited data is available in respect of alternate forms of medicine for treating mental illness in Bihar, which makes it difficult to point to any one factor with certainty. DMHP is the only scheme operational exclusively for mental healthcare but its reach is restricted and it lacks proper implementation. The state mechanism for monitoring and evaluation of DMHP implementation and the mental healthcare provisions in public and private institutions in general, is mostly non-existent. Inadequacy of infrastructure, human resource, finances, service delivery and drugs in the mental healthcare system in Bihar, has been consistently highlighted by various stakeholders, including the judiciary, NGOs and statutory bodies. The enormity of the problem suggests the need for a comprehensive course of action, which is holistic, prudent, integrated, equitable and inclusive.

Proposed Areas of Focus

A. Policy, Legislation & Programmes

State policy and an action plan illustrates how a state hopes to address mental health issues and it is imperative for development and guidance of the overall mental health system towards prevention, treatment and rehabilitation for mental illness. National Mental Health Policy (2014) & National Mental Health Action Plan 365 together, allows stakeholders to initiate action across various mental health issues in order to develop a comprehensive mental health response at the national level. However, since Bihar does not have a state policy or action plan for mental health, the state's position on this issue remains ambiguous. Rectification of the apparent gap in mental health policy making, is prerequisite to determining a compendious response to mental health issues in Bihar. In this context, mental health policy with a wider preventive focus would help alleviate current and future mental illness burden. To this end, evidence drawn from quantitative and qualitative data will allow the state to

formulate effective policy involving the various stakeholders in the system. For, informed policy making, the State should conduct surveys to map the available public and private health infrastructure, human resources and finances. The prevalence of mental disorders, predictors of these disorders and patterns of medical treatment available, needs to be investigated, in order to assess the problems that will shape the mental health response of the state through policy formulation.

The efficacious implementation of the National Mental Healthcare Act (2017) will complement the guiding policy by providing a legal framework for operation of mental health authorities and regulation of mental health institutions in Bihar. In addition, the justiciable rights for persons with mental illness under Chapter V, would enable accountability in respect of discharge of state obligations to ensure socio-economic inclusion of persons with mental illness, through accessible, affordable and quality mental healthcare. Paucity of programmes and schemes for mental healthcare as highlighted by this paper, can be addressed once the vision of the state is finalized and the goals and objectives are set through state policy. Meanwhile, successful implementation and expansion of the District Mental Health Programme to other districts will assist in reduction of the existing mental illness burden of the state.

B. Human Rights framework

The human rights-based approach secures inclusion of the perspectives of social and economic determinants in the mental health understanding of the state and provides a mechanism for evaluation of the success and clarifies the accountability of the various stakeholders involved. The national human rights framework protects fundamental freedoms as guaranteed by the Constitution, national and state legislations and International Human Rights Law and enforceable by courts in India'. In case of violation of rights available under the Mental Healthcare Act (2017), application can be made to the Mental Health Review Board, with provision of further appeal to the State High Court. The national human rights framework taken in consonance with enforcement mechanism under the 2017 Act should protect the rights of persons with mental illness, provided there is allocation of sufficient funds for proper implementation and implementation of these laws is effectively done on the ground by the different stakeholders.

The National Human Rights Commission has taken up the responsibility of monitoring and evaluating the mental health system in the country, including the state of Bihar. The State Human Rights Commission with its powers to *suo moto* take cognizance and investigate matters of human rights violations, needs to participate actively to ensure a check on the mental health institutions, in the state. With findings

of violation of rights of persons with mental illness, the SHRC can recommend the government to take action, or file for prosecution in the court of law, by itself. The legal framework needs to be strengthened through enforcement of existing legal provisions, as well as active and consistent, engagement or intervention by the different key players.

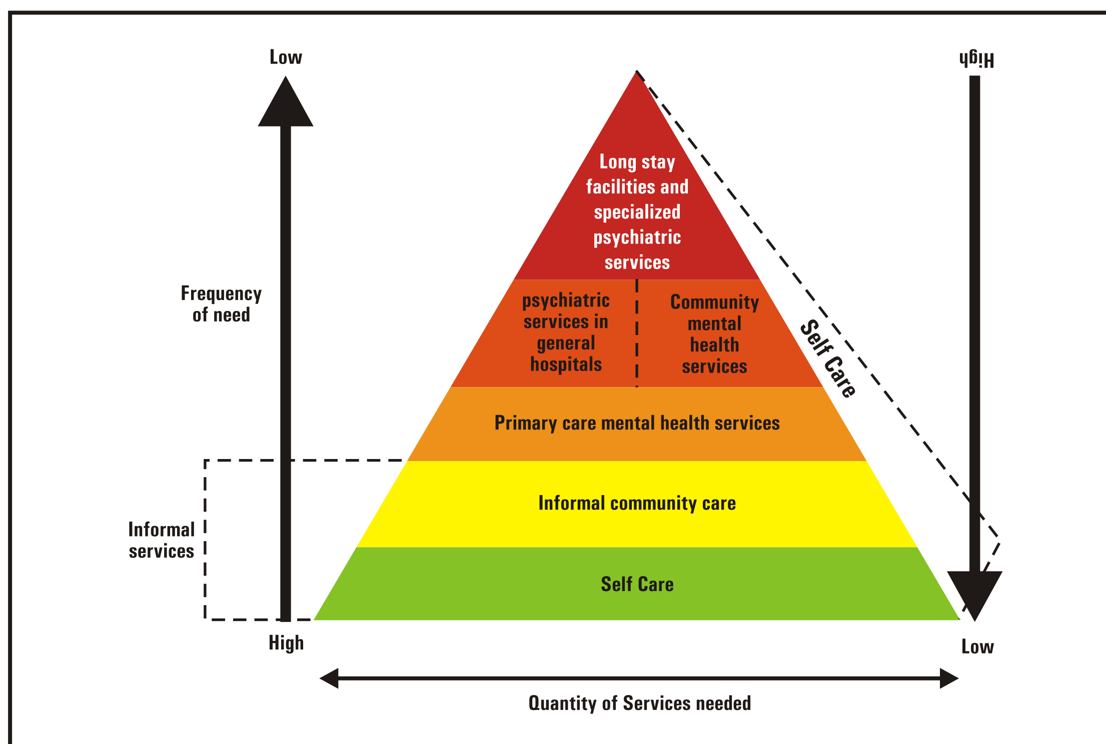
C. Mental Health service delivery

Limited mental health services are available at the few DMHP centers that are functional in the state. Present state of affairs, reflects the lack of framework for an effective service delivery system resulting in paucity of services. In this connection, the WHOs optimal mix of mental health services model which combines some best practices in this sector, can be explored. These provisions can also be found in the Mental Health Policy (2014) and National Mental Health Programme- District Health Programme. The WHO model seeks to limit mental hospitals, build community mental health services, integrate mental healthcare into primary healthcare, build informal community mental health services and promote self-care.[80] Mental hospitals involve high costs, poor clinical outcomes and are often associated with human rights violations. Development of mental health services within general hospitals i.e. district hospitals and hospitals within medical institutions in Bihar, will address this and provide optimal care for co-morbid conditions as well. Emphasis is laid on integration of mental health services into primary healthcare because, it enhances physical accessibility for mentally ill; provides an integrated treatment approach by combining physical and mental health; and serves to de-stigmatize availing of mental health services by including it within the general healthcare framework. The WHO model further advocates development of informal community mental health services to complement the formal system of mental healthcare in the state aimed to strengthen the protection against human right violations of persons with mental illness. Finally, promotion and advancement of mentally ill persons autonomy and ability to care for themselves is a cross-cutting principle across this model.

The state of Kerala in southern India, known across the world for its model of development, has been successful in integrating mental health services into primary care in various districts. The state is a pioneer of community-based rehabilitation for mental illness in the country. Its innovations include, home based care for homeless mentally ill and ASHA bhawans. Kerala has made considerable progress in implementation of DMHP in 14 districts and plans to expand to all the districts in the state. Best practices from Kerala, if successfully implemented in Bihar, can cause a monumental change in the discourse around mental health for the betterment of

mental healthcare in the state. But, the proposed ideas and best practices need to be contextualized according to Bihar's demographic profile and peculiar characteristics, before being incorporated to develop a service delivery model for the state. This exercise can positively influence the treatment gap, by ensuring availability and accessibility of psycho tropic drugs, in-patient and out-patient facilities, counselling and IEC activities across the state.

Figure 1: WHO pyramid for optimal mix of mental health services.



D. Human Resource

An effective mental health workforce constitutes a crucial component for the establishment of an efficient public health system that can cater to the mental health needs of the community. To deal with the barrier of lack of specialized mental health human resource, the government should institute a framework for planning, training and development of mental healthcare professionals. This would entail a comprehensive analysis of the current mental health service needs and assessment of the existent workforce, in order to identify the gaps and provide solutions that fit the problem. Involvement of general health workers such as Angan Wadi workers (AWW), Anxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) should curb the gap in availability of mental health human resource to some

extent. Training of medical officers at the Sub-centres, PHCs and CHCs will further add to the mental health workforce. BIMHANS and other medical educational institutions with an established psychiatry department should be up-scaled to permit more students for graduation and post-graduation studies. Inclusion of a psychiatry department in other medical educational institutions in the state would further complement this effort. District hospitals should be encouraged to incorporate a psychiatry division/department with mental health specialists to train the health workers at the district and block level. Incentivizing the private sector to collaborate with the public health system will ensure enlarged participation.

Low staff motivation has come across as a significant roadblock for employment of an effective mental health workforce in Bihar. In this regard, WHO recommendations on improving health system and services for mental health offers that improvement of salary conditions; establishment of career development and promotion structure; improvement of working conditions; investment in management training; and development of supervision and support structures, can substantially address the gap in mental health human resources.[81] Sustained education and training will benefit the health workers and equip them to address the mental illness burden with improved quality of mental health services.

E. Health Management Information System (HMIS)

HMIS is a system for collecting, processing, analyzing, disseminating and using information about health service and health needs of the population it serves, to improve their health.[82] It was established as part of the Integrated Disease Surveillance Programme (IDSP) and is operative in Bihar. Collection of data from various mental health service settings at different levels- episode level, case level, facility level and system level will help inform different stakeholders. Policy makers can employ it to formulate informed health policy, health workers can use it to assess the needs of the population and ascertain the health outcomes of their interventions, and individuals can learn about mental health services and the entailing health outcomes. A pilot project in Kolar district, Karnataka, conducted by NIMHANS demonstrates how successful integration of information of Mental, Neurological and Substance use disorders within the HMIS system is possible. It recommends building up simple patient case records with relevant demographic details and medical information; reporting on Programme activities; and inclusion of simple indicators to monitor progress of Programme. These recommendations can be considered if the state amends the present HMIS operative in the state to include information on mental healthcare.

F. Financing

The expenditure on health has gone down in the state, if the figure of 2015-16 and 2016-17 state health budget figures are analyzed together. This needs to change; public health has to be prioritized by the government in order to include mental healthcare in the state. To integrate mental health services within general healthcare, it is pertinent to include the coverage of mental health services in general health financing.[83] It is important to include line items for mental healthcare, which is currently lacking in the budgetary scheme of the state. Specialized mental health services can be itemized under heads such as: mental health services at sub-centres, PHCs, CHCs and district hospitals; mental health services at other medical institutions. Mental Health Human Resource and Mental Health Information System can be other specialized items on the budget. To prevent funds from remaining static or being utilized for other items, tracking of funds spent on mental health is required by the state.[84,84] Before allocation of financial resources is undertaken, a mapping of available resources, mental illness burden, mental health service needs and expected health outcomes should be done. This systematic approach to instituting a mental health finance system will reduce costs and advance economically viable solutions with positive health outcomes.

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Notes

The Centre for Health Policy (CHP) at the Asian Development Research Institute (ADRI) has been set up with support from the Bill & Melinda Gates Foundation to strengthen the health sector in Bihar with a multidimensional and multi-disciplinary approach. Its aim is to engage in rigorous analysis of the health system and inform policy makers to fine-tune interventions for even stronger outcomes.

- Research and Analytical Studies

  It constitutes the core of CHP's activities. The areas of research include health infrastructure and delivery with emphasis on equity, health outcomes such as IMR, MMR, TFR and its predictors, health financing, private-public partnerships, regulatory framework and its implementation, and other issues which might emerge.

- Informing Policymakers on Strengthening the Existing Health System

  CHP aims to be the trusted partner of the state Government in providing evidence-based inputs in making the health system stronger, resilient and equitable.

- Sustainable Health Solutions

  CHP recognizes the need for establishing a strong health system which will be self-sustaining. It means immunity to natural disasters/calamities, financial uncertainties and other unanticipated factors. These pillars may be interrelated; CHP will provide a framework of synergy among actors working on these pillars.

- Collaboration

  CHP engages in collaboration with an extensive network of academic and policy research institutions both in India and abroad in health and the broader social sciences.