# Understanding mental health system governance in India: perspectives of key stakeholders

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## Abstract

*Introduction*

Governance, the least studied health system component, comprises a system of rules and processes, and is a key determinant for effective decision making for health care planning. This study aims to identify institutional, legal and policy factors which are either barriers or facilitators for the implementation of integrated mental health in primary care in the India.

*Methods*

Semi-structured interviews were conducted with 33 key informants at the district and national levels with policy makers, state level health care planners and district planners and managers in India. The data were analysed using thematic analysis using the qualitative software NViVO 10.

*Findings*

Participants stated that a conducive environment for mental health service delivery is necessary at the legislative, policy and planning levels, to facilitate integration of mental health into primary care. Amongst other factors, the need for active involvement of civil society and service user organisations, strengthening mental health information systems, and building the non-technical skills of the mental health workforce, were identified as particularly necessary to deliver adequate mental health services.

*Conclusion*

Amidst the favourable policy context supporting collaborative and integrated care in India, this study identified low resourcing, weak collaborations and inadequate information to be crucial for integrated mental health in India at present.

## Introduction

Mental disorders pose a significant health burden in India [1], yet the treatment gap is large. According to the National Mental Health Survey of India 2015-2016, the treatment gap for various mental disorders (including epilepsy, bipolar disorders, mood disorders, psychotic disorders, neurosis, alcohol use disorders and depressive disorders) ranges from 28% to 83%. Even though effective treatments for mental disorders exist, many people in need are thus denied the potential for alleviation of their symptoms or recovery in India [2].

Efforts to reduce the treatment gap in India are underway, with integrated mental health care at the primary health care level central to India's mental health and broader health policy and plans. The national health policy in India was revised in 2017. Mental health care has been given specific objectives within this revised health policy. Directing public financing to increase the number of mental health specialists, creating a psychosocial support system in communities, and investing in digital technologies to improve access to mental health care have been envisioned as specific priority activities within the policy [3].

India's first national mental health policies were published in 2014 [4]. The Mental Health Care Bill 2017 (GOI [5] and the National Mental Health Programme (NMHP) (MOHFW [6] envisage the delivery of mental health services by integrating these with primary care as the mechanism to close the treatment gap. As part of the NMHP, the District Mental Health Programme (DMHP) is a community mental health programme that aims to ensure mental health care for all by minimising the distress, disability and mortality arising from mental disorders.

India's mental health budget is a small proportion of the total health budget, with just 1.3% of the total health budget spent on the NMHP [7]. Funds for mental health are primarily used for maintaining and running the national and state level mental health hospitals, leaving even less

budget for primary care [8]. Apart from tertiary care, a small proportion of these funds is also spent on district mental health programmes (DMHP); mostly for outpatient services.

The DMHP enables the diagnosis and treatment of people with mental disorders by primary care providers such as doctors, nurses and frontline health workers. Apart from providing drugs, treatment is also planned to involve psychological interventions delivered by nurses and counsellors. For the management of severe cases, or cases with treatment resistant conditions, an upward referral system is envisaged to facilitate specialised care either at district hospitals, mental hospitals or other speciality facilities (ICMR [9]. However, current DMHP evaluations indicate its ineffective implementation (Shidhaye et al., 2016).

Strengthening the key health system pillars of service delivery, health workforce, health information systems, access to essential medicines, financing, leadership, and governance, are all necessary to make optimal use of these limited resources (WHO [10]. Good governance is central to strengthening these health system pillars to create a system that enables integration. According to the World Health Organization [11], good governance ensures a "strategic policy environment where services are delivered effectively with better regulation and there exists coalition building and attention to system-design and accountability" (WHO [12]. Therefore, poor governance can negatively affect mental health service delivery in primary care. The study forms part of the Emerald (Emerging mental health systems in low- and middle-income countries) research programme, aiming to generate evidence on scaling up delivery of mental health services in Lower and Middle-Income Countries and by doing so to strengthen mental health systems [13]. The aim of this study is to understand the system-level governance barriers and facilitators faced by India in implementing mental health services at the primary care level, by using Sehore district of Madhya Pradesh as an illustrative example.

**Methods**

Study design, settings and participants

A qualitative research design was used, with key-informant interviews (KIIs) with policy makers, planners and managers working within the mental health system at the national and state levels in India, and in one district site (Sehore in Madhya Pradesh, India). Sehore district was selected as an example in the semi structured question guide as setting for interviewing programme managers, service providers and planners as it is one of the districts where mental health services are implemented into primary care through PRIME programme [14]. A baseline situational analysis of mental health services in Sehore district has been described previously [15].

While there are a number of different governance assessment frameworks in the literature, this study was informed by a hybrid of two governance frameworks. The first is that of Siddiqui and colleagues [16] who describe ten governance principles (see Table 1 for definitions of these principles). These principles are rule of law; strategic vision; participation and consensus orientation; transparency; responsiveness; equity; effectiveness and efficiency; accountability; intelligence and information; and ethics. The second framework is that of Mikkelsen-Lopez and colleagues [17] who incorporated an evaluation of governance as it pertains to the WHO's six health system building blocks.

Siddiqui's governance principles have been combined with Mikkelsen-Lopez and colleagues' health systems approach (see Table 1) to create a combined framework, which has previously been used to assess governance to identify and address barriers to health systems' performance [18]. This framework recognises that Siddiqui's principles are inter-related. For instance, both the responsiveness and effectiveness principles are concerned with meeting

the needs of the population while making the best use of resources. Similarly, the transparency and accountability principles are closely intertwined.

[Insert Table 1 about here]

Participants

Purposive sampling was used to select key informants from different stakeholder groups to maximize the range of different perspectives. To be considered key informants, stakeholders were required to have knowledge and/or experience regarding the integration of mental health services in primary care. State level respondents were selected from the Directorate of Health Services, Madhya Pradesh, and the national level respondents were selected from the Ministry of Health and Family Welfare [6], Government of India. Respondents from institutes that serve as technical resource agencies to MOHFW such as the National Institute of Health and Family Welfare, National Health System Research Centre and National Mental Health Policy Group were also interviewed. District level respondents were selected from the community health centres where mental health services were integrated with primary care. There is was a poor representation of stakeholders at district level because of a poor response to interview requests.

Data collection and tools

A common cross-country semi-structured interview guide was developed for the six low- and middle-income countries included in the Emerald study, which focused on identifying and addressing barriers to health system performance, based on the hybrid framework in Table 1. This guide was subsequently adapted for the context of India, and details on the district and state level mental health plans were added. The main topics covered included domains for rule of law, strategic vision, participation and collaboration, responsiveness and effectiveness, equity and inclusiveness, ethics and oversight and accountability and transparency [19] . Three

interviewers working as research associates in the project were trained in qualitative research methodologies and had prior experience in conducting qualitative research. Two separate guides were used for district and state/national level respondents. Data were collected in June-July 2015. The interviews were audio taped and field notes were taken after receiving participants' consent. Interviews were transcribed verbatim and the interviews, which were conducted in the local Hindi language (n=33), were subsequently translated into English.

Data analysis

The Framework Approach was used to guide the analysis of qualitative data [20], which includes stages of familiarisation with the data, indexing and charting, coding of the interviews using NVivo-10 software, and mapping and interpretation of results by two independent researchers [21,22]. Data were analysed using both deductive and inductive approaches, using the health governance framework domains as 'a priori' themes, with sub-themes under each category subsequently derived inductively from the data.

The overarching nodes/themes were made up of the different elements of the governance framework, with sub-themes extracted from the respondents'' responses. A table of all the thick descriptive data coded in NVIVO-10, were then exported to Excel. Within Excel, the responses under each overarching node/theme were compared across different groups of stakeholders, to identify common sub-themes in participant responses by the lead researcher as well as providing information on the number r of participants who endorsed a sub-theme

**Results**

A total of 33 in-depth interviews with key informants were conducted at the national (n=19), state (n=6) and district (n=8) levels. Table 2 provides the number and type of respondents included in the study. The results are presented under the governance principles as set out below.

[Insert Table 2 about here]

Rule of Law

India's revised Mental Health Care Bill was approved by Parliament in March 2017. The bill was at a draft stage at the time of interviews and was later approved. However, levels of awareness of mental health laws amongst citizens, as reported by state and district authorities, were low. Within our respondents, awareness was least amongst medical officers. The Mental Health Care Bill was generally regarded as a necessary reform. Participants speculated, however, that the implementation of the new act would be challenging due to a lack of ownership at various administrative and executive levels. As one respondent stated:

> "It is difficult you see… There is a draft new mental health bill online, it is extensive and then having a structure to enforce them and implement is a separate task altogether. They don't own it, no one does". (Consultant, national level).

Respondents from caregiver organisations pointed out the importance of collective ownership for the mental health problem, which can be revealed by involving various civil society organisations. Many respondents highlighted that in the formulation of the new bill, service users, civil society, public health professionals, psychiatrists and psychologists were consulted. However, service user and care giver organisations commented that their level of involvement in the implementation of the bill was marginal. Respondents from service user

and care giver organisations indicated that they would have liked more active involvement in all spheres of the Bill, including its preparation and implementation. Respondents indicated that implementation of the Bill to be facilitated, government needs to ensure that the necessary budget is available.

Strategic vision

Strategic vision, as conceptualised in the health governance framework employed here, relates to a broad and long-term perspective on overall health and human development. The revised mental health policy envisions universal health coverage for all its citizens by incorporating both a preventive and promotive healthcare agenda in its developmental policies [3].

There was a general consensus by participants that there is increased scope for the development of mental health action plans at the national or district level in the next few years, in the context of the new policy and Mental Health Care Bill. A few of the mental health policy group members also stated that the growing evidence of high rates of suicides and mental disorders in general provided an opportunity to advocate for mental health services for all. As one respondent pointed out:

> "I believe over the last 5 years if you see in India, there is hard evidence on human rights abuse, suicides, burden of mental disorders, especially suicides. All such evidence I believe have contributed to policy group formulation in India, for the first time you see".  (Policy Group Member; National level)

Decentralisation was seen as pivotal to primary health care [23]. In the health sector in India, decentralisation is exercised through Programme Implementation Plans (PIPs) where PIPs are consolidated at the state and/or district level in consultation with partners at the district and/or block levels, respectively. Respondents highlighted that there is considerable tension between the state, district and block levels, primarily due to power dynamics. The issue of

distribution of power is said to be problematic and has affected the level of participation of peripheral level staff in the process of decentralisation in health.

State level respondents felt that mental health was not a regular agenda item on district planning committees, at which state PIPs are translated into strategies and budgets are allocated to achieve the required health outcomes. Most states do not include mental health in the PIPs. Participants did, however, suggest that a shift towards non-communicable diseases (NCDs) and approaches that target multiple chronic conditions, including mental health services, may help facilitate the integration of mental health services.

However, there was one example of decentralisation in mental health in Madhya Pradesh that was mentioned stated by a few respondents, which is the "Mental Health Action Plan 365". The Mental Health Action Plan 365 is a state level initiative to align the state level mental health programme with the new mental health policy released in 2014. District level officials, service users and service providers were consulted by the National Health Mission in formulating this plan to address community needs.

Responsiveness and effectiveness of the health system

Effectiveness and efficiency in delivering mental health services are essential for achieving better health outcomes. Under this heading, system level facilitators and barriers related to the system building blocks were explored, such as health workforce, financing, medicines and technologies and services delivery.

### Human resources

Human resources mainly comprise two groups; service providers and health managers, including other support staff. Respondents highlighted that the number of service providers is profoundly low. Mental health providers at the state level in Madhya Pradesh stated that contractual job policies and poor opportunities for professional growth have contributed to this scarcity:

"There were 8 [positions] advertised by the state government and they could only find 3 psychologists. They were paid less than half that central government pays and they were on rolling contracts. For psychology, there are no colleges for specialisation in Madhya Pradesh" (Consultant, State level)

Also, according to state and district planners, the Indian medical education system is not conducive to producing mental health specialists, since few government medical colleges offer specialisation in psychiatry.

Respondents in the study also emphasised a need for more practical placements of medical students to learn and practise providing basic care for people with mental illnesses. Although under the DMHP, medical officers are mandated to undergo in-service training every three years, a need for refresher trainings was identified by most of the respondents. The need for training in managerial skills for nurses, paramedics and medical officers also came up during the interviews.

Financing

Funds can directly accelerate or hinder integration of mental health into primary care. Since only a small proportion of the health budget is spent on mental health, most of which is reserved for tertiary care, funds for DMHP targeting mental health services at primary care are often too little to cover the demands adequately. The process of disbursements from central government to states and then from states to districts is also lengthy, taking up to several months, which according to some participants impeded financial flow and service delivery. State level respondents who were involved in parallel health programmes, such as for tuberculosis and HIV, were of the view that the costing of strategies and subsequent activities was a struggle across all of health care, due to limited capacity and poor investment in health system research. Such issues were further exacerbated in mental health.

Medicines and technologies

Mobilising psychotropic drugs from tertiary care to primary care is key to integrating mental health at the primary level. While the essential drug list (EDL) approved by the Ministry of Health and the respective state directorates includes 18 psychotropic drugs for district and sub-district hospitals, many respondents in this study highlighted that none of these are available in primary health care settings. District officials expressed concerns regarding a vicious cycle of poor procurement of psychotropic drugs and poor demand for mental health services, since drugs will only be provided when there is a demonstrated need for them in the clinics. This vicious cycle was also mentioned by a state level planner:

> "There is an interest of mental health at state level in Madhya Pradesh and there is a possibility of mobilizing medicine, for example like you see the medicine budget. But as there is no true integration in mental health and primary care systems anywhere in India except at islands in some districts in India particularly South India. This makes it difficult you see" (Consultant, State level)

Respondents noted that the managers at the district store, under the control of the Chief Medical and Health Office, are mainly responsible for supplying medicines to primary care providers in primary and community health centres. The district store is also involved whenever there is a need for local purchasing of these medicines. All officials responsible for the procurement and supply of essential drugs to primary care facilities were reported to be cooperative, according to participants. However, medicines that are not included in the EDL or are less in demand often face delays in procurement due to the lengthy administrative process, such as gaining approvals from the local purchase committee, putting through new purchase orders and conducting quality checks.

Supervisors of mental health programmes at the state level believed that continuous supervision and hand-holding is required for facilitating drug procurement in any national programme.

> "It is not possible to have buffer supplies; we do not have a proper pharmacist also at sub-district level. This helper who works as a pharmacist has to do some reporting also. So, it is difficult in that sense… But yes, if you follow up actively their people who can find ways to do it quickly" (Programme Manager, State level)

Participation and collaboration

Treating mental disorders requires a collaborative approach, with participation from different ministries such as the Ministry of Social Justice and Empowerment, the Ministry of Education and Labour and the Ministry of Health. According to respondents, the policy groups formulated to create India's first ever mental health policy had no representation from the Ministry of Social Justice and Empowerment or the Ministry of Education, as stated below by one respondent.

> "Certainly, various key ministries such as social justice were never represented; there are no talks at central level and surely not on [the] ground. If [you] go to the level of [the] field, reflections of poor collaboration [can be] seen" (Policy Group Member, National)

A further sub-theme related to this governance element related to the lack of inter-sectoral and intra-sectoral collaboration suggesting a weaker collaboration within the health system but also across various sectors including social sector, education and justice.  Within the health system, the respondents described the system as characterised by fragmentation between the private and public sectors, and between modern and traditional care.

They also described ambiguous partitions between prevention, primary, secondary and tertiary levels of care as well as between the state and national levels.

Equity and inclusiveness

Mental disorders affect people of all demographic groups, but those vulnerable groups who are already socially or economically marginalised are particularly at risk, leading to further exclusion and in some cases contributors in violations of their human rights. Respondents in this study noted that geographical inequities, mental health stigma, and the use of traditional treatments hinder equitable provision of mental health services to some of the most at-risk groups.

Respondents indicated that there was inequity in relation to the implementation of the District Mental Health Programme across states in India.  Furthermore, a respondent pointed out that due to diversity in Indian states, there was also inequity in the reach of services to vulnerable populations and differing barriers to generating awareness of services among groups of low socio-economic status.

> "I think that like in India there are so many differences, you can't have a same approach for, let's say, a district in Tamil Nadu and a district in Madhya Pradesh because they would have different infrastructure, human resource and other indicator(s). So, I think there needs to be prioritization and one of the essential functions of the national level mental health programme is to help districts to prioritize to the immediate action based on where they are located and then, I think pick up states like Kerala and Tamil Nadu, the literacy level is so high, the use of local newspaper in vernacular language is so high there is so much stuff written in vernacular that there is large potential of disseminating information. Contrast that with the district in Bihar and Madhya Pradesh where you will not find vernacular newspaper reaching out to the villagers and the vulnerable." (Consultant, State level)

Medical officers at the state level pointed out inequities in access to mental health services with some groups of people with mental illnesses such as the homeless, migrants and other lower economic groups using traditional services even during acute episodes of severe mental illnesses such as psychosis. Poor mental health literacy and marked stigma around mental health contributes to poor access in these populations.

According to a mental health policy group member, barring the NMHP and a national level disability scheme (called Niramaya), no other schemes financially protect people living with mental disorders.

Ethics and oversight

Ethical considerations in mental health treatment and in conducting research were both explored in this section. Regarding the ethos around treatment, national level respondents noted that the regulations around coerced psychiatric in-patient care were poor. It should be noted that these responses were gathered before the new mental health care act was approved, however. The new Act includes advance directives, which allow a person with mental illness to demand in advance how he/she wishes to be cared for when they lack capacity [5].

Another ethical concern brought up by many respondents was the irrational prescription of psychotropic medicines. Both the content of medicines and the completeness of prescription sheets were pointed to as reasons for irrational prescriptions.

Safeguards for conducting research, as set by research bodies such as the Indian Council of Medical Research [9], were considered to be comprehensive. However, policy group members were against the stringent guidelines for conducting clinical trials for newer antipsychotics. According to them, these guidelines have prevented the implementation of new clinical trials, forcing researchers and service providers to rely on evidence originating from other countries.

Information systems

This principle focuses on monitoring and evaluation, and its importance in planning and evaluating performance. Data availability on mental health was reported to have improved substantially over the last five years. In particular, respondents noted an improvement in the collection of data related to the number of reported suicides. However, the data on mental health is often derived from large scale surveys and not from the routine health management information systems, as stated by a few participants. According to one national level respondent:

> "Out of 1.2 billion people hardly 10% of the information on mental health comes from routine HMIS [health management information systems]; captured at district level through merely two indicators capturing information on major and minor mental health illnesses. Even these [mental health indicators] are always doubted for quality."
> (Consultant, National level)

Routine information systems in states like Madhya Pradesh contain indicators on major and minor disorders, as part of monitoring for the DMHP. However, this system of classifying mental disorders into major (relates to severe mental disorders like schizophrenia) and minor (relates to common mental disorders such as depression) is outdated and needs revision, according to state level respondents. Respondents also underlined other issues pertaining to the quality of the data for mental health collected through routine systems. Some said that data collected through routine information systems are not a true depiction of the burden, since severe mental disorders such as psychosis tend to be included and common mental disorders such as anxiety and depression are left out. Others reflected on the lack of comprehensive information in these routine systems. Absent or incomplete information, such as on medical history and prior treatment, further impedes the use of data collected by routine systems.

> "What is happening is most cumulative work on one to one bases in an OPD
>
> contact. There is not [a] health system approach in that you have [a] family folder
>
> where you record the history of the family and ensure that they do receive the
>
> care as [and] when the time comes." (NCD consultant, National level)

However, the new mental health plan was reported to have a revitalized mental health information systems component, seen as a facilitating factor towards an integrated information system for mental health.

> "For mental health, there is hardly any reporting. Although you will be surprised
>
> but in the plan [it] has a separate budget for mental health, health management
>
> information system HMIS. [The} district part has been approved, cabinet has still
>
> to approve it. Once it is approved we can have a database, a HMIS for mental
>
> health. We will have to implement it" (MOHFW consultant, National level)

The possibility of integrating mental health data with other priority programmes such as the maternal and child health and non-communicable disease programmes was also reported by respondents. A respondent explains integration as a feasible approach to improving data quality on mental health.

> "I think there are convergence possibilities, where the existing maternal and child
>
> health data and even NCD data is used to capture basic information such as number
>
> of facilities and later adding columns to include mental health data came to be a
>
> feasible approach towards integration." (NCD officer, National level)

Accountability and transparency

Fewer responses were obtained from the interviewees on accountability and transparency. The domains involved under this combined principle encompass internal and external

accountability, decision making and transparency in allocation. There is, a possibility that these are the two areas of governance that require more attention.

Some states have a State Mental Health Authority to oversee the implementation of the mental health plans. However, respondents felt that there was no accountability of these authorities to ensure implementation of mental health programmes. Even though community accountability systems are in place in the National Rural Health Mission in the Maternal and Child Health programmes, no equivalent of this exists for mental health initiatives, as mentioned by respondents.

Similarly, it was reported that transparency exists in other programmes but not in the field of mental health. Some measures such as establishing review boards to enhance accountability are starting to be rolled out for mental health, however [5].

National level respondents felt that the existence of an integrated finance division within MOHFW ensures transparent budgeting. It also acts as a watchdog in the Ministry of Health for finance-related activities. Again, monitoring to ensure the transparency of decisions around mental health services was perceived to be poor, although the Right to Information (RTI) is present which is designed to make information transparent to the public. This is primarily related to the low priority of mental health within public health, as highlighted by many respondents.

## Discussion

Strengthening leadership and governance for mental health is the first objective of the WHO's Comprehensive Mental Health Care Plan 2013-2020 [24] which was adopted by India in 2013. In line with the WHO's Mental Health Care Plan, India developed and updated its mental health laws, polices and plans. However, despite robust plans and knowledge on what works for people with mental disorders, understanding how to mainstream and integrate mental health intervention has been the biggest challenge.

This study applied a framework to better understand the current governance challenges that India faces in achieving goals set out in the recent mental health policy.

First, in relation to the rule of law principle, to gain perspectives of service user and care giver organisations, the findings of this study re- emphasised the importance of involving civil society in assisting the development of mental health laws, plans and strategies. People led movements by a network of civil society organisations have influenced development of laws. For example, the movement called Jan Arogya Abhiyan (JAA) organised a Patient's Rights Convention in Pune to protect the rights of patients receiving treatments in private hospitals which was later fed into the drafting of the rights protection law [25]. Studies on the Indian mental health system has elaborated on the poor involvement of service user and care giver organisations by quoting stigma and provider-centric health system as barriers to meaningful involvement. However, disentangling the steps of involvement by assessing the needs or service users/care givers, organising them and creating a support group have been suggested to strengthen their involvement in the Indian health system [26].

Second, with the new Mental Health Care Act 2017 protecting rights of a person with mental illness and enabling treatment by advance directives provides a national platform to address to mental health issues, assisted by the conducive environment of the new mental health policy 2014 makes it clear that India has increased the prominence of mental health at the

national level. Therefore, the challenges identified in this study related to the translating policy and legislation that promote the integrated mental health into practice.

The mental health care Act 2017 now gives provides a legal obligation to provide mental health care but fails to provide either guidelines or other financial and human resource implications. Clarity in roles of health workers who can determine mental disorders, training of appropriate cadre and collecting data on treatment coverage can assist in implementation of the act. [27]

Also with regard to strategic vision, the role of decentralised planning was emphasised with genuine bottom-up interaction. The need for district managers in the development and planning of the district mental health plans and setting up mental health services was documented in other district level studies in Madhya Pradesh, India [14].

The gap in the knowledge and awareness of respondents regarding mental ill health as suggested in the findings of this study needs to be addressed by increasing advocacy efforts to increase the public health priority of mental health in India. Recently involvement of policy makers and planners through long term long term engagement and mentoring to develop sustainable relationships, through awareness workshops and ongoing dialogue was recommended in a study in India [28]. This can gradually enable buy-in for mental health at state and at national level in India.

Third, in relation to the human resources element, this study indicated the need to strengthen the diverse cadres of the health workforce delivering mental health services, specially so of professionals with public health perspectives and implementation skills, needed to utilise the underspending in the Indian states. As recent study assessed the incorporation and assessment of implementation outcomes to improve implementation of mental health services at primary care in India. The implementation strategies such as active facilitation of primary care facility staff by an external support to improve quality of care is suggested [29]. The scarcity of the mental health professionals has already been extensively cited in the literature [1]. Until

recently, resource estimates have relied upon WHO's Mental Health Atlas [30], and only in 2016 a more detailed data on the prevalence of mental disorders and resource estimates was generated by the National Mental Health Surveys 2015-2016. [31]. The increase in number of medical schools in the country, as insisted by the Medical Council of India addresses the overall health workforce shortages but has encouraged privatisation of the medical profession but has serious shortcomings in the quality of training provided [32].

On the other hand in the field of public mental health, in various projects in India frontline workers in PRIME [14] and community health workers in Vidharbha Stress and Health Programme (VISHRAM) [33] have been successfully delivering psychosocial interventions and overall programme support. However, a critical mass of technical specialists such as psychologists and psychiatrists and public health specialists are still required to prevent staff burn out within this task sharing approach [34].

Fourth, as for the finance element of the effectiveness principle, even though less than one percent of the national health care budget is allocated to mental health in countries such as India and China [8], in bigger states like Madhya Pradesh more than half of the budget allocated to mental health for 51 districts went unspent in 2015 [35], which is consistent with our findings in the financing domain. One of the reasons for under-spending of the health budget that this study revealed under the principle of responsiveness and effectiveness is demand generation. The gap between the community's needs and the availability of services in the community is huge. In other studies, barriers to demand included low levels of mental health awareness, stigma, costs, attitudes and beliefs around the causation of mental disorders [8]. Generating awareness on where to access mental health services, and training frontline workers, can assist in generating demand from the community [36,37].

Once we are able to address underspent budget by generating demand by engaging new community based human resources, these new resources can be involved in delivering psychosocial interventions, as recommended by community projects such as VISHRAM [33].

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However, to move towards a more integrated approach, it is important these services are not only co-located but integrated [38]. Especially considering treatment of mental health problems overlaps with other chronic care conditions and share pathways of determinants. [39]. Therefore, a more biopsychosocial approach throughout the primary care [40], with counsellors or case managers trained in recognising the interactions between mental and physical health care and providing care for both, is recommended. As stated in the rule of law principle, involvement of civil society organisations can be instrumental in bringing the biopsychosocial perspectives to the delivery of care. This is because of the vast experience of non-governmental organisations and the civil society organisations in meeting mental health needs in India [8]

Fifth, with regard to the sub-theme on medicines, due to lack of demand, few essential psychotropic medicines were said to be available in the primary facilities. The drug procurement situation is also similar for other national programmes, where procurement is contingent on demand. Various other studies have also shown the lack of availability of essential medicines at primary care in Indian states [41]. This suggests the situation of a general health system at primary care level is weak and needs strengthening. Similarly, other studies in India have argued for a need of paradigm shift from introducing mental health interventions in a fragile primary care system to instead first strengthen general health infrastructure [42].

Sixth, in relation to participation and collaboration, with the exception of the development of the new act, the study showed weak or negligible dialogue amongst sectors that deliver mental health care. There are few examples of inter-sectoral collaborations in health in India, although the supplementary nutrition programme has emerged as a successful example in which the National Rural Health Mission and the Integrated Child Development Scheme have worked together for several decades [43].

Like other chronic conditions, care for long-standing mental illnesses includes community care, integrated care at primary health centres and continued residential facilities [44]. This

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requires participation from various sectors and departments. Until as recently as 2016, in states like Madhya Pradesh, mental health care was delivered under the Department of Medical Education rather than the Department of Health, which led to poor service delivery of mental health services [15]. Our study suggests newer measures for effective collaborations need to be sought for chronic conditions including mental health.

Seventh, findings from the ethics and oversight principle suggest a need for stringent laws on non-indicated prescriptions of psychotropic medications, especially in programmes where care is delivered through newly trained doctors and those working in private health care services. There is evidence of irrational prescription of drugs by resident doctors, and poor knowledge of dosage combinations for psychotropic drugs has also been well documented [45]. Re-emphasising rational prescriptions of anti-psychotic drugs within the medical curriculum and encouraging doctors to rely on evidence-based practice coupled with their clinical judgement has been advised to avoid unethical prescriptions in the field of mental health in India [46]. However other studies in India suggest that these issues are not restricted to mental health, better regulation and rethinking in the medical education system is needed in both public and private sectors, across all areas of health [47]. These recommendations stretch beyond the health sector to promote and protect the mental health of the population. To safeguard the rights of the patient, ethical considerations on coercive medication and irrational prescriptions need careful monitoring [48] [5]

Eighth, with regard to intelligence and information, this study found a dearth of evidence on basic mental health indicators such as prevalence and service coverage, which represents an important systems-level challenge in integrating mental health with general health services. Similar to other literature [49], the need to integrate mental health indicators into routine information systems was emphasised. Literature also suggests that it is difficult to get data on basic services delivered in primary and community care settings [50]. Our study found that the poor quality of routine data hinders its use. Other studies have attributed inaccurate and

incomplete reporting to low staff motivation levels [51]. Such inadequate information systems translate into weak evidence, leaving decision making for future planning unaccountable. For planning mental health service delivery, a range of service indicators have been proposed by projects such as MHaPP [52] in four African countries at the district and provincial levels. Similar work on strengthening routine information systems is now being undertaken in various LMICs [13] including India [53]. Information systems within governance are the least studied system domains but are also leverage points in a health system affecting accountability of health programmes [12].

However, the quality of routine data from health information systems as a measure of population needs is dubious [54]. Information on service use is instrumental in designing, implementing and improving mental health programmes.  A progressively integrated system can save time, inform clinical decisions and contribute to quality of implementation. However, data from mental health information system can only provide data on service use and not suffice population needs. Since the time of the study, the National Mental Health Survey 2015-2016 [31] have partially addressed this need for survey data which will help to inform evidence based service planning in future.

Overall the barriers and the recommendations although generated from examples from the context of Sehore district, they are likely to be applicable more widely and can foster an enabling environment needed for implementing mental health care at primary care settings. There has been an increasing research on how to reduce the evidence and practice gap. This study has suggested some factors and potential strategies to be considered at the design stage of mental health implementation at primary care to reduce the evidence to practice gap

Key Messages:

1. Build public health perspective and improve implementation skills within the health services to utilise the underspending of the mental health budget at state level in India.

2. Effectively utilising mental health budget by improving demand for services at the community level but also by introducing case managers at primary care level trained in both mental and physical conditions enabling a biopsychosocial approach to health care in India.

3. Strengthening mental health information systems to improve service use, to generate data on population needs and hence accountability in the Indian public health systems.

4. Enhancing inter-sectoral collaborative arrangements so as to directly and indirectly involve participation of service users and civil society organisations, although challenging, is to be emphasised.

Limitations of the study

One of the main limitations of our study is that the interviews focussed on assessing governance principles for integrated mental health service delivery with reference to one district, where mental health services are being integrated with general health services. Due to this limited focus and the small sample size, generalising these findings to other contexts within India should be done with caution. Second, some of the nuances around the human rights issues relating to persons with physical and mental disabilities such as the Convention on the Rights of Persons with Disabilities [48] to which India is a signatory, was not included in the topic guides and did not come out of the interviews and hence were not discussed. Third there was relatively limited representation of stakeholders at district level, despite 7 district

stakeholders being approached and invited to participate in the study only 2 agreed. Reasons for refusal included time constraints and little to no involvement in the planning and delivery of mental health services in the district. Only two medical officers where mental health services were integrated into primary care through PRIME programme agreed to participate. Inclusion of more doctors and primary care workers could have represented the challenges they face in implementing mental health plans.

Furthermore, these findings are based on the perceptions of policy makers, planners and implementers, who may withhold information based on their organisation's policies. Our researchers faced difficulty in contacting respondents, who were service providers and planners and as such were extremely busy. Hence three of the interviews, although they provided rich information, were ended prematurely.

## Conclusions

With a governance lens, this study draws on the experiences of stakeholders involved in delivering or planning mental health services. Governance sits as a backbone to addressing challenges in other health system blocks, focusing on health system inputs (human resources, financing, medicine and supplies), processes (interventions, plans and policies) to result in better health system outcomes (measured through routine information systems). Overall, the study has identified measures to mitigate the mental health disease burden in India by understanding governance principles affecting mental health service delivery using the specific case study of Sehore district in Madhya Pradesh. Two fundamental elements were identified in this study. First, poor implementation of plans and policies needs to be tackled through measures such as broadly strengthening a health system platform at primary care level to deliver mental health intervention, specifically strengthening teams of specialists and

implementers/managers, and strengthening and integrating routine monitoring systems. Second, apart from these system level reorganization strategies, measures to generate awareness and involve civil society in service planning, legal and advocacy measures are also required to generate demand.

Conflict of Interest

The authors declare that they have no competing interests.

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Ethical Standards

Ethical approvals for the study were granted by the Public Health Foundation of India Institutional Ethics Committee, Health Ministry Screening Committee (Indian Council for Medical Research), as well as from the King's College London Research Ethics Committee and the World Health Organisation Research Ethics Review Committee (WHO REC).

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