Sattva Knowledge Institute SKI primer

MENTAL HEALTH LANDSCAPE IN INDIA

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Acknowledgements

About the Authors

This primer has been written by **Yashasvi Murali** and **Disha Kouli** with support from **Anshika Singh, Suraksha Jain** and **Karthika Kumar**. They were supported by **Devlina Bhattacharjee, Arnab Mukherjee** and **Pragati Keswani** as well as **Veda Kulkarni, Manmath Agarwal** and **Gopinadh Lakkoju** supported on data analysis. The technical review was done by **Lakshmi Sethuraman**.

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Sattva Knowledge Institute (SKI), established in 2022, is our official knowledge platform at Sattva. The SKI platform aims to guide investment decisions for impact, shedding light on urgent problems and high potential solutions, so that stakeholders can build greater awareness and a bias towards concerted action. Our focus is on offering solutions over symptoms, carefully curating strong evidence-based research, and engaging decision-makers actively with our insights. Overall, **SKI aims to shift intent and action toward greater impact by influencing leaders with knowledge.** All of our content proactively leverages the capabilities, experience and proprietary data from across Sattva.

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EXECUTIVE SUMMARY

Prevalence of Mental Illnesses in India

Over 13% of India's population suffers from some form of mental illness. Substance use disorders form the major chunk of the mental health burden of the country. The situation is aggravated **by systemic factors and inequities along socioeconomic and regional lines**. Despite the heavy caseload, the **access to care for mental health issues is sporadic** and skewed in favour of urban, high-income groups. Lack of awareness, the stigma around mental illnesses, prohibitive treatment costs and scarcity of healthcare facilities prevent 70-90% of mental health patients from receiving care.

Policy Landscape

The policy landscape in India reflects an emphasis on mental health. However, **government initiatives are scattered** and the lack of sufficient resource allocations and governance has led to a considerable gap in implementation. Private stakeholders, a crucial component in service delivery, are also seen to work in silos. Consequently, the democratisation of mental health care has emerged as an area for urgent action. Solutions under development seek to provide sustainable and comprehensive mental health care at the last mile. The **strengthening of the primary health care system is an essential pathway** to enable mental healthcare access to all. In particular, innovations that harness technology are being seen as key to enhancing the efficiency and reach of mental healthcare.

Solutions

The current solution ecosystem indicates that **models that have successfully integrated mental health with primary healthcare, operate within all levers of the continuum of care (CoC) and health-system pillars (HSP)**, and provide sustainable and comprehensive mental healthcare. Emerging process innovations have demonstrated effective delivery of care at a primary care level with the potential to scale and make it sustainable over time. In addition, **product innovations harnessing technology, such as predictive analytics, self-care and telemental health applications**, complement processes and present an opportunity to enhance efficiency and reach of mental health services to the last mile.

Challenges to Universal Access

Several challenges need to be overcome to achieve universal access to care. Mental health is allocated a meagre 0.7% of the entire health budget, which affects infrastructure development, resource management and training of mental health professionals. The **inconsistent implementation and monitoring** of existing initiatives such as the District Mental Health Programme form an additional impediment. **Structural disparities** further expose marginalised groups such as women, LGBTQIA+, and underprivileged castes to mental health risks. Migration due to climate change, man-made disasters and urbanisation add to the quantum of vulnerable populations. Proposed solutions, many of which are heavily reliant on technology, also need to navigate **the ethics of tech-enabled care delivery, consent, and data privacy**. Mental health treatment continues to demand high out-of-pocket expenditure, which calls for **regulatory measures to include mental illnesses under insurance coverage.**

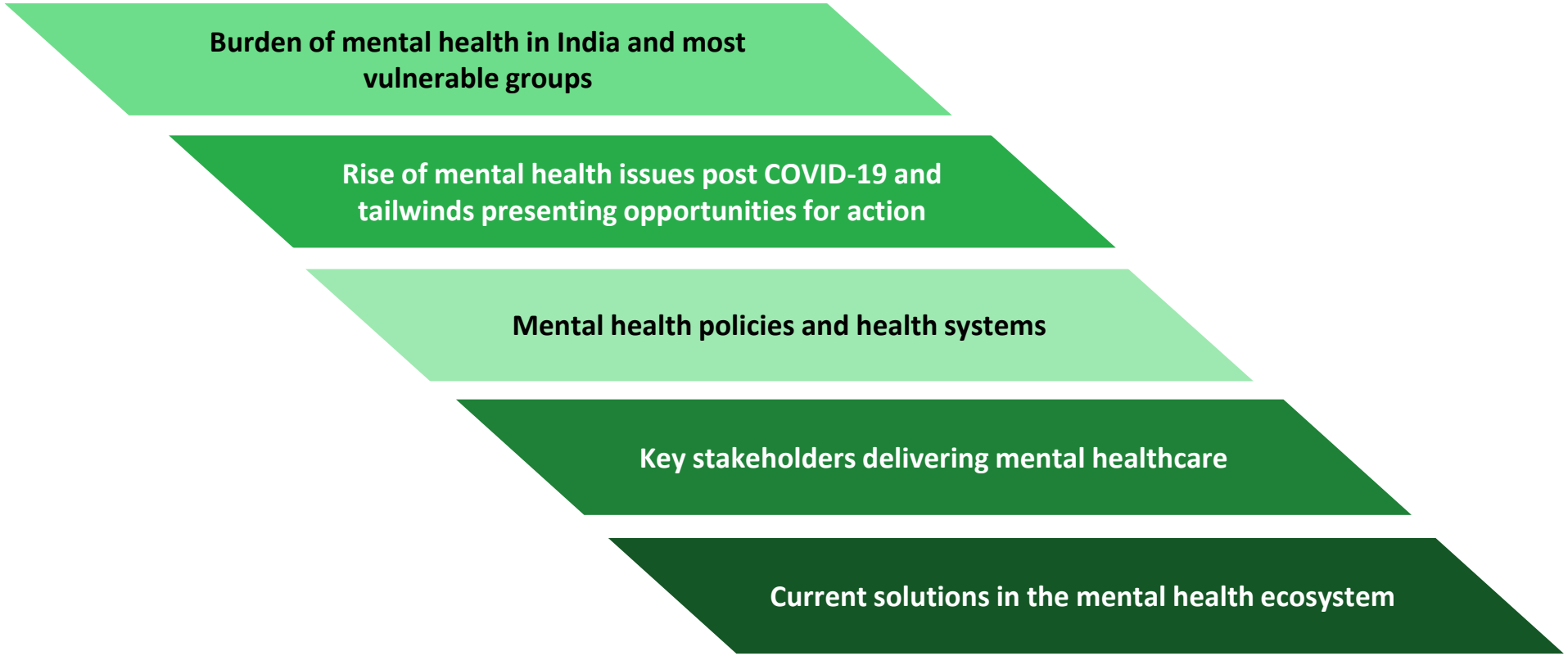
Recommendations for Action

A multistakeholder approach is necessary to **disrupt the prevalent siloed functioning for common mental health challenges.** The alignment of mental health paradigms is an important starting point, which would enable the conceptualisation of mental health around common principles. **Establishing a common nomenclature and defining universal concepts** are essential to ensure consistency in service delivery at scale**. Businesses and social enterprises** have a crucial role to play in steering conversations with an inclusive orientation. Governments should undertake infrastructure-strengthening and capacity-building measures to provide a robust foundation for implementing solutions. Implementing organisations should ensure that **solutions account for systemic inequities** and also serve marginalised communities in low-resource settings. **Philanthropy is particularly equipped to channel resources** towards these areas of priority, thus ensuring the necessary support for democratising access to mental health for the larger population.

BACKGROUND AND CONTEXT

Setting the context: The mental health landscape

This background provides an overview of the mental health status quo in India; the impact of the pandemic on the citizens' mental health; tailwinds, and policy and systemic interventions; key players across public and private sectors; and the current solution ecosystem.



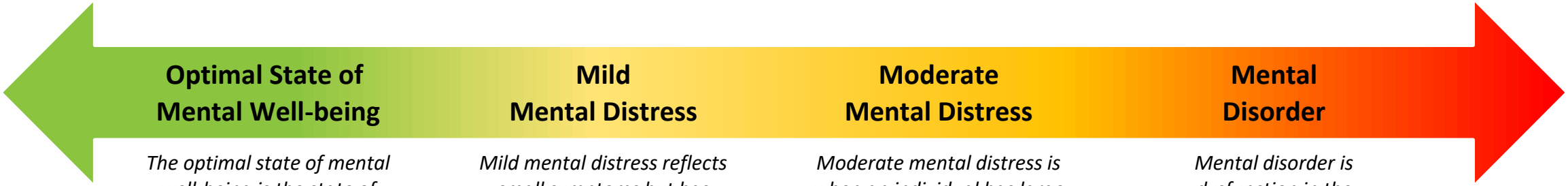
RISING INCIDENCE OF MENTAL HEALTH IN INDIA

What is mental health?

The World Health Organization (WHO) defines mental health as:

"A state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community – essential to an individual's capacity to lead a fulfilling life."

Mental health lies on a complex continuum and is not merely the absence of mental illness. (WHO 2022b)



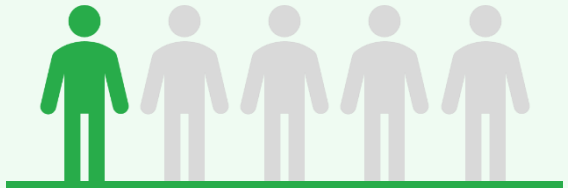
The optimal state of mental well-being is the state of social and cognitive well-being as well as the ability to cope with daily fluctuations. (WHO 2022b; Chen et al. 2020)

Mild mental distress reflects small symptoms but has limited effect on one's daily mental-well being. (NICE 2011)

Moderate mental distress is when an individual has large number of symptoms that make one's daily life much more difficult than usual. (NICE 2011)

Mental disorder is dysfunction in the psychological, biological, or developmental processes that affects mental and behavioural functioning. (WHO 2022a)

India faces an acute mental health crisis today.



1 in 5 Indians

may suffer from depression in their lifetime

(World Economic Forum 2018)

13.9% of India's males

7.5% of India's females

7.3% of India's children

suffer from some sort of mental health issues

(NMHS 2016)

More than 13% of the Indian population suffers from mental illnesses (Dattani et al. 2021);

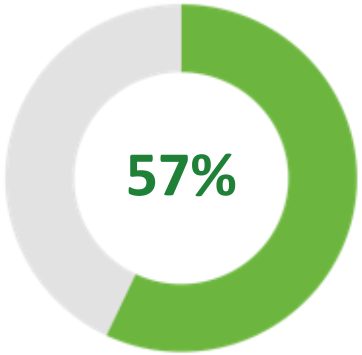
Substance use disorders affecting 22.4% of the population, form the highest burden on mental health disorders (NMHS 2016)

Limited resources and infrastructure have resulted in a large treatment gap.

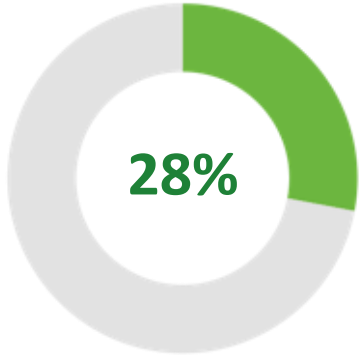
Unmet care needs, lack of access and awareness, and stigma around mental health connote high demand gaps

> **70-90%** of people who need mental care are not receiving it (NMHS 2016)

In a study that covered 10,233 individuals across 175 districts in India (Dey 2019):



Not aware of any person with mental illness



Did not consider suicide to be associated with mental illness

Lack of resources and infrastructure to cater to the citizens' mental wellbeing lead to high supply gaps

> India has **1.93 mental health workers per 1,00,000 population** (NMHS 2016)

The global average is 9 while the average for high-income countries is 70 (WHO 2018a)

26,000

Beds available to treat mental health patients (Mishra et al. 2018)

₹1000

Average out of pocket expenditure (OOPE) in rural areas to access mental health treatment (NMHS 2016 pp. 24)

20-40 KM

Average distance rural patients have to travel to access mental health treatment (Dhillon 2020)

Certain vulnerable groups are at a greater risk for mental illness due to structural stressors.

Target Groups

Children and Adolescents

- **12.5% and 16.5%** prevalence of mental illness amongst children and adolescents in rural and urban areas respectively in 2014 (Hossain & Purohit 2019).
- **23.3%** of school children and adolescents were found to have psychiatric disorders (as compared to a **community average of 6.5%**) in 2017 (Mehra et al. 2022).

Working Age Population

- **36%** of Indian **employees** had mental health issues as per The7thFold's 2020 survey of 509 employees (India Today 2020).
- **14.3%** of the total working population (**197 million people** aged 15-59) experienced mental illnesses in 2017 as per a Global Burden of Disease study (Pandya et al. 2022).

Elderly

- **34.4%** of the elderly population in India suffer from **depression** as estimated by a study in 2016 (Pilania et al. 2019).
- **82.4%** of older people had **health anxiety** and **63%** have developed symptoms of depression due to **COVID-19** (Mint 2021).

Structural Stressors Exacerbating Marginalisation

Caste

40% higher rate of depression was observed in low-income communities which often belong to historically disadvantaged castes (Muzaffar 2019).

Disability

81% of Persons with Disabilities (PwD) reported experiencing high levels of stress due to factors such as isolation, abandonment and violence, especially during the lockdown period (Murthy et al. 2020).

Gender

On average**, women are 2-3 times at a greater risk** of being affected by common mental disorders, which are as strongly associated with women as they are with poverty (Malhotra & Shah 2015).

Income

There is a **high risk of mental illness among households with lower income** since food, shelter and healthcare insecurities lead to feelings of exclusion and hopelessness (NMHS 2015 - 2016; Sareen et al. 2011).

Geography

Rural residents reported the **highest prevalence of mild to severe depressive symptoms** (Albers et al. 2016).

COVID-19 increased the incidence of mental health issues and created challenges in accessing treatment.

India witnessed a steep rise in suicides across all age groups, with a concerning **18% rise in suicides among children and adolescents in 2020** (NCRB 2020).

Use of outpatient services fell drastically after COVID, with **rural facilities** recording a critically low **20% usage** and **urban facilities** recording a moderately higher **50% usage** (HMIS 2022).

Figure 1. Number of Suicides and Suicide Rate - India (2010-20) (per Lakh population) (NCRB 2020)

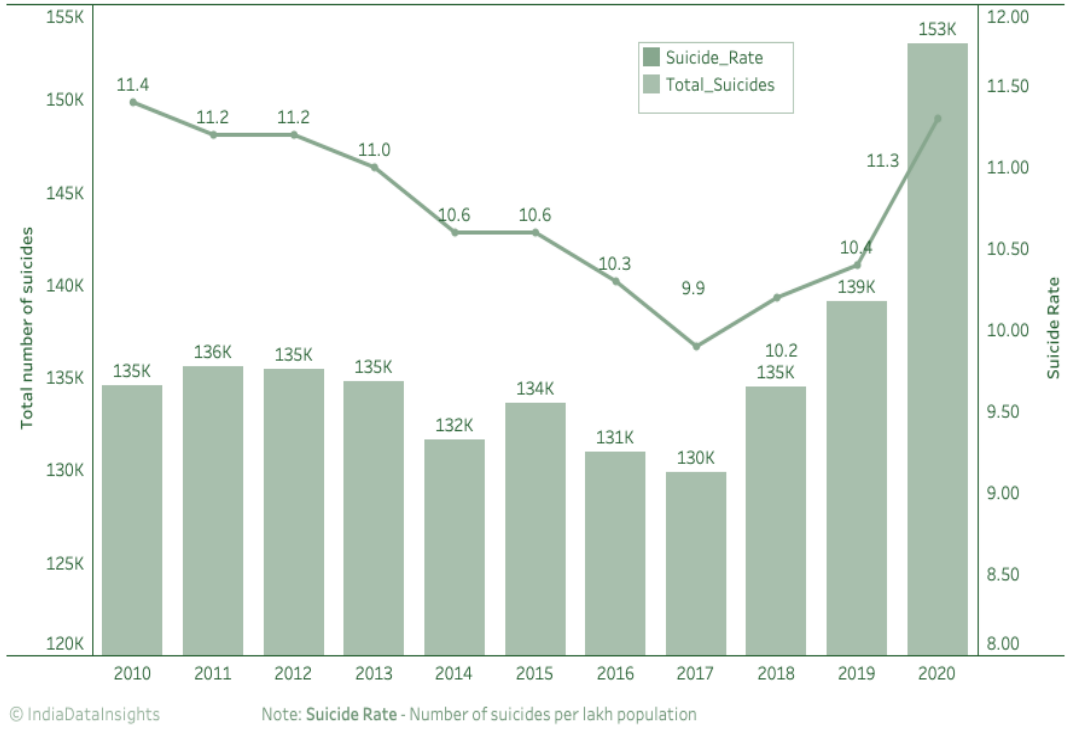
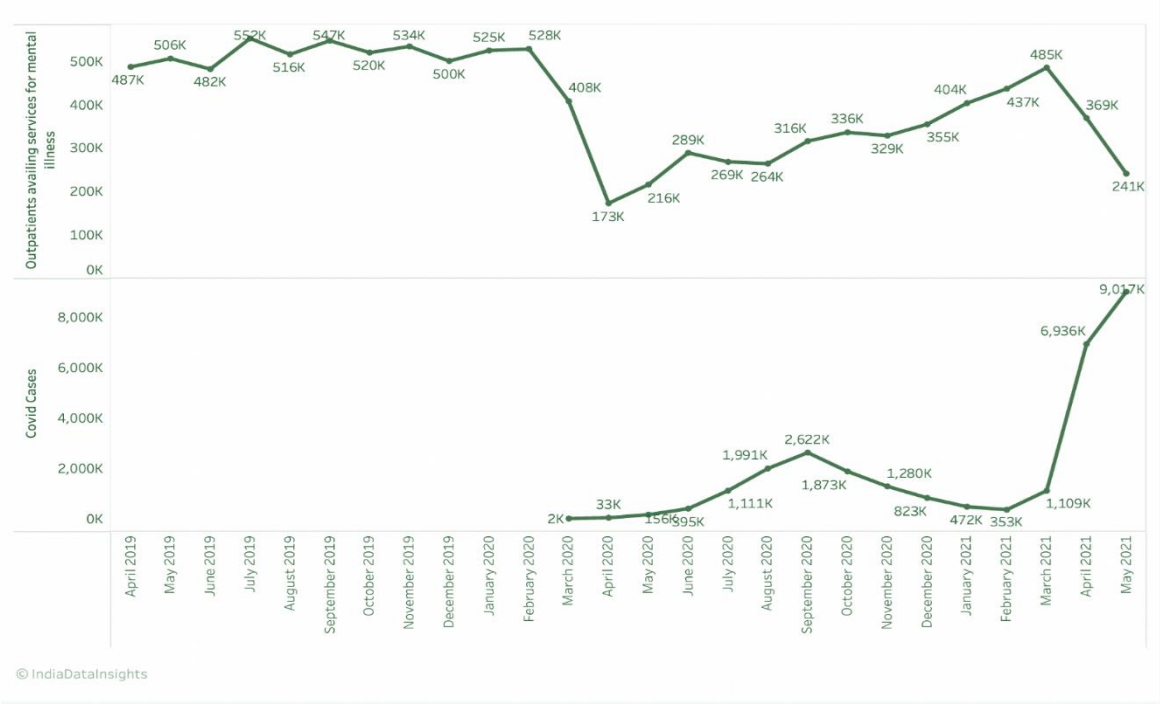


Figure 2. Impact of COVID on use of Outpatient Services for Mental illness - India (2019-21) (Total Numbers) (HMIS 2022)



While on one hand, trends are leading to a rise in mental health issues, there are also tailwinds presenting opportunities for solutions.

Recent global and national trends pose challenges for mental health...

Climate change, water scarcity and reduced food security

In 2018, India's **carbon emission levels were 335.33% higher** than that in 1990. (Pandey 2020). Mental health consequences of changing climate include mild stress and distress, high-risk coping behaviour such as increased alcohol use and, occasionally, mental disorders such as depression, anxiety and PTSD (APA n.d.).

Increasing domestic violence

In 2018, India witnessed a **53% increase in domestic violence against women** since 2001 (Dandona et.al 2022). The pandemic further exacerbated domestic violence, contributing to adverse mental health outcomes among women (Sharma, Dwivedi & Tripathi 2022).

Strain due to urban migration

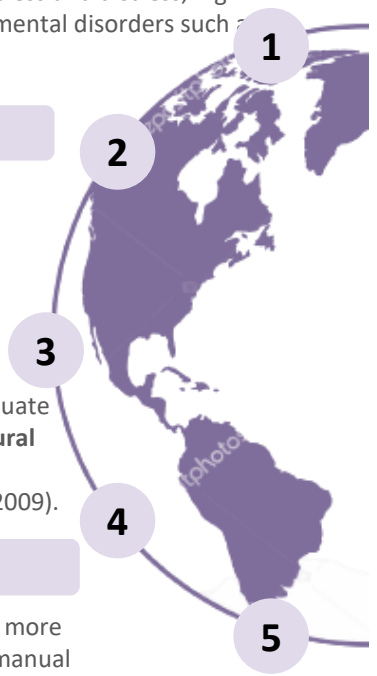
Urbanisation introduces stresses due to unfamiliar territory and inadequate social support, also leading to **older populations living in isolation in rural areas. Women often disproportionately bear the burden** of changes associated with urbanisation, including the rise in violence (Srivastava 2009).

Workplace stress

Rising skills and education levels in emerging economies are creating a more competitive **and stress-inducing job market.** Technology supplanting manual work **adds to anxiety** (VicHealth & CSIRO 2015).

Increase in isolation due to digitisation

Isolation from digital lives lead **to depression, irritability, stress, paranoid ideation, somatic symptoms, and psychoses** (Sternlicht & Sternlicht n.d.).



...while certain tailwinds suggest opportunities to tackle these challenges

Better access due to digitisation of the mental health space

Metaverse mental wellness applications by virtual reality companies are in the pipeline and are **set to make mental well-being more accessible** (Bloomberg 2021).

Increased government emphasis on mental health

The GoI has launched the 'National Tele-Mental Health Programme' **for better access to quality mental health counselling and care services**, and the T-MANAS initiative to provide free tele-mental health services, particularly to people living in remote or under-served areas. (Wadhwa 2021) .

Mainstreaming of mental health issues

A survey showed **a 38% increase** in the number of respondents who said that they would seek mental health treatment and be supportive of an individual accessing mental health care (Live Love Laugh Foundation 2021).

Innovations in mental illness treatment

Data collected from increased use of AI and predictive analytics can help **drive accurate mental health progression predictions or regression**. This will provide caregivers valuable insights to calculate and predict the probability of occurrence and treatment (Minds 2020).

However, a majority of these opportunities target the higher-income population segment; rarely do benefits trickle down to the marginalised sections.

POLICIES AND HEALTH SYSTEMS

The policy landscape has evolved to a rights-based approach.

1912

Indian Lunacy Act, 1912 (Indian Lunacy Act 1912)

- Lacked the human rights lens.
- Viewed people with mental illness as lunatics and focused on segregating them from society.

National Mental Health Programme, 1982 (Ministry Of Health and Family Welfare n.d.a)

- Aimed to ensure availability and accessibility of minimum mental healthcare for all, especially for vulnerable groups.

Mental Health Act, 1987 (The Mental Health Act 1987)

- Replaced the ILA of 1912 and removed derogatory terms.
- Strived to protect the rights of people with mental illness.

1995

District Mental Health Programme, 1995 (National Health Mission n.d. ; Ministry Of Health and Family Welfare 2015)

- Adopted a community-based approach.
- Introduced components of training of healthcare providers and public awareness generation through Information, Education & Communication (IEC).

2013

National Mental Health Policy, 2014 (Ministry of Health and Family Welfare 2014)

- Adopted an Integrated participatory, rights and evidence-based approach.
- Focuses on a vulnerable population.
- Recognises the interplay of various determinants that affect mental health outcomes.

Mental Healthcare Bill, 2013 (Narayan and Shankar 2015; Ministry Of Health and Family Welfare n.d. b)

- Introduced a rights-based approach.
- Ensures accessible and affordable mental healthcare for all.
- Included insurance coverage for mental treatment.
- Initiated the state and central mental authorities' supervision and registration of mental health professionals.
- Decriminalised suicide and prohibited electroconvulsive therapy.

Persons with Disabilities Act, 1995 (Persons with Disabilities Act 1995)

- Inclusive act which ensures fundamental rights to people with disabilities and provision of equal opportunities for all.

2016

The Rights of Person with Disabilities Act, 2016 (Ministry of Law and Justice 2016)

- Added different categories of disabilities such as specific learning disabilities, autism spectrum disorders, and chronic neurological disorders.
- Legal provisions for people with disabilities.

Mental Healthcare Act, 2017 (Ministry of Law and Justice 2017)

- Uses a rights-based approach.
- Strives to provide high-quality free mental healthcare treatment for homeless people and those below the poverty line.
- Retained decriminalisation of suicide.

Programme
Bill
Act
Policy

The National Mental Health Policy 2014 put forth strategies to strengthen systems.

National Mental Health Policy, 2014 (Ministry of Health and Family Welfare 2014)

- The National Mental Health Policy of 2014 is inclusive in nature and has adopted an integrated participatory, rights and evidence-based approach to ensure that all segments of the population have access to affordable and quality mental healthcare services.
- The NHMP emphasises the mental health needs of certain vulnerable groups including the homeless, those living in remote areas or difficult terrain, internally displaced persons, children without access to education, caregivers for the elderly, and victims of human trafficking, among others.

Policy Provisions

Assisted living facilities for persons with chronic and long term mental illness	Short and long term stay as well as integrated recovery pathways into the community.
Financial support including monetary and tax benefits to primary caregivers	Financial support to caregivers for their continued assistance of mentally ill friends and family.
Comprehensive mental health services at all multispeciality government hospitals	Access to mental health services across the continuum of care.
Mental health funds for chronic patients	Access to social welfare benefits for chronic and long-term mental illness patients, inclusive of those who are beneficiaries of existing programmes.
Life skills education to children within and outside the formal education system	Promotion of psychological and physical wellbeing of children and adolescents.

Strategic Direction and Areas for Action

- Effective governance and accountability for mental health.
- Promotion of mental health.
- Prevention of mental illness and reduction of suicide and attempted suicide.
- Universal access to mental healthcare services.
- Improve availability of adequately trained mental health human resources to address the mental needs of the community.
- Community participation in the implementation of mental health programmes and committees.
- Development of a comprehensive research agenda, fostering partnerships towards implementing and evaluating the potential of traditional knowledge and practices.

The Indian Mental Healthcare Act, 2017 guarantees rights to mentally ill people and provides states with directives for implementation.

Indian Mental Healthcare Act, 2017 (The Mental Healthcare Act 2017)

- The new legislation aims 'to provide mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.'
- The Act mandates every State Government to establish a State Mental Health Authority (SMHA) within nine months of the directive of the Act. The SMHAs are to register all facilities, develop service provision norms, supervise establishments and register all mental health professionals in the state.

Provisions of the Act

Rehabilitation services to mentally ill individuals and their family	Mental healthcare services, quality accommodation, hospital and community-based rehabilitation, and support services to the patient's family.
Free treatment for people below poverty line	Free access to mental health treatment and services for the destitute, homeless, and those living below the poverty line.
Inclusion of mental illness in all types of insurance	Medical insurance companies, plans, and provisions to give the same treatment and status to mental illness as they do to physical illness.
Advance directive to patient to dictate their course of treatment	Mentally ill persons are to possess the right to make an advance directive toward the way they wish to be treated for the requisite illness and with regards to their nominated representative, and shall be vetted by a medical practitioner.

Rights under the Act

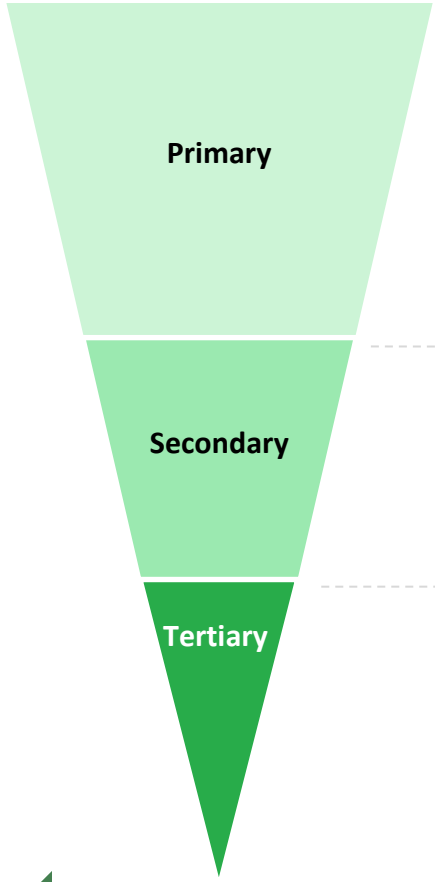
Right to information	• Confidentiality, privacy and access to medical records. • Information on relevant legislative provisions and 'criteria for admission'. • Legal aid and the right to register grievances about deficiencies in the provision of services.
Right to proper remuneration	• Security from forced work in mental health establishments and the right to receive appropriate remuneration for work when undertaken.
Right to hygiene and proper care	• Protection from all forms of physical, verbal, emotional and sexual abuse. • Adequate provision for wholesome food, sanitation, space and access to articles of personal hygiene. • The right to not be subject to tonsuring (shaving of hair on the head).

Other health provisions have begun to prioritise mental health.

Mental Health Boards (MHBs)	**Mental Health Boards (MHB), quasi-judicial bodies, have been established under the MHA, 2017 to ensure the effective implementation of rights and provisions:** • The Board comprises of a) a district judge or state judicial officer, b) a representative of a district collector or district magistrate c) a psychiatrist and a medical practitioner d) two members who shall be persons with mental illness or caregivers or representatives of organisations providing care. • The MHBs are required to register and review advance directives, appoint nominated representatives, decide objections against mental health programmes, decide on nondisclosure of persons with mental illness information, visit jails, and protect human rights. (Mental Health Act 2017).
Ayushman Bharat- Health and Wellness Centers (AB-HWCs)	**AB-HWCs include mental health as one of the 12 NCDs under Ayushman Bharat and the mandate of HWCs** (NHSRC 2022): • Services are delivered through coordinated efforts by Auxiliary Nurse Midwives (ANM), Accredited Social Health Activists (ASHA), Anganwadi workers, and volunteers or local community-based organisations. • HWCs will primarily focus on screening, initial management and referral of persons with mental ailments. • Rollout of mental health is being done in a phased manner. 48% of 102 HWCs and 65% of HWCS at the primary health centre level provided mental health services, as per a limited assessment in 18 states in 2022. • However, several states have complained about the lack of training sessions in this area, thus leading to mental health services being the least implemented services of all.
SAMVAD	**SAMVAD, a national initiative and integrated resource under the Ministry of Women and Child Development, seeks to protect children and provide them with mental healthcare and psychological support** (Press Information Bureau 2021): • SAMVAD aims to train one lakh stakeholders including child protection functionaries, tele counsellors, teachers, and lawyers among others, in teaching coping mechanisms to children in distress. • SAMVAD also aims to integrate into the Panchayat Raj systems to further widen its reach to vulnerable children across the nation.
Tele MANAS	**Mental Health and Normalcy Augmentation System (MANAS) was established to create digital health records through a statewide database** (Office of Principal Scientific Advisory 2021): • MANAS provides online registration for all centres and specialists offering mental health services; those registered may access patient health records and provide treatments. • Tele Manas was a highly successful campaign in Karnataka which the government intends to replicate in Maharashtra and then scale nationally.

Both public and private stakeholders in the mental health ecosystem have a crucial role to play across the care continuum.

Governmental delivery of mental health care ← → *Non-governmental delivery of mental healthcare* (Sattva 2022)

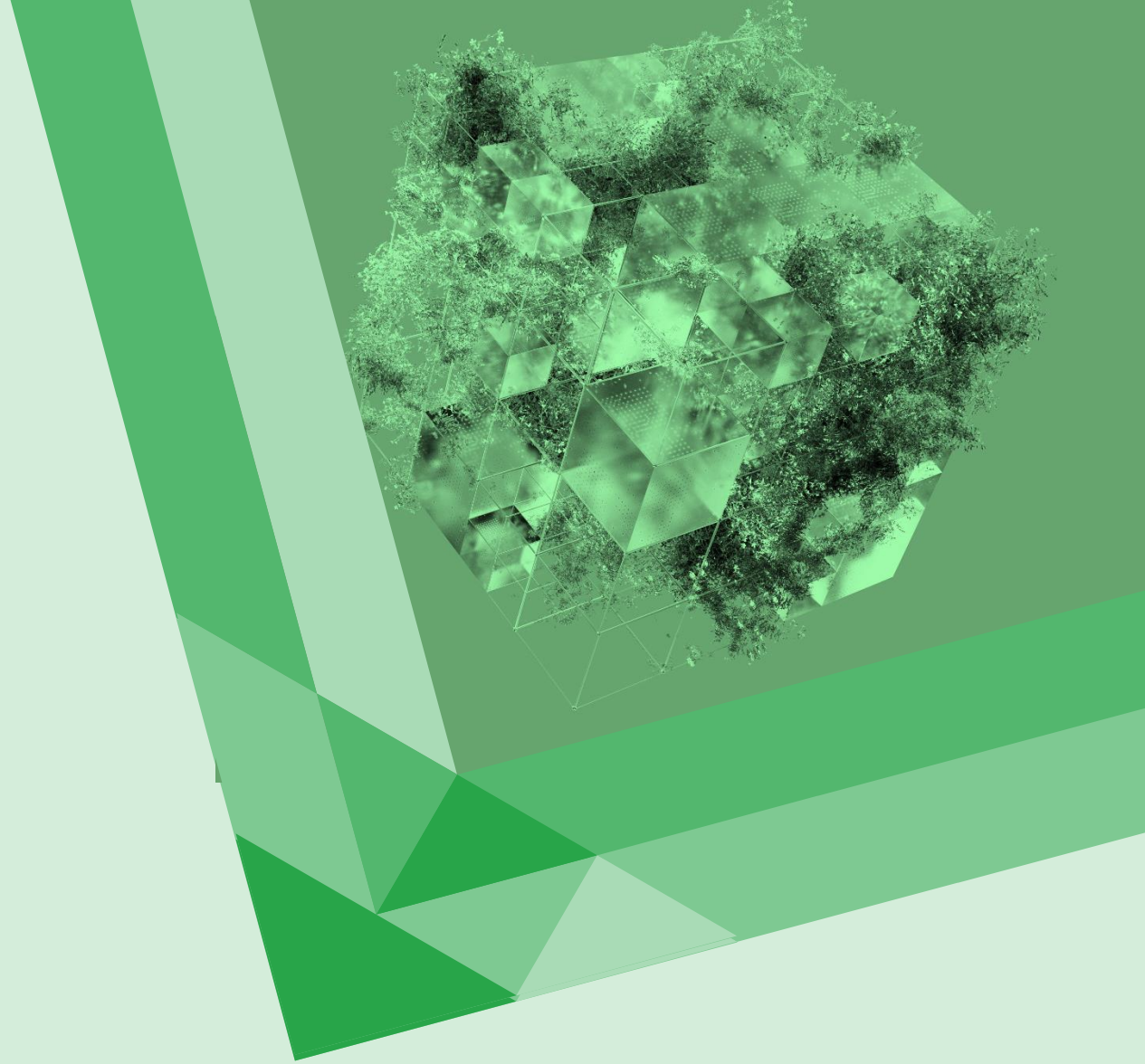


	Providers	Services (Wig 1993)	Implementing Organisations	Healthcare Providers
Primary	• Accredited Social Health Activist and Anganwadi workers (Rahul et al. 2021). • Health and wellness centres. • Medical officers at Primary Health Centres (PHCs) and Community Health Centres (Press Information Bureau 2020).	• Raise awareness and provide first-level screening. • Conduct elementary diagnosis and first-level treatment in uncomplicated cases.	• Work towards raising awareness and reducing social stigma around mental health. • Provide first-level screening and referral to further higher standards of care. • Support crisis prevention through helplines and telemedicine.	• Provide facility-based treatment and care. • Conduct training and certification courses for the delivery of mental healthcare. • Provide therapy sessions. • Support recovery in rehabilitation centres and other such facilities.
Secondary	• Mental health professionals at district hospitals (Murthy 2010).	• Provide specialised treatment for mental illnesses. • Conduct training and provide consultation for PHC and CHC officers.	• Work with district-level authorities to establish bi-directional linkages across the value chain of care to ensure the delivery of appropriate and high-quality care.	• Refer people with severe mental illness to specialised care facilities.
Tertiary	• Department of Psychiatry at medical colleges and psychiatric institutions (Colizzi et al. 2020).	• Provide specialised treatment and care. • Foster innovation through research. • Provide training to mental health human resources.	• Provide specialised treatment and care via outpatient and mobile clinics.	• Provide psychiatrist care for people with severe and chronic mental illness. • Provide essential medications. • Ensure follow-up and in-patient care. • Provide rehabilitation for long-term and short-term homestays and reintegration pathways.

Digital Solutions

Digital solutions are cross-cutting across both public and private sectors, providing support and enabling the delivery of effective and quality care.

CURRENT SOLUTION ECOSYSTEM



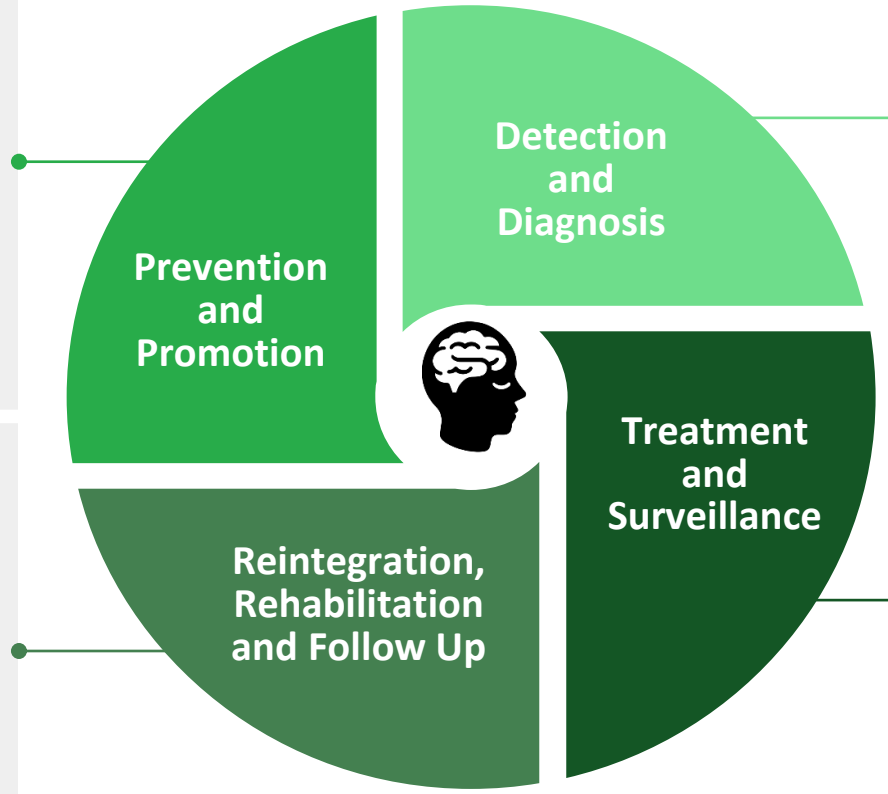
Solutions across the continuum of care target four levers, to ensure empowered communities.

Promotion and Prevention refer to the process of promoting mental healthcare-seeking behaviour and improving coping capacities (WHO 2002).

- Drive mental health awareness campaigns in the community.
- Provide an enabling environment that would encourage the individual to seek mental healthcare.
- Conduct timely and accurate detection and diagnosis.
- Create pathways to treat severe mental illness and provide rehabilitation.

Reintegration, Rehabilitation and Follow-up help people with long-term and chronic mental illness to reintegrate into the community (Jun & Choi 2019).

- Set up community care facilities for short-term and long-term stays (WHO 2021).
- Use vocational training centres to facilitate employment and other social benefits (Rossler 2006).
- Perform continuous check-in of patients that have reintegrated into the community to track progress (Carson et al. 2015).



Detection and Diagnosis is the process of identifying and evaluating people with mild to severe mental illness (Mayo Clinic 2019).

- Utilise referral pathways to specialise care for people with severe mental illness (Colizzi et al. 2020; Goyal et al. 2022).
- Prescribe medication or psychotherapy based on diagnosis (Casarella 2020).

Treatment and Surveillance provide for appropriate treatment and synthesis of data to enable evidence-based decision-making on disease control and prevention, and service provision and delivery (Gater et al).

- Set up monitoring and evaluation systems to routinely collect data.
- Create bi-directional linkages across the value chain of care, between the community, primary healthcare providers, and specialised facilities (WHO 2018b).

Solutions target the entire continuum of care while strengthening systemic pillars for sustainable impact.

Mental health programmes that have successfully integrated mental health with primary healthcare have operated within all levers of the continuum of care (CoC) and health-system pillars (HSP).

CoC (WHO 2018b)	**Prevention and Promotion**	**Detection and Diagnosis**	**Treatment and Surveillance**	**Reintegration and Rehabilitation**
HSPs (WHO 2010)	**Healthcare Delivery & Quality**	**Healthcare Finance**	**Healthcare Workforce**	**Healthcare Technology**

All the 25+ programmes that have been analysed have created impact due to their holistic focus across HSP and CoC levers

Few notable examples:

ANJALI | The Banyan | SCARF India Schizophrenia Research Foundation | ANTARA | Sankalpa SUPPORT FOR THE MIND | the ant the action northeast trust 20 years | BAPU TRUST FOR RESEARCH ON MIND & DISCOURSE | THE ASSOCIATION OF PEOPLE WITH DISABILITY | mhat Rebuilding Lives... | Sangath | TATA TRUSTS | CMH Centre for Mental Health Law & Policy | ASHADEEP GUWAHATI

Process innovations have demonstrated effective models at a primary care level with the potential for scale.

Digital Systems and Applications

Use of web-based systems or applications on phones to record and enforce treatment protocols.

- e.g. Project MITA (The ANT n.d.)

Mobile Clinics and Telemedicine

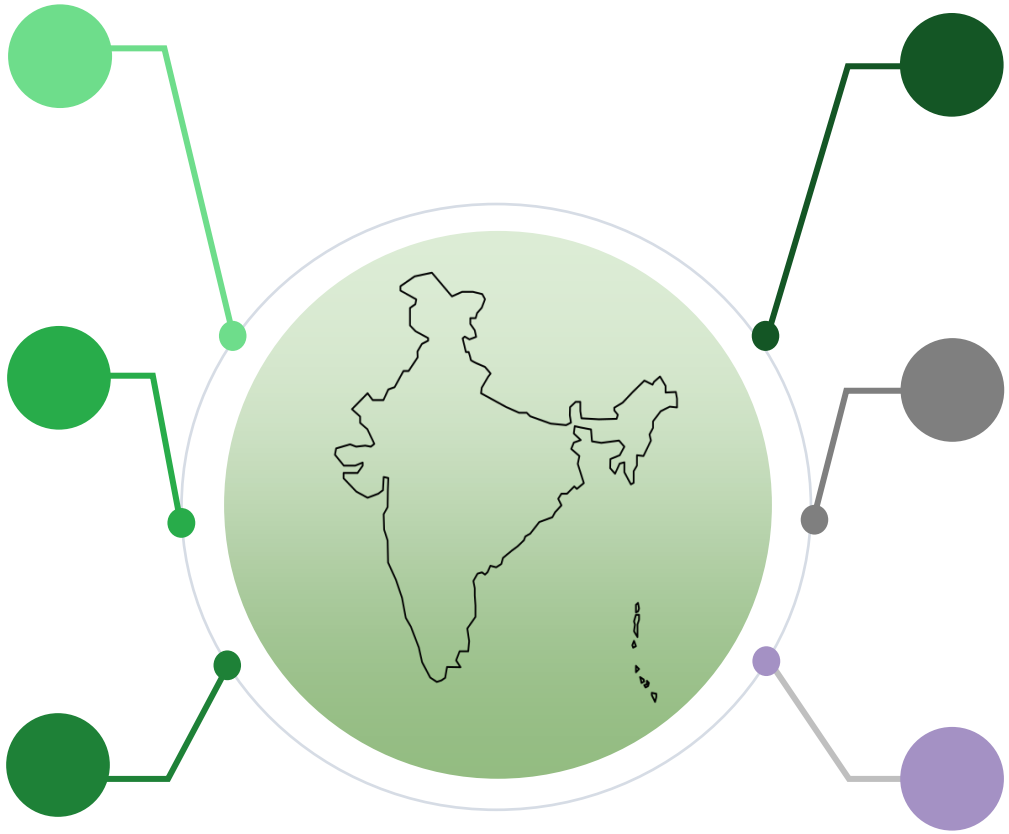
Provision of accessible and affordable mental healthcare services to hard-to-reach geographies through the **integration of mobile clinics and telemedicine.**

- e.g. SCARF's mobile telepsychiatry programme (Thara & Sujit 2013)

Task-Sharing Model

Training non-specialised health workers and lay counsellors to deliver psychosocial interventions.

- e.g. Innovation by Sangath (Sangath n.d.)



Information via Multimedia

Short films on common social issues that the community experiences (unemployment, domestic violence, alcohol use etc) highlight their relation to mental health and localise the context.

- e.g. Atmiyata project (Joag et al. 2020)

Peer-to-Peer Supervision Tools

Digital tools that supervise non-specialist providers delivering psychosocial interventions to improve the quality of Health Activity Programme (HAP) treatment for depression.

- e.g. PEERS project (Sangath n.d.)

Safe Space Community Centers

Last mile access and inclusive mental health services including talk-listen-talk counselling at a nominal fee along with a quarterly event for women and girls to talk about their mental health without any stigma or discrimination.

- e.g. Janamanas project (Anjali n.d.)

Product innovations complement process ones and present an opportunity to enhance the efficiency and reach of services.

Predictive Analytics

(Hahn et al. 2017)

Predictive analytics use AI and data modelling algorithms to:

- Predict therapeutic responses and support the selection of optimised interventions through comparative study.
- Support differential diagnosis, minimising side-effects from treatments.
- Apply preventive measures during the early stages of a disorder or even before the onset of the disease.

Telehealth Applications

Mental health applications on mobile devices screen, manage, refer and treat mental illness, via:

- Text messages for follow-up.
- Referral management applications.
- Remote treatment support via tele-counselling.

e.g. The SMART Mental Health Project (Tewari et al. 2021), Satellite Clinics (Antara n.d.), Mobile Telepsychiatry in Pudukkottai (MHI 2014)

Self-Care Applications

(Ahmed et al. 2021; Gerry 2021)

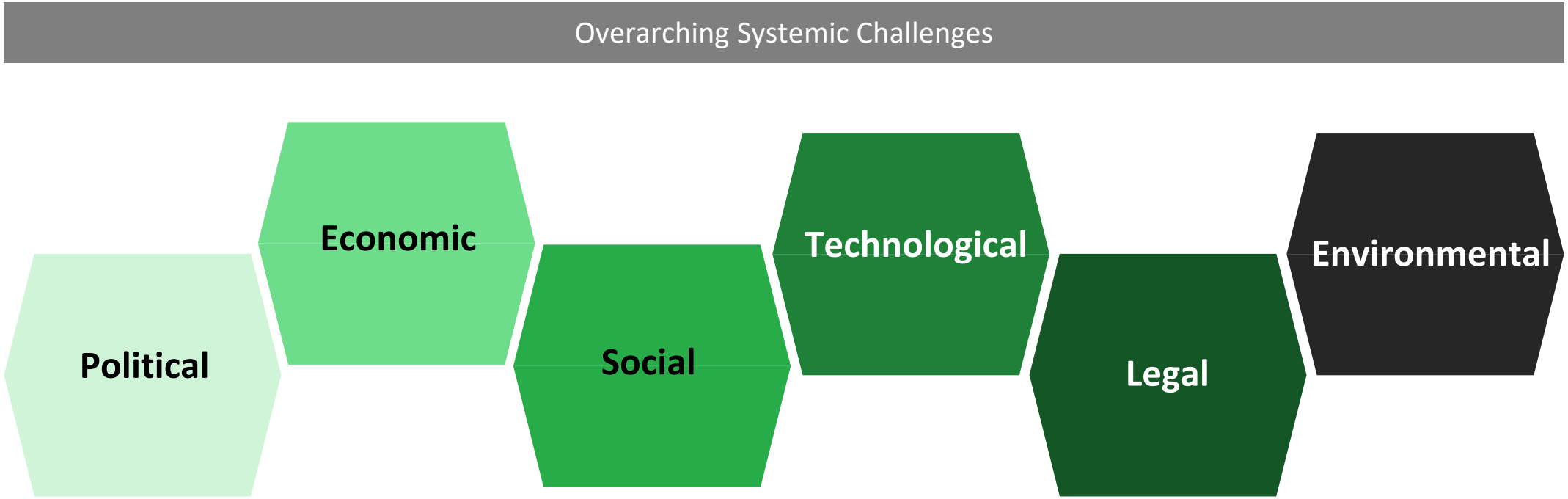
Self-care applications are designed to facilitate self-care actions or practices which would allow a person to self-regulate their health needs via:

- Daily reminders, feelings trackers, learning materials about mental health guided exercises and meditation.
- Access to programmes that would help manage one's anxiety and stress.

e.g. Showcased by WYSA, Amaha, iWill, and Cure.fit, among others (Bisht 2021)

CHALLENGES

Despite policies and solutions available to bridge the treatment gap, challenges continue to exist in the ecosystem.



This primer uses the **PESTLE framework** to provide a comprehensive 360-degree view of all the challenges that exist in the ecosystem.

Overarching systemic challenges require concerted efforts.

1. **Siloed interventions among stakeholders** with limited dialogue and transfer of learnings and best practices.

2. **Narrow implementation of solutions without a systemic approach** (e.g. Implementing digital solutions without addressing systemic gaps around provider receptiveness and lack of inclusivity, thus leading to low impact).

3. **Lack of quality measures and standardised process guidelines for delivery of care** to guide and inform practitioners, thereby resulting in ineffective provision of care.

4. **Lack of a community-centred approach with respect to both design and delivery of programmes**, leading to exclusion of underserved populations and low acceptance and impact of interventions.

5. **Absence of governance and accountability mechanisms** results in limited monitoring and evaluation of existing programmes, and implementation of programmes which do not complement policy provisions and targets.

6. **Lack of a standardised nomenclature for defining mental health**, leading to varied understanding of types of mental disorders, and thus creating challenges in measuring the outcomes and impact of interventions.

Each aspect of the ecosystem has challenges that require attention.

Social

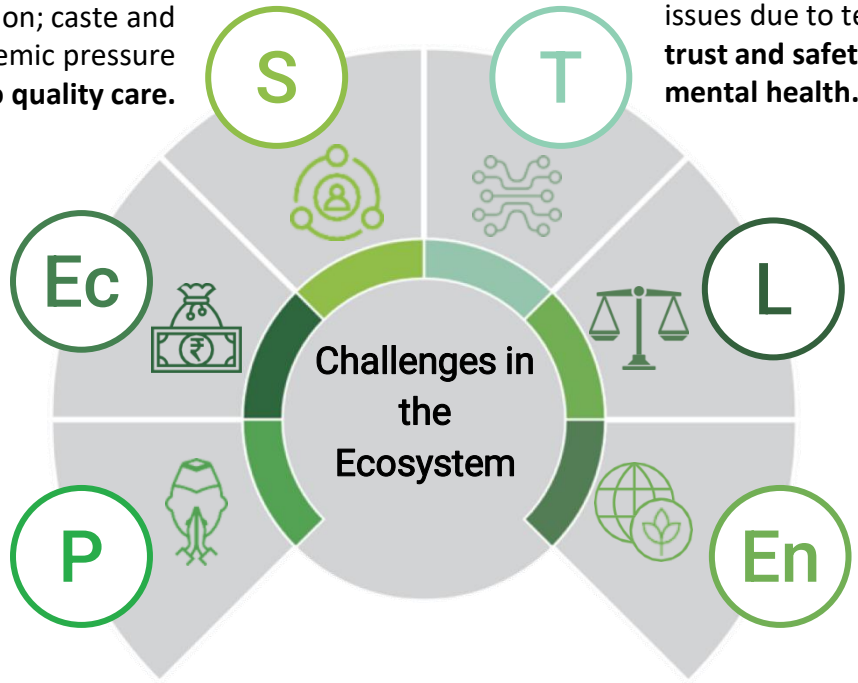
Social drivers of mental health such as gender-based violence; inequitable access to resources and livelihood opportunities; an increase in the aged population; caste and religion-based discrimination; and academic pressure leading to **inequitable access to quality care.**

Technological

Limited efficacy and access to digital solutions for mental health; lack of clarity on user privacy and confidentiality; and a rise in mental health issues due to technology (including cyberbullying, addiction etc.) **lead to trust and safety challenges in the adoption of tech-based solutions for mental health.**

Economic

Factors such as neglect of mental health at workplaces; limited private sector funding; and significant economic costs of lowered productivity **constrain innovations in mental health and add to the prevalence of mental health issues across the country.**



Legal

Ineffective implementation of MHA 2017; exclusion of mental health in insurance; absence of systemic regulation of user privacy; and limited availability of standardised guidelines for care delivery **increase out-of-pocket expense for mental health services while simultaneously leading to poor quality mental health care.**

Political

Key barriers such as sub-optimal policy implementation; lack of state-level accountability; under-trained providers as well as over-burdened staff; inadequate funding; poor utilisation of funds; and inefficient delivery across HWCs contribute to a widening care and access gap.

Environmental

Emerging environmental challenges such as urbanisation; climate patterns and climate change; pollution; health disasters as well as man-made and natural disasters pose **barriers to care and increase the risk of post-traumatic disorders and psychological distress.**

Political and Policy Challenges

Low budget allocation and utilisation, poor implementation and ineffective governance of mental health programmes, and lack of regulation and accountability amount to low state support for mental health (Sharma 2018).

Ineffective Policy Implementation	• Inactive systems with no active prioritisation of mental health, in the absence of central accountability. • Negligible focus on preventive and advocacy activities and components of the programme, such as the training manuals, treatment guidelines, and IEC activities, all of which are developed to a limited extent and poorly disseminated. • Lack of trained professionals, heavy reliance on psychiatrists and specialists, and lack of strong established referral systems to enable a stepped care system via task-sharing. • Ineffective M&E due to the absence of state-level mechanisms for governance, work regulation, and administration of outcomes (Porter 2022).
Lack of State-Level Accountability	• Inadequate provision of care with a mere 1.1 lakh HWCs, which are a key lever for preventive and curative care, operational across the country in 2022 (The Print 2022). • Only 48% of 102 HWCs and 65% of HWCS at the primary health centre-level provided mental health services as per a limited assessment in 18 states in 2022. Mental health was one of the least rolled out services under the scheme, besides elderly and palliative care (NHSRC 2022).
Inadequate Funding and Poor Utilisation	• Inadequate budgetary allocation to the mental health of only 0.7% of the overall healthcare budget (IMHO 2022). • Underutilised District Mental Health Programme budget in a majority of the districts, leading to a lack of awareness about mental health and associated services. • Underutilisation of medical health professionals' salary allocation under the District Mental Health programme, signifying low capacity and prioritisation of capacity building (Fernandes 2021). • Underutilisation of funds allocated for drugs and equipment (Fernandes 2021).
Lack of Trained Providers and Over-Burdened Staff	• Shortage of trained mental health professionals due to the absence of standardised or mandatory education that would equip trainees to detect mental illnesses and deliver appropriate services in a timely manner. • No training for community leaders and lay counsellors to support the delivery of mental health services or drive awareness amongst the community (Meltzer n.d.).
Inadequate Delivery across HWCs	• In the absence of accountability, states fail to ensure action and drive positive outcomes unlike other health areas. They have not prioritised the implementation of provisions under the NMHP and the MHA, 2017, leading to fragmented results. • Lack of transparency and information regarding procedures that the expert committee in the Mental Health Review Board follows to review the implementation of the Mental Health Act (Dutta 2022).

Economic Challenges

Less recognition of the economic benefits of investment hinder growth and the perceived lack of measurable outcomes beyond treatment affect equitable private sector flow across solutions (James 2019).

Neglect of Mental Health at Workplaces	• According to a pre-pandemic report, only 1,000 companies of the 1.1 million active companies are estimated to have a structured employee assistance program (EAP) for mental health (Optum Health International) (Goel 2021). • Albeit dialogue around mental health may be growing at workplaces, team leaders and HR managers require mental health sensitisation and training on how to respond to employees' mental illnesses (Pandya et al. 2022).
Significant Economic Costs of Lowered Productivity	• WHO estimates that India will suffer economic losses amounting to a staggering USD ~1 trillion from mental health conditions between 2012 and 2030 (Birla 2019; Fatima et al. 2019). • WHO has also noted that for every $1 invested toward treating common mental disorders, there is a $4 return in improved health and productivity, revealing the economics benefits of the prioritisation of mental wellness, a concept that is yet to be largely unrecognised in India (WHO 2016). • Researchers estimate that 12 billion productive work days are lost every year to depression and anxiety alone, at a cost of nearly USD 1 trillion. This includes days lost to absenteeism, presenteeism (when people go to work but underperform) and staff turnover (WHO 2022b).
Limited Private Sector Funding	• As of 2021, mental health in India is underfunded by more than USD 1.5 trillion compared to the global wellness market (Sood 2021; Olsen 2022). • In 2021, the total funding for mental health startups in India was ~INR 0.8 billion and that from 2016 to 2020 amounted to ~ INR 1.5 billion, while mental health companies in the USA brought in USD 4.5 billion in funding in 2021 (Brassey et al. 2021). • Investment in mental health startups continues to be slow due to perceived challenges with measuring tangible outcomes and profits (Mittal 2021; Kanwal 2022).

Sociocultural Challenges

Sociocultural inequities, gender, religion, caste and occupation-based discrimination and violence, made worse by stigma and taboo, limit access to care and cause the deterioration of mental health (Jenkins et al. 2011).

Gender-Based Violence	• Domestic violence (DV) against women results in behavioural problems, depression, anxiety, posttraumatic stress disorder (PTSD), self-harm, poor self-esteem, etc. Women experiencing DV are more likely to experience mental illnesses and suicidal tendencies (Sharma et al. 2019). • Depression, anxiety, and PTSD are very high across victims of sexual assault, with more than 55% of sexually assaulted teenage girls developing a mental health disorder a few months after the event (Khadr et al. 2018).
Inequitable Access to Resources and Livelihood Opportunities	• Hunger and lack of food security causes mental health problems such as depression and anxiety (Rani et al. 2018; Fang et al. 2021) • Unemployment causes depression, anxiety and lower self-esteem. 61% of the unemployed report stress, 47% anxiety, and 42% anger (The 7th Fold) (Wilson & Finch 2021; Artazcoz et al. 2004). • Rural to urban migration for jobs may cause psychological distress due to lack of preparedness, difficulties in adjusting, and the complexity of local systems. This is particularly true for single, widowed, divorced and separated individuals, unskilled and daily wage workers, and illiterate migrants. (Sarkar 2020; Padgett 2020).
Increase in Aged Population	• Demographic and social changes, such as the rise of the nuclear family, are adversely affecting the aged population. A study by Longitudinal Ageing Study in India (LASI) found that 1 in 5 elderly persons in India has mental health issues and more than 1 in 10 have “probable major depression,” making them highly vulnerable groups (Chitravanshi 2021).
Caste and Religion-Based Discrimination	• Differential treatment based on caste produces asymmetry in mental health. A study shows that Scheduled Castes have worse self-reported mental health than upper-caste Hindus (TOI 2022). • Religious beliefs and practices often contribute to certain psychiatric disorders with regards to obsessions, anxiety and depression, especially among minorities. This is highly prevalent in India in light of rising religious polarisation (Gupta & Coffey 2020).
Academic Pressure	• Students, mainly adolescents, face academic pressure from parents, teachers and sometimes even peers which commonly leads to anxiety, stress, or depression, and in some cases even suicide. 63.5% of Indian students reported stress from academic pressure (TOI 2022).

Technological Challenges

Absence of mechanisms to evaluate the privacy and effectiveness of interventions, systemic inequities in design and inequitable access of digital solutions among marginalised populations (Sehgal & Kapoor 2021).

Limited Efficacy and Access of Digital Solutions	• While digital solutions are increasingly leveraged for treatment, low smartphone penetration coupled with issues such as lack of digital literacy and trust lowers the adoption of such solutions, making them particularly inaccessible and costly for marginalised populations (Mohan et al. 2022; Dilipkumar & Lohchab 2021). • Lack of a personal touch is raising concerns that care via remote counselling is inadequate. Technological errors and scepticism over privacy make it difficult to establish trustworthy and secure digital counselling spaces. • Currently, there are no national standards for evaluating the effectiveness of the hundreds of mental health applications available. There also exists no scientific evidence to prove that these innovative tools work and work as well as traditional methods (NIMH n.d.).
Lack of Clarity on Privacy and Confidentiality	• Health privacy is increasingly emerging as a concern due to the rapid rate of technology integration in healthcare. New technologies (e.g., mobile apps and devices) can track, record and leverage substantially larger amounts of sensitive patient information but in the absence of central regulations on data, there is no guarantee of privacy and data security (Wadhwa 2021; Stuart 2006).
Exposure to Triggering Digital Content	• Social media exposes people to risky content, making them vulnerable to cyber-bullying, changing their behavioural patterns, causing feelings of inferiority, and resulting in grave mental health issues. In the absence of well-defined measures for controlling crime, monitoring access and safeguarding people, young children and adolescents are particularly at risk (Chauhan & Yachu 2022). • Internet-based gaming addiction has seen a significant rise, especially during and post-pandemic, causing a rise in behavioural disorders among adolescents and children as well as an increase in mental health issues (Amin et al. 2022).

Legal Challenges

Absence of legal provisions to regulate the quality of care and digital solutions, lack of central regulation of inclusion of mental health in insurance policies, limited state-level accountability on policy implementation is creating systemic challenges in access and quality (Karia 2020; Chadda 2020).

Ineffective Implementation of Mental Healthcare Act of 2017	• Most states do not fulfil the MHA, 2017 mandate of having a functional authority within nine months of the enactment of the law. A majority of the states are yet to draft the rules of the Act and ten states have not yet set up SMHAs (The Pioneer 2019). This lack of state-level prioritisation and functioning SMHAs is a concern (Pratap 2021). • There are insufficient judicial and quasi-judicial officers to chair the Mental Health Review Board and inadequate membership due to a lack of trained eligible psychiatrists, highlighting a supply-demand gap (Agarwal 2021).
Exclusion of Mental Health in Insurance	• The IRDA doesn't regulate and monitor the implementation of Section 21(4) of the MHA which requires insurance companies to include mental health as part of their health Insurance plans, thereby causing major affordability challenges (Financial Express 2020).
Absence of Systemic Regulation of User Privacy	• Although the Health Data Management Policy under the National Digital Health Mission provides guidelines for the management of health data and records, there is limited information on third-party regulations, increasing the risk of privacy breaches of users. • Although the Personal Data Protection Bill, 2019 calls for a national-level Data Protection Authority (DPA) to supervise and regulate data fiduciaries, coverage of mental health apps under its purview is unclear (Personal Data Protection Bill 2019).
Lack of Standardised Guidelines for Mental Healthcare	• Despite the provision of standard guidelines for delivering mental healthcare, there is a need of a 'guidance document' or 'Code of Practice' from a statutory body to ensure that all stakeholders are able to implement it to provide consistent care across all states (Nallur 2019). • There is no central database regulating or verifying both the qualifications of professionals providing mental healthcare and the number of patients receiving care. The integration of mental health data in the proposed ABDM registry is unclear (Vishwanath 2022). • Quality standards and protocols are absent and are creating challenges in delivering effective and accessible interventions (Rajan 2022).

MHCA – Mental Healthcare Act; CMHA – Central Mental Health Authority; SMHA – State Mental Health Authority; IRDA - Insurance Regulatory and Development Authority.

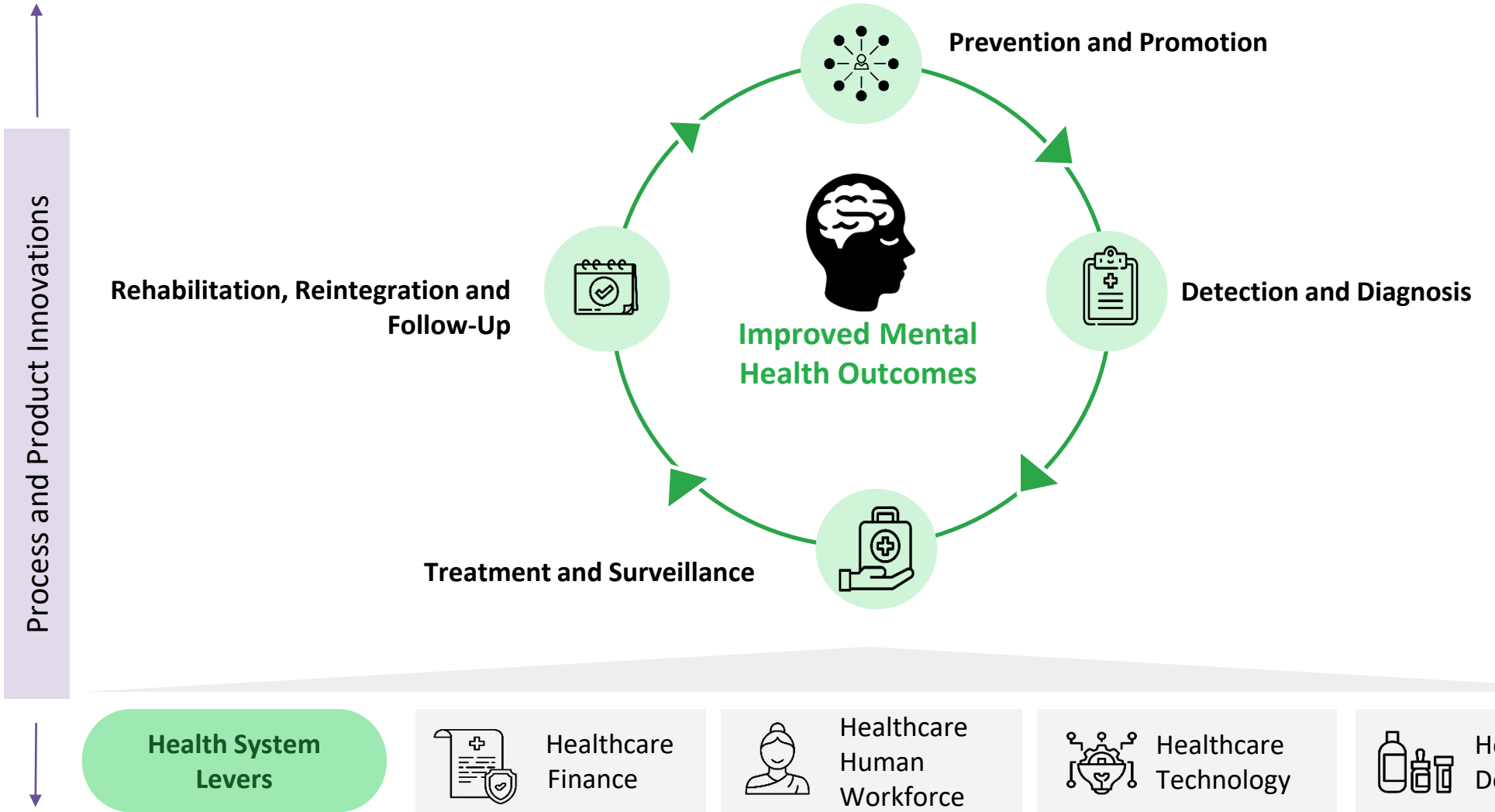
Environmental Challenges

Climate change, pollution, health disasters complimented with rising urbanisation are increasing the prevalence of mental disorders and impeding equitable delivery and access to care.

Urbanisation	• Living in overcrowded or unsafe spaces, especially in high-density regions in rural India, causes communicable and noncommunicable diseases, which may lead to psychological distress, stress and anxiety. • Greenery is known to lower the prevalence of disorders, and the lack thereof is contributing to a rise in mental health issues (Bolton et al. 2022; The Health Site n.d.).
Climate Patterns and Climate Change	• Climate change poses a rising threat to mental health and psychosocial well-being, where affected persons showed signs varying from emotional distress to anxiety, depression, grief, PTSD, and suicidal behaviour (Intergovernmental Panel on Climate Change) (APA n.d.; WHO 2022b). • Adverse environmental conditions limiting access to clean food, air, water, and loss of livelihood lead to stress and anxiety (Padhy et al. 2015).
Pollution	• Increased exposure to air pollution, specifically particulate matter, induces inflammation and stress in the brain that can lead to depression, anxiety, schizophrenia, personality disorders, and even suicide (Rakshit 2021). • Studies show that noise pollution induces stress and is associated with a two-fold higher prevalence of depression and anxiety in the general population (Binder et al. 2016).
Health Disasters	• Health disasters cause public havoc and may require isolation which leads to extreme psychological distress, poor sleep, anxiety and depression. The severe illness or death of loved ones may cause PTSD, mood disorders and even suicidal tendencies in affected persons. Depressive and anxiety disorders both saw an increase of 28% and 26% post-COVID (Panchal 2021).
Manmade and Natural Disasters	• Many studies reported an increase in short-term and long-term mental health consequences, such as depression, PTSD, anxiety and suicidal tendencies among disaster survivors (Kar 2010; Public Health Degrees n.d.; Makwana 2019).

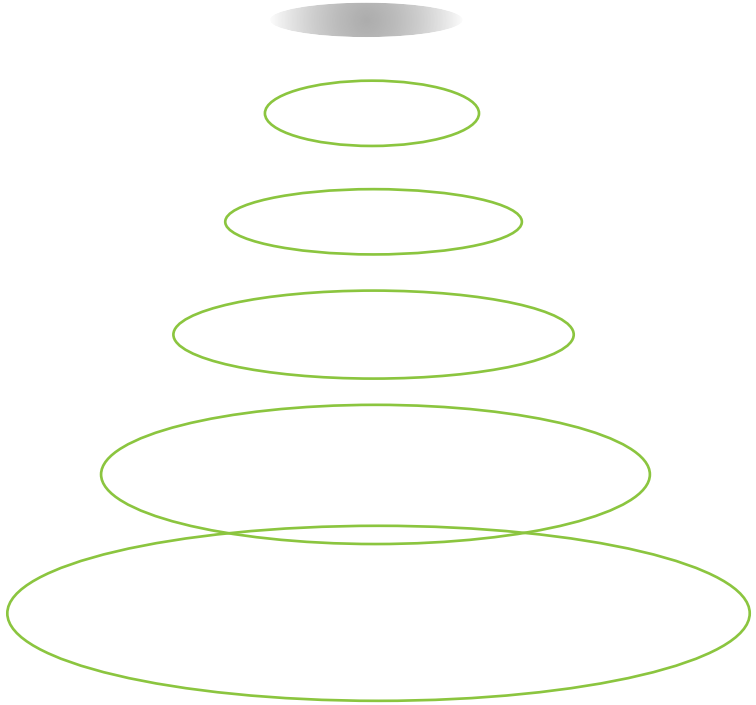
RECOMMENDATIONS FOR ACTION

There are eight critical levers across the continuum of care and health system, that are key thrust areas to drive action in mental health.



A multistakeholder approach at all levels is critical.

All stakeholders in the mental health ecosystem play a strong and unique role in supporting necessary programmatic interventions as well as enabling appropriate, evidence-based care in a sustainable manner



1. Apex leadership (state and central governments and quasi-government bodies) play an indispensable role in strengthening health systems, setting up governance mechanisms, and driving accountability and inclusion at all levels of the system.

2. Funders, businesses and solution providers are critical enablers for innovation, data and evidence-building, and prioritisation of effective solutions, through the adoption of inclusive and integrated approaches.

3. Those organisations and state machinery that lead implementation in states are uniquely positioned to drive direct impact at scale. Collaborations with governments, funders and solution providers, with a focus on proven models, can enable sustainable systemic change in mental health.

Each stakeholder is uniquely positioned to drive mental health outcomes.

Stakeholders	Prioritisation	Investment/Ownership	Successful Solutions	Role
Apex Leadership: Central Government, State Government and Quasi Government Bodies				Implementer Funder Enabler
Innovators and Solution Providers				Enabler
Businesses (Workplaces)				Implementer
Funders: Domestic Funders, International Funders, and Corporates				Funder
Healthcare Providers				Implementer
Implementing Organisations: NGOs, Training Institutions and Think Tanks				Implementer

Key:


Nascent


Emerging


Active/Notable

Community incubators and accelerators are also critical for implementation and adoption across communities. We view them more as key players that support action rather than stakeholders who drive change in the broader mental health ecosystem.

5 key principles should guide stakeholder actions.

1. **Focus on the continuum of care and health system pillars**
   Stakeholders should focus **on driving solutions across the continuum of care and health system pillars**, enabling sustainable, scalable and inclusive mental health services.

2. **Recognise and address drivers of mental health**
   Stakeholders need to view mental health as a **function of social determinants and stressors** and ensure that mechanisms for the delivery of care recognise underlying stressors and root causes for sustainable interventions.

3. **Enable task-sharing**
   For mental health to be truly democratised at the primary level, it is important to **train non-specialist workers from within the community itself**, who can complement the services offered by PHC personnel and other referral systems with contextualised care.

4. **Adopt an intersectoral approach**
   Integration of mental health with other sectoral interventions will facilitate trust-building and acceptance among communities to drive greater impact for mental health outcomes and also channelise investment to mental health with others sectors.

5. **Ensure community-centric action**
   Stakeholders should adopt a structured approach to ensure that the **community is at the core of both design and delivery of care**; care should be specific to community needs and sociocultural environments, and solutions should integrate care within existing community systems and platforms to enable ownership and sustainable impact.

The government must focus on increasing budgets, ensuring the effective implementation of policies across states, and establishing standards for the quality of care as well as for the regulatory mechanisms of digital solutions.

The government is uniquely positioned as an enabler, implementer, active investor, and resource provider, capable of driving higher impact through the strengthening of technological, economic and legal pillars.

P

- Increase budgetary allocations for mental health and encourage spending.
- Set up M&E mechanisms to ensure implementation of all the provisions of the policy and the Act across all states.
- Set up referral linkages across the value chain of care to streamline the delivery of care and strengthen primary care.

Ec

- Mandate mental health provisions for employees in both formal and informal sectors.
- Enable market systems to encourage increased investment in mental health.
- Enable innovations and digital solutions in mental health, with defined systems for regulation, privacy and accountability.

S

- Drive mental health literacy in communities.
- Address sociocultural drivers of mental health through integrated approaches.
- Leverage community platforms and champions to strengthen primary care delivery, including implementation of DMHP.

T

- Build guidelines and regulatory mechanisms to govern the quality of care provided by mental health practitioners.
- Create institutionalised channels for testing, adoption and monitoring of digital solutions.

L

- Ensure accountability of states for implementation of DMHP and functioning of State Mental Health Authorities.
- Ensure equity and inclusion in mental health policies and practice, across public and private sectors.

En

- Devise effective policies and allocate budget to better manage and provide for mitigation of mental health issues arising from climate-led crises and natural disasters.
- Integrate mental health as a component in existing environmental policies.
- Provide distress management support and mental health services for climate change-induced victims of livelihood loss and internal migration.

The government is strategically positioned to prioritise solutions in:

- **Healthcare Infrastructure:** To enable last mile service delivery.
- **Healthcare Finance:** To ensure that solution providers are able to finance and provide sustainable mental healthcare services.
- **Healthcare Human Workforce:** To ensure a trained mental health workforce for the timely detection and treatment of mental illness.

Funders can increase mental health funding across portfolios, integrate mental health across sectoral interventions, and promote equitable access to solutions for all marginalised groups.

Funders are uniquely positioned as an enabler to enable high impact through the strengthening of technological, economic and social pillars and by mainstreaming mental health as an area of funding.

P

- Invest on building evidence around mental health which can help in designing and strengthening policies for mental health.
- Drive collaborative approaches to integrate solutions with existing public health systems and catalyse systemic action.

T

- Leverage risk capital to invest in innovative scalable and sustainable solutions.
- Develop a common platform to collaborate with existing mental health organisations to share best practices and identify areas of investment.
- Create responsive platforms for healthcare delivery, as well as channels for product innovation that facilitate peer-to-peer learning.

Ec

- Develop life programmes for marginalised and vulnerable youth.
- Provide vocational training and pathways to enable better employment opportunities for people with chronic and severe mental illness.

En

- Invest in existing programmes and develop new mental health programmes and interventions for people who have been affected by climate change and developmental projects.

S

- Invest in projects and programmes that are focused on community involvement, locally contextualised solutions and psychosocial intervention.
- Invest in awareness programmes targeted at vulnerable groups such as minorities, blue-collar workforce, and migrants.

Funders are strategically positioned to prioritise solutions in:

- **Healthcare Finance:** Leverage impact finance to scale innovative mental healthcare models.
- **Rehabilitation, Reintegration and Follow-up**: Invest in programmes that provide pathways for people with chronic and severe mental health to reintegrate into the community and access employment opportunities.
- **Promotion and Prevention:** Provide mental health programmes with access to sustainable funding.

Businesses can promote mental well-being at workplaces and address sociocultural stressors leading to mental health issues

Businesses are uniquely positioned as an implementer to enable high impact by prioritising mental health at both formal and informal workplaces and recognising the economic benefits of investing in mental health.

Ec

- Drive sustainable well-being practices across the supply chain to ensure the mental well-being of employees at all levels.
- Establish a confidential Employee Assistance Program to support employees with stress and anxiety both at the workplace and in their personal life.
- Formulate mental health policy for the workplace to ensure productivity and overall mental well-being of employees.
- Include mental health in the extended value chain recognising broader economic benefits from increased productivity, lower absenteeism and lower turnover.

S

- Recognise structural stressors to create a workplace free from discrimination, bias and harassment.
- Promote equity in practices to ensure inclusion of vulnerable groups such as minorities, blue-collar workforce, migrants and more.

L

- Provision for leaves and compensation for people suffering from mental illness to create a well-being-focused work environment.
- Drive inclusion of mental health in health insurance for employees and create systems to address barriers in access.

Businesses and social enterprises are strategically positioned to prioritise solutions in:

- **Prevention and Promotion:** To drive mental health conversations and ensure provisions that support mental health at work.

Implementing organisations can integrate efforts with existing public systems, customise solutions to sociocultural needs, and ensure community-led models and capacity building.

NGO

Implementing organisations are uniquely positioned to enable high impact by strengthening the technological, economic and social pillars.

P

- Set up a robust data-driven MLE process to collect evidence from the field which can then be synthesised to enable advocacy and policy reform.
- Collaborate with public systems and enable systemic strengthening around mental health.
- Advocate with local government bodies to prioritise local needs that require action.
- Advocate for better implementation of DMHP as well as capacity-building of government staff for better delivery of care.
- Allow community voices to guide programmes, and ensure that the community is at the centre of all design and delivery of care.

En

- Provide psychosocial support to people affected by environmental disasters.
- Design programmes at the intersection of mental health and the environment to ensure that vulnerable groups adversely affected by disaster receive mental health support.

T

- Embed technology solutions to increase accessibility and affordability of mental health services, in a sustainable way.
- Integrate digitally equitable solutions and tools to train both health and non-health cadres in delivering mental health services.

S

- Embed mental health services within existing essential services and programmes.
- Train community members and non-medical resources to enable task shifting towards a Stepped Care Model, to deliver mental health services.
- Design programmes that address the social stressors of mental health and democratise access to mental health services.

Implementing organisations are strategically positioned to prioritise solutions in:

- **All four Levers of the Continuum of Care**: To ensure availability, accessibility and affordability of mental healthcare services for the underserved, drive awareness and health-seeking behaviour, and de-stigmatise mental illness within the community.
- **Healthcare Technology**: To adopt technological solutions that enhance the delivery of mental health services.
- **Healthcare Human Workforce:** To train community members and local leaders and enable task-shifting for basic counselling and care delivery.

Healthcare providers can move beyond a treatment-focused approach, exchange knowledge on best practices, and enable the capacity building of a non-specialist cadre.

Healthcare providers are uniquely positioned as implementers to enable high impact by strengthening the social and political pillars and encouraging adoption of non-medical and psychosocial approaches for addressing common mental disorders.

P

- Advocate creation of curriculums and tools for detecting mental illness to frontline workers, teachers and stakeholders at the primary care level.
- Advocate Inclusion of mental health as a part of the pre-service core curriculum for general medical professionals.

T

- Create certificate training programmes for non-medical providers and community members to ensure the adoption of technology solutions, and act as primary touchpoints for queries.

Ec

- Initiate Public Private Partnership to facilitate the integration of private sector providers and pharmacies to build capacity and create referral channels.

S

- Adopt psycho-social approaches to engage with communities and community influencers to build trust and create an enabling environment for care.
- Design of care delivery model in partnership with existing structures such as Jan Arogya Samitis, local HWCs etc., that the community trusts enough to participate in.
- Ensure recognition of local contexts and structural stressors in the provision of care.
- Move beyond a treatment-focused approach to prioritise and actively engage in prevention, promotion and self-care.
- Enable task-sharing and support capacity building of non-specialist staff for mental health screening and basic care.

Healthcare providers, training institutions and the community are strategically positioned to prioritise solutions in:

- **Prevention and Promotion:** To drive mental health conversations and ensure provisions that support mental health at work, moving beyond a solely treatment-focused approach.
- **Detection and Diagnosis:** To advocate for standardised approaches to early detection and diagnosis of mental illness.

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