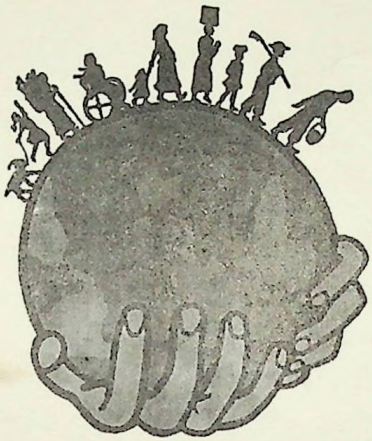
Mental Health in India

– An Overview



Prepared for the Second National Health Assembly (NHA-2)

Bhopal, Madhya Pradesh

March 2007

Work in progress

(This section is to be included in a booklet on 'Defending the Right to Health for Various Sections of the Indian people!' In case you have any suggestions, please contact D. M. Naidu (naidu@basicneedsindia.org), Bhargavi Davar (bvdavar@gmail.com) or Kamayani (cehat@vsnl.com).

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1. INTRODUCTION

Mental, behavioral and social health problems are an increasing part of health problems in the world and in India too. Though the burden of illness resulting from psychiatric and behavioral disorders is enormous; it is grossly under represented by conventional public health statistics, which lead to focus on mortality rather than morbidity and on being dysfunctional. The number of people with mental illness will increase substantially in the coming decades. It is seen that there is an increase in the number of young adults with mental disorders, and 50-75% of mental disorders begin during youth. Secondly, there has been substantial increase in the geriatric population having mental health problems, as the life expectancy is increasing. Thirdly, social factors which are established risk factors are also causing a change in the rate of depression seen in all age groups. For instance, besides depression, anxiety and stress caused by different reasons are also affecting children.

Mental and behavioral disorders account for 12% of the global burden of disease. It is estimated that nearly 450 million people suffer from a mental or behavioral disorders in the world. Nearly 10 % of disability adjusted life years (DALYs) across all age groups are due to depressive disorders, suicides and alcohol related problems. Depression ranks third among men and second among women, yet mental health budgets of most of the countries are less than 1% of the total health expenditure. Mental disorders also kill in many indirect ways such as suicides, worsening the outcome of physical illness, medical complications and injuries related to alcohol abuse (i.e mental disorders as a risk factor for other health problems),unhealthy lifestyles and so on.

2. GROUND REALITIES

2.1 Demographic Characteristics

India is a country with an approximate area of 3287 thousand square kilometres (UNO, 2001). Its population is over one billion and the sex ratio (men per hundred women) is 106 (UNO 2004). The literacy rate is 68.4 % for men and 45.4% for women. The proportion of population under the age of 15 years is 32 % and the proportion of population above the age of 60 years is 8%. The life expectancy at birth is 60.1 years for males and 62 years for females. The healthy life expectancy at birth is 53 years for males and 54 years for females.

2.2 Prevalence

A majority of the classical psychiatric epidemiological studies in the last four decades have been population based, focusing on general psychiatric morbidity in a small to medium population. From these house-to-house surveys, it is found that:

- An estimated 1 percent of the population, including children suffer from severe mental disorders.
- Five to ten percent of the population are reported to have common mental disorders.
- 15 – 20 % (in some studies it is 40 %) of the people approaching primary health care centers, general hospitals or private clinics for general health problems requires psychiatric assessment and evaluation. Some of them are not aware of it. They think and believe that they have some physical illness, and take various methods of treatment for relief, often in vain. Some of them are not aware they suffer from a biomedical mental illness, but they are aware that their symptoms are related to stress. In most other cases, the morbidity is unrecognized by doctors who treat the condition with symptomatic drugs .

If this figure is projected in India, there would be more than ten million people suffering from severe mental illness, and the figures for common mental disorders would be five to ten times that of severe mental illness. In addition there are issues related to suicide, substance abuse and mental disorders in children. There is also a close association of mental illness with the larger social development agenda, such as the Millennium Development Goals (MDGs).

2.3 Mental Health Care

Mental health care has always been influenced and determined by contemporary beliefs, and India is no different. Traditionally, mentally ill people were often cared in temples and religious institutions, based on the principles that mental illness is a form of spiritual affliction and could thus be cured by religion. Superstition with inadequate mental health services in the community makes subjects people with mental illness to various harmful treatments. Often, certain treatment practices by black-magicians, village quacks, witches and physical abuse in the name of treatment can have harmful effects on the people with mental illness. They are kept outside the margin of the community by being chained, locked in rooms, found wandering on the streets, or staying for ever in closed wards of asylums, hospitals, etc. Bhoot mela in Chincholi in M.P. and Pingalwada in Rajasthan are examples of societal responses to mental health problems. While the situation described above is mostly applicable only for the rarer, severe forms of mental disorder (e.g. psychotic disorders) the vast majority of mental disorders are either managed at home or through primary care

2.4 Stigma and Discrimination

A large section of people with mental illness are still locked inside their houses without any treatment, because their family members don't recognize the illness or they find it embarrassing to be recognized as family member of a mentally ill person, who are commonly called as 'mad'. There is also a fear that they would be victims of disgrace and indignity and thereby lose the status or acceptance they enjoy in the community. The stigma is so tremendous that people feel ashamed and deny the illness. Therefore, the first and foremost element that shrouds the realm of mental illness is stigma attached to it. The very thought of some one in the family getting mental illness is a big shock and they do not want to believe it.

Due to stigma attached to the families, people with mental illness become the victims of discrimination and human rights abuse. The discrimination is seen from the family members and goes right up to the policy makers and state authorities. The attitude of the public is often, "*who cares about what is done for people with mental illness*". People with mental illness have been treated as second-class citizens with no adequate facilities given, either at the state or the central government. As a result they face chronic ill health, and are seen as an economic and social burden to the community, leading to social destitution. Soon families lose hope and are left to the mercy of others.

Demand for dowry and the mental torture associated with it is the single most important gender related cause of exogenous depression and anxiety, being responsible for suicides by young married women, who prefer dying to living a life of torture, with NO HOPE OF ESCAPE. The mental torture faced by childless women & women who "fail" to produce a male child has continued to remain unaddressed , rape & sexual harassment of girls & women & their sense of feeling "polluted for life " and therefore unfit to live has been responsible

for many lives being scarred for life , when it should be the rapists who should be made to feel the shame rather than the victims.

2.5 Human Rights Violations

People lock or chain their kith and kin under pressure from others, due to helplessness and ignorance. It happens due to the ignorance of family members and community in which they live. It happens in hospitals, asylums and special homes. It is grossly inhuman. Violence against women is a public health concern in all countries and especially women with mental illness are often subjected to physical and sexual abuse.

2.6 Existing Laws

As per the law, a person with mental illness cannot sign any documents of sale, purchase, lease or any contract. The act is silent on these issues during the lucid moments or stabilized stage. Family members, mostly brothers, take undue advantage of this clause to deny property rights to the person with mental illness and enjoy all the property.

Marriage and Divorce Act also permits legal separation of life partners if one of them is found to be mentally ill (certified by a psychiatrist). Generally in rural communities men are permitted to marry for the second time if his first wife is suffering from any disease like mental illness, epilepsy and so on. On the other hand if a married man becomes mentally ill, the community insists that the wife continues to be the caregiver. If a family has a person with mental illness, getting life partner for a boy or girl from that family is almost next to impossible because of the stigma, as it is seen as a family illness. There are occasions where they hide the information and problems erupt after the marriage. It is also common that a close relative gets pressurized to marry such a person.

Mental Health Act has been misused by many men to dump their perfectly normal wives ,by getting them falsely certified as mentally unsound , many times after paying the doctor for providing such a false report . This allows the husband to remarry for another round of dowry or for just getting the wife out of the picture so as to lead a life of "freedom" and to not be reminded of their responsibilities

Stigma also affects health care insurance - many companies exclude mental illness from their cover.

2.7 Social Determinants

Poor people with mental illness are not only vulnerable due to their condition, but also due to the vulnerability brought about by poverty, which is related to their condition. One of the main reasons that people find it hard to accept people with mental illness as equal members of their communities is that they do not see them as capable of contributing to the household or the community. The effects of social determinants such as poverty, conflict, gender disadvantage, social exclusion, etc. on mental illnesses are well known. It is also found that, people are not able to access care due to their social conditions. And due to inadequate treatment, people with mental disorders remain disabled for longer and incur greater health care costs and lesser ability to work, thus worsening poverty.

3. INFRASTRUCTURE AND PRESENT STATUS

The major changes in mental health scenario began with the tragedy at Erwadi, the asylum fire in the Ramanathapuram district of Tamil Nadu. It was a disaster that opened the eyes of policy makers and the general public to attend to the needs and voices of people with mental illness. During the last 50 years, the place of mental health as part of the general health has changed to some extent. From a situation of no organized mental health care at the time of independence, currently mental health issues are seen as part of the public agenda in a few places at least and part of the credit goes to the intervention of the judiciary.

While mental health has been stated as part of primary health care system on paper, primary health centers (PHCs) are not equipped to treat people with mental illnesses in their centers. Only few primary health centers (where programmes such as the District Mental Health Programme or DMHP are implemented) provide mental health care and treatment in the community. In addition, PHCs are not geared towards the provision of chronic disease care (which is a characteristic of most mental disorders), and psychosocial interventions are rarely available in any sector.

3.1 Treatment Facilities

Most of the district hospitals are not fully equipped and supplied with psychiatric medicines to treat people with mental illness; most often they are referred to multi specialty centers in the capital cities or big towns. Many medical professionals view mental health as an alien subject and do not give importance to either learn or practice it in their day-to-day practice.

There are 42 mental hospitals in the country with the bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 people with severe mental illness and 5,12,51,625 people with common mental disorders needing immediate attention.

Psychiatric medicines have been supplied only in a few primary health centers, community centers and district hospitals. Amitriptyline, lithium, chlorpromazine (CPZ), phenobarbital, phenytoin sodium, haloperidol, carbamazepine, imipramine and risperidone are made available in a few district hospital. The rates of risperidone (better drug than CPZ in terms of side effects) are cheaper then CPZ. Unfortunately, drugs like CPZ which have lesser utility have been purchased in surplus, (for example in Karnataka). Adequate laboratories facilities are also lacking in the district hospitals to find out the serum level for lithium administration. None of these drugs are routinely distributed by government to the primary health centers except in some districts, where DMHP is operational.

In many places, Electro Convulsive Therapy (ECT's) continues to be misused and overused and if used where indicated, it is often used irrationally in higher doses & without adequate use of muscle relaxants..The guidelines drawn up are not adequately circulated & rational use of mental health medicines and technologies are not emphasised. The high costs of medicines for mental health promotion and treatment of mental disorders for extended periods of time puts a great strain on the family members and other care givers.

Services like child guidance and rehabilitative services are also available only in mental hospitals and in big cities.

One third of the mental health beds are in the state of Maharastra and several states do not have mental hospitals. Some mental hospitals have more than 1000 beds and several still have a large proportion of long stay patients. During the past two decades, many hospitals have been reformed through the intervention of the voluntary organizations, media, National Human Rights Commission (NHRC) and the judiciary.

Availability of psychiatric beds in India

Total psychiatric beds per 10,000 population	0.25
Psychiatric beds in mental hospitals per 10,000 population	0.2
Psychiatric beds in general hospitals per 10,000 population	0.05
Psychiatric beds in other settings per 10,000 population	0.01

The survey of 37 mental hospitals conducted between November 2001 and January 2002 revealed a dismal picture. Apart from poor infrastructure, the greatest deficiencies were in the area of qualified staff. Some mental hospitals do not have even a single psychiatrist on their permanent roster.

Survey results of mental health facilities in India

Sl. No.	Facilities	Adequate		Inadequate	
		Number	%	Number	%
1	Infrastructure	12	32.4	25	67.6
2	Staff	10	27	27	73
3	Clinical services including investigations	16	43.2	21	56.8
4	Availability of medicines and treatment modalities	28	75.7	9	24.3
5	Quality of food	23	62.2	14	37.8
6	Availability of clothing and linen	15	40.5	22	59.5
7	Recreational facilities	18	48.6	19	51.4
8	Vocational rehabilitation facilities	14	37.8	23	62.2

The fact that many mentally challenged and ill persons are being taken to faith healers is also because of the absence of mental health facilities. Many of these illnesses are preventable, as well as treatable as they are acute reactions to a situation ,only if they are diagnosed in time and handled appropriately, not allowing them to be neglected, so that they progress unchecked into a chronic mental health problem.

In the above context, helping build a high emotional quotient to deal with ups & downs of life is very important. Contributing to building this in the health as well as education system is important. Use of simple tools like the Holmes & Rahe Stress Index to assess levels of stress before the fall-out presents itself as acute crisis or a serious psychsomatic disease, could be done. Stress management approaches have to be adapted to deal with the problem and its root causes, long before the stress manifests as a mental problem.

3.2 Mental Health professionals

We have limited facilities to train human resource in mental health. The irony is that inspite of this, all centers have become centers to export trained mental health professionals abroad. Many mental

health professionals are immigrating to other developed countries, where jobs are more lucrative. For instance in 2003 itself, more than 82 psychiatrist sought short term and long term employment in the United Kingdom in response to the latter's international recruitment drive.

Undergraduate training in psychiatry is not changing in spite of many efforts and this continues to be a major barrier to create medical doctors adequately trained in psychiatry after their basic training. Some of the government and private medical colleges do not have the departments of psychiatry in its full strengths to train young medical graduates in psychiatry,

The inadequacy of mental health human resource is a major barrier in caring for people with mental illness in the community. Even most of districts don't have public sector psychiatrists. Comparatively mental health professionals are more in the states of Kerala and Tamil Nadu. Very few mental health professionals are based in rural areas. Many states allow public sector psychiatrist to have private clinics.

Availability of mental health professionals in India

Number of psychiatrist per 100, 000 population	0.2
Number of psychiatric nurses per 100,000 population	0.05
Number of psychologist per 100,000 population	0.03

3.3 General Hospital Psychiatry

It is speculated that the birth of general hospital psychiatry in India was due to lack of sufficient funds to open more mental hospitals. These new units needed mobilization of very few resources like a little space in an already functioning hospital and few mental health professionals to manage the people with mental illnesses. What probably started as an economic necessity, has now become a major

force in the delivery of health care. A provision for establishment of inpatients wards for people with mental illnesses requiring admission has been provided in the Mental Health Act. It has to be noted that the psychiatric units in the general hospitals are not well established, and are not able able to take care of psychiatric problems associated with other illnesses.

3.4 Private Psychiatry

It is interesting to note that very large numbers of private psychiatrist have located themselves in cities that are district headquarters but are not the state capitals. The reason could be that most state capitals have medical college departments of psychiatry or some other governmental psychiatric facility and a private psychiatric facility would be more welcomed in other cities of the state where no such facility exists. It seems that distribution of private psychiatrists in India is in a way related to the position of the states in socioeconomic hierarchy. Thus relatively prosperous states with higher number of literate people (like Kerala and Tamil Nadu) have the highest number of psychiatrists. North zone has proportionately lesser number with the exception of Punjab and Delhi. States of the Central and East zone have the least number of psychiatrists in private practice.

3.5 Mental Health Financing

The country spends 2.05% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurance and social insurance. Government fund for health services are provided both by the states and the center. In the tenth five-year plan estimates, mental health constituted 2.05% of the total plan outlay for health. The country has a Disability Act, which has included mental illness as the seventh disability. However in reality, people with mental illness rarely avail any benefits available under disability schemes.

3.6 Regional Disparity

The state run health care system in India is striving hard to overcome the regional disparity between rural and urban. The adequate health services and the normal health standards in rural areas seem to be much below the average. Cities and big towns are growing with private health care facilities catering to the needs of middle class and rich communities. The costs for diagnosis and treatment are so exorbitant that some get into debt traps. In rural areas hardly any facilities exist and the attitude of the government health professionals are often not patient friendly. The budgetary allocation for mental health is very meager, as most of it goes to maintenance of hospitals and a very little portion for treatment.

3.7 Non-Governmental Organisations (NGOs)

NGOs are involved with mental health in the country mainly in the areas of advocacy, promotion, prevention, treatment and rehabilitation. They are also involved in counseling, suicide prevention, training of lay counselors, and provision of rehabilitation programmes through day care, sheltered workshops, halfway homes, hostels for recovering patients and long term facilities. There are also self-help groups of parents and people with mental illness that have been recently established. It has to be noted that most of the NGOs have their setups and outlets in the urban areas catering to the needs of middleclass and higher economic groups.

It is evident from the above reading that mental health care in India is characterized by:

(i) Very limited mental health care facilities;

(ii) Grossly inadequate professionals to provide mental health care;

(iii) Less than 10% of those needing urgent care are getting any modern medical care;

(iv) Families are the current care providers but with limited support and skills for care

(v) No support schemes for voluntary organization;

(vi) Lack of a regular mechanism for public mental health education;

(vii) Limited administrative structure for monitoring the mental health programme and

(viii) Limited budget for mental health care as part of the total budget

4. POLICY AND LEGISLATION

4.1 National Mental Health Programme (NMHP) 1982

The National Mental Health Program is the outcome of the developments in providing mental health care through different methods as well as the overall goals of the health care in general. The first concerted efforts to formulate a national program were held in July 1981. Later, on August 2 1982, a small group of experts met to consider the revised document and finalize the same. This document was presented to the central council of health and family welfare and the committee recommended the NMHP for implementation.

The **objectives** of the program are:

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged of the population
- To encourage application of mental health knowledge in general health care and social development.
- To promote community participation in mental health services development and to stimulate effort towards self–help in the community.

The specific **approaches** suggested for the implementation of the NMHP are:

- Diffusion of mental health skills to the periphery of the health service system
- Appropriate appointment of tasks in mental health care
- Equitable and balanced territorial distribution of resources
- Integration of basic mental health care with general health services
- Linkage to community

4.1.1 Progress of the NMHP

From the time of the formulation of the NMHP in August 1982, in the last two decades the following initiatives and activities have been taken up in districts where the district mental health programme has been implemented:

- Sensitization and involvement of state level programme officers
- Workshops for voluntary agencies
- Workshops for mental health professionals namely psychologists, psychiatric social workers and psychiatric nurses
- Training programmes in public mental health for programme managers
- State level workshops for the health directorate personnel, development of models of integration of mental health into primary health up to the district level
- Preparation of support materials in the form of manuals, health records for different types of health personnel and health education materials

- Training program for teachers of undergraduate psychiatry
- Initiation of district mental health programme in 28 districts of 22 states
- Expansion of district mental health programme for 100 districts with the budgetary allocation of rupees 190 crores in the 10th five-year plan (2002-03 to 2006-07).

4.2 The District Mental Health Programme (DMHP)

The DMHP, which operates as part of the National Mental Health Programme was launched in 1996-97 in four districts. By 2000 the DMHP was extended to 22 districts in 20 States and Union Territories and by 2002 the DMHP further extended to 27 districts in 22 States and Union Territories, providing for services to over 40 million of the population. In the current 10th plan period the government has announced the programmes extension to 100 districts across the states, with a total budget outlay of 200 crore rupees

There have been many barriers to reach the goals set out in the 1982 document. The goals were too ambitious to begin with and sufficient attention was not paid to all aspects of implementation of NMHP. The other important barrier has been the lack of funding. Though NMHP came up in 1982 the subsequent three five years plans did not make adequate funding allocation. Further even the funds allotted were not fully utilized. It was only in the 9th Five-year plan that a substantial amount of Rs 28 cores was made available and it was projected to be Rs 190 cores in the 10th Five-year plan.

The critical review of District Mental health programme reveals that:

a. There was lack of administrative clarity to utilize the allocated funds. The programme looked good on paper, but was extremely unrealistic in its targets, especially considering the available resources of manpower and funds for its implementation.

b. The approach was top down and did not take into consideration the ground realities. The poor functioning of the primary health care in India in general as well as the poor morale of the health workers not taken into account. A structure that was attending to given tasks so inadequately would certainly be unable to absorb new targets of integration.

c. The DMHP continues to be the extension of professionals rather than integration of mental health with primary care

Central Government has sanctioned DMHP in 100 districts in the year 2004. The districts are yet to implement the programme and to appoint required mental health professionals for the programmes. It has to be noted that a few districts do not have psychiatrists and the facilities in the district hospital to support the mobile team of the district mental health programme.

4.3 National Health Policy- 2002

The 2002 National Health Policy (NHP 2002) refers twice to mental health. In its assessment of the current scenario, Section 2.13 states that: '*Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalisation and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP 2002 will address itself to these deficiencies in the public health sector*'.

Section 4.13 states the policy prescription towards mental health: *'NHP 2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.*

The proposed National Mental Health Policy outlines the prioritized agenda for extending within a pragmatic time frame basic mental health care facilities to all sections of the populations across the country by the year 2020.

4.4 Legislations Related to Mental Health:

The Mental Health Act of 1987 and the Persons with Disabilities Act 1995 are the two legislations that are directly applicable to people with mental illness. While these are legislations, the World Mental Health Atlas 2005, reports that there is no Mental Health Policy in India.

4.4.1 The Mental Health Act (MHA), 1987

Mental Health Act is "*an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their properly and affairs and for matters connected therewith or incidental thereto*". In the Mental Health Act, 1987, a modest attempt has also been made to bring mental illnesses on par with physical illnesses, thus reducing the stigma attached to mental illnesses

The Mental Health Act is not just a cosmetic improvement over the out dated Indian Lunacy Act 1912, but represents the conclusion of lengthy presentation by the Indian Psychiatric Society to the Government of India. This Act came into force in April 1993, as per the Government of India order, even though it is still in hibernation in some states. The establishment of mental health authorities, both

at the center and state is a welcome step. These authorities are expected to act as a friend, philosopher and guide to the mental health services. Provisions have been made for establishing separate hospitals for children under the age of 16 years; for people abusing alcohol and other drugs and for other special groups. Emphasis on outpatient care has been made to safeguard the human rights of the mentally ill person. Stringent punishment has also been prescribed for those who subject the mentally ill to physical and mental indignity within hospitals.

The notion of care in the community has not been addressed in the current legislation. No effort has been made to provide after care services for the discharged patients. There is no thinking over the alternative to hospital care. Authorities are using the clauses of the act leading to many medico-legal problems, and difficulties for the private nursing homes.

The Ground Realities of its Implementation: The Mental Health Act has not been implemented in Arunchal Pradesh, Chhattisgarh, Uttaranchal, Bihar, and Orrisa. State Mental health Authority has not been constituted in Arunchal Pradesh, Chhattisgarh, Uttaranchal, Bihar and Orrisa. Mental health rules have been framed only in Goa, Manipur, Sikkim, Assam, Chandigarh, Delhi, Gujarat, Madya Pradesh, Mizoram, and Tamil Nadu.

4.4.2 The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, commonly called the PWD act came into force on February 7, 1996. This law is an important landmark and is a significant step in the direction of ensuring equal opportunities for people with disabilities and their full participation in the nation building. The Act provides for both preventive and promotional aspects of rehabilitation like education, employment and

vocational training, job reservation, research and manpower development, creation of barrier-free environment, rehabilitation of persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with severe disability etc. There are also statutory bodies for implementing the Act at central and state levels.

Even though it is encouraging that mental illness has been considered in the act, the later chapters of the act do not talk about any provisions to be given or set aside for people with mental illness. The act also does not assure the right to treatment. While there is much talk about the implementation or lack of implementation of the Act, there is little understanding about the indicators to measure the level of implementation. At present, conducting a session on the Act or putting up posters on the Act, are referred to as 'advocacy'. A clearly defined set of indicators for the implementation needs to be worked out. There is also a great need to come up with strategies to decentralize the implementation of the Act at the district/ taluk and village level.

5. CONCLUSION

The rate of mental illness is being increasingly recognised across different divides like the rich and the poor, urban and rural and so on. With some help from the judiciary, it seems like the states are taking notice of the gravity of the issue and attempting to address the needs of people with mental illness.

Health including mental health is a fundamental right. Millions in India perhaps, don't know that it is their right to avail treatment. People with mental illness are crying ***"My name is today"*** Do we hear their voice?

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Prepared for NHA II
by CHC

for more details, please contact

Community Health Cell (CHC),
Society for Community Health Awareness, Research and Action,
359, 'Srinivasa Nilaya, Jakkasandra 1st Main,
1st Block, Koramangala, Bangalore - 560 034
Tel : +91-80-2553 15 18 Telefax : +91-80-2552 53 72
email : chc@sochara.org Website : www.sochara.org