The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 8, Issue 2, April- June, 2020
DIP: 18.01.067/20200802, DOI: 10.25215/0802.067
http://www.ijip.in

Research Paper

# Mental health: the cat is out of the bag!

Richa Sharma[1]*, Upendra Singh[2], Satabdi Chakraborty[3]

## ABSTRACT

***Background:*** The COVID-19 global pandemic is forcing public systems to re conceptualize themselves. Much white-collar work is now being carried out in the online mode and out of nowhere, mental health, which was never a hot topic, has become an important part of public discourse. ***Aim:*** The aim of this paper is to identify some barriers in mental healthcare for all and to offer suggestions for availability of these services in a post COVID world. ***Conclusion:*** Availability of mental health services for all remains a distant dream in India. This paper offers a few suggestions towards making that distant dream a reality, in the backdrop of a global pandemic.

***Keywords:*** *COVID- 19, Universal mental health, Right to mental healthcare*

Worldwide, mental health continues to remain a stigmatized and neglected area of the public health discourse. Even though, globally, there have been shifts in the approach towards mental health and in several parts of the world, a rights-based perspective, universal access to quality mental health remains a distant dream. The COVID-19 global pandemic is forcing public systems to re conceptualize themselves. Much white-collar work is now being carried out in the online mode and out of nowhere, mental health, which was never a hot topic, has become an important part of public discourse.

The aim of this paper is to identify some barriers in mental healthcare for all and to offer suggestions for availability of these services in a post COVID world.

To provide a bit of historical background, the first instance of establishment of mental health hospitals in Modern India, comes from the pre independence era. In the year 1912, the Central European Hospital was established at Ranchi, under Col. Berkeley Hill, for the care of European patients with mental illness[1]. This institution came to be called, Central Institute of Psychiatry. This was closely followed by the enactment of the Indian Lunacy Act, which still maintained a regressive standpoint towards mental illnesses. Eventually, by the 1940s, the focus returned to the reformation aspect of mental health services, with the report of the Bhore Committee in 1946, which emphasized on the need for improving the quality of

[1]M Phil Scholar, Dept. of Psychiatric Social Work, CEIMH, ABVIMS & Dr. RML Hospital, New Delhi, India
[2]Faculty, Dept. of Psychiatric Social Work, CEIMH, ABVIMS & Dr. RML Hospital, New Delhi, India
[3]Faculty, Dept. of Psychiatric Social Work, CEIMH, ABVIMS & Dr. RML Hospital, New Delhi, India
*Responding Author

**Received: April 30, 2020; Revision Received: June 7, 2020; Accepted: June 25, 2020**

public healthcare by a process of decentralization of mental health services. The recommendations pointed out the necessity for a universal healthcare system and laid the brickwork for the National Health Plan[2]. Of the other recommendations the important guidelines which still hold relevance today, were utilizations of the lay health workers in enhancing the coverage of health services.

The recommendations of the Mudaliar committee of 1962, laid the ground work for availability of mental health services and hospital beds for psychiatry patients at the district level[3]. This was followed by a series of national conferences which worked upon highlighting the lacunae in the existing mental health services infrastructure and highlighting that it merely custodial in nature, more than anything else. This led to the eventual formulation of the National Mental Health Program, 1982. The year 1987 saw the replacement of the draconian Indian Lunacy Act by a more balanced, Mental Health Act, 1987, putting down procedures for admissions, discharge, conditions of living in institutional set up for persons with mental illness. Years of reformation, deliberation and experience on the ground after the Mental Health Act, 1987, led to the promulgation of the Mental Healthcare Act, which received the presidential assent in 2017.The new act makes quality mental healthcare a right for all those who need it. However, a right is only good insofar as it is utilised. This is going to be covered under the next section, i.e the operationalization and utilization of the mental healthcare act.

***Operationalization and utilization of The Mental Healthcare Act, 2017***

All services and rights that a welfare state might provide to its citizens might not be utilized by them. There are several examples which point towards this behaviour of healthcare services consumption in India as well as other countries. As Abhijit Banerjee and Esther Duflo mention in their book, "Poor Economics", most of the health care and service seeking decisions by people are based, not upon hard facts or even the medical services available to people, but instead, upon the beliefs that people had about what worked for them[4].For instance, many people believe that medicines had were directly delivered to the blood stream (injectables) had better treatment outcomes, therefore, they would insist upon being treated with injectables and not go to doctors who didn't think injection would be necessary. This non utilization of best evidence medical facilities has further been compounded by misinformation, ignorance and myths about illnesses.

For instance, in the same book, Banerjee and Duflo point out to the example of Udaipur and the experiences with seeking treatment at the hospital and faith healing. In their experience, they realized that people sought treatment, both at the government hospital facilities, as well as, with the faith healers (Bhopas). They seemed to have identified and categorized diseases, those that would require intervention at the hospital (more serious illnesses, like cancer) and those that would require visiting the "bhopa" (cough and cold or mental health issues). Unfortunately, mental illnesses, continue to be an area dominated by the "bhopas" in the Indian context, instead of evidence based practice[5]. Another problem with accessing mental healthcare, with so many myths and taboos already surrounding it, is the issue of incentives. Often, the government infrastructure is slow and overcrowded. For some people trying to access mental health services, one day at a mental health establishment means a loss of the day's wage[6]. This perceived opportunity cost for accessing mental health services might outweigh the perceived benefits of availing these services for a large chunk of people.

All of these factors when compounded with the stigma towards mental illnesses, highly diminish the potential for using mental healthcare services by a lot of people. Therefore,

provisions in rights based act, such as the mental healthcare act, 2017, have very limited benefits, till large sections of people are made aware of and enabled and empowered to seek what has been guaranteed to them as a right. One also needs to recognize that incidence of a mental illness, due to its global impact on thinking, decision making and functioning, might diminish an individual's ability to reach out to healthcare services[7]. Therefore, the approach to ensure that mental health services are being accessed by people should educate, enable and empower them to access these services. COVID-19 has made us perceive mental health services in new light and with a sense of urgency.

***Opening a public dialogue on mental health***

Dialogues and discussions around mental health have been conspicuously missing from the public domain and often mental healthcare is not public health priority, nor emergency.

However, various sources are now indicating that a mental health epidemic might be staring us in the face as people undergo prolonged periods of social isolation, stress and anxiety due to uncertainty[8]. While the situation is unprecedented, it is refreshing to see that the government of India and other countries of the world, have started dedicated psychosocial helplines to alleviate the emotional and psychological distress of the people.

This goes a long way in breaking the stigma of talking about one's feelings and seeking help. Diversity of emotional experience and struggling to cope with the emotions, becomes a norm, rather than something that needs hiding. This has the potential to create the much-needed talk, awareness and de stigmatization around mental illnesses.

***Acknowledgement of the distress of living with a mental health condition***

In the recent past, the world has received some shocking news items. Recently, in the Indian context, a 50-year-old COVID-19 patient committed suicide in a hospital in Karnataka[9]. There have also been news of healthcare workers succumbing to their psychological trauma and committing suicide[10]. These reports have compelled people to rethink their attitudes and outlook towards mental ill health. While, it is all too easy to blame the person with mental illness with their condition, when frontline workers and world leaders start succumbing to mental stresses, one cannot, but acknowledge the potential of a mental illness to afflict anybody and makes one ponder before attributing the blame for mental illness to the individual living with it. The dialogue upon mental health can be taken one step forward and different aspects and myths about mental illness can be addressed by the government. This can be done by also incorporating mental health component in all IEC material that gets created for COVID 19. This can go a long way in changing attitudes and breaking myths and stigma around mental illness.

***Advancement of tele mental health support***

The tele mental health model that is offering help to people currently, during the pandemic, san in fact become a mainstream model. In the past, in disaster scenarios, too, telepsychiatry and telephonic psychological first aid has been used, for instance, in the case of Tsunami, 2010[11]. These interventions can provide us insight into previously unexplored sections of population that are vulnerable and enable us to tailor specific interventions, suited to culture and language. Extensive work needs to be done in increasing the outreach of the telemental health services, while incorporating culture specific elements in the interventions. In the context of COVID-19, concerns regarding mental health of frontline health workers have also surfaced and several interventions are being tailored for the same. The interventions, infrastructure and resources developed during the current crisis, can continue to be retained,

improvised and adapted as standard healthcare protocols. These can go a long way in providing long term support to persons with mental illness in a cost effective manner. This also goes a long way in empowering people from the lower socio economic strata to seek help for their psychological issues because they will not need to forgo their daily wages to access mental health services.

***Fostering community building and resilience***

COVID-19 has provided an opportunity to communities, governments and people to incorporate compassion as an essential ingredient in their actions. Such positive human emotions, as hope, compassion and resilience are never usually highlighted or talked about in media, at schools or through the government machinery. Due to COVID 19, public dialogue has clearly shifted towards the importance of possessing better coping skills, having a positive mental health and instrumental importance of life skills. This is an opportunity for mental health professionals to create more knowledge and application-based interventions for fostering positive mental health traits among people and communities. This is also a good time to give a thought about thoroughly integrating mental health and life skills education into mainstream school curriculum and also to look into mental health at work place.

## CONCLUSION

The history of evolution of mental health services has been a long and tough one. Mental health interventions have never been a front runner when it comes to public health policy. However, unless there is a major thrust on promotion of positive mental health and empowerment of people to utilize mental health services, the actualization of people's right to mental healthcare will remain a distant dream. This paper offers a few suggestions towards making that distant dream a reality, in the backdrop of a global pandemic. The need for scaling up our mental health services and infrastructure has always been felt in our country, COVID 19 has only brought the issue out in the limelight and has forewarned us of the repercussions if it continues to be neglected any longer.

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***Acknowledgements***
The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interest***
The author declared no conflict of interest.

**How to cite this article:** R Sharma, U Singh & S Chakraborty (2020). Mental health: the cat is out of the bag! *International Journal of Indian Psychology*, *8*(2), 565-569. DIP:18.01.067/20200802, DOI:10.25215/0802.067