ASSOCIATION OF HEALTHCARE PROVIDERS INDIA

PUBLIC HEALTH FOUNDATION of INDIA

NATIONAL HEALTH CONCLAVE 2021

"Mental Health - From Distress to Wellness"

White Paper
March 2021



Prelude

The Association of Healthcare Providers - India (AHPI) and the Public Health Foundation of India (PHFI) are two premier national organizations involved in addressing current healthcare issues and arriving at tangible solutions.

In this direction, AHPI and PHFI have jointly held two National Health Conclaves, one on Non-Communicable Diseases Chronic Care – Innovation, Opportunities and Challenges and the other on Climate Change and Health – Role of the Health Sector. The deliberations of the Conclaves have resulted in the publication of two white papers which have been submitted to the Government and many of the recommendations therein have been accepted and implemented.

The third National Health Conclave 2021 on Mental Health – From Distress to Wellness was held on 12-13 March, 2021. The Conclave was organised in the backdrop of the ongoing COVID-19 pandemic that has greatly aggravated the mental health burden, the impact of which is likely to be felt in the coming years.

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Introduction

Mental health is a crucial dimension of health as it is a foundation for the wellbeing and effective functioning for an individual and the community. Mental health encompasses more than the absence of mental illness and is strongly associated with physical health, behaviour and lifestyle choices which may be influenced by our environment.

Globally, 10.7% or slightly more than one in ten live with a mental disorder such as depression, anxiety, bipolar disorders, eating disorders, schizophrenia and substance use disorders. In India, one in seven individuals [around 197.3 million people] are affected with a mental disorder (depression and anxiety leading the way), closely followed by alcohol and substance disorders. With such a heavy burden of disease, the services available to tackle it are grossly inadequate, with 0.3 psychiatrists, 0.12 nurses. 0.07 psychologists and 0.07 social workers per 100,000 population. According to the Union Ministry of Health and Family Welfare, our country needs 11,500 psychiatrists and the current availability is 3,500.

The Lancet Commission on Global Mental Health and Sustainable Development 2018 proposed two major shifts in approach – firstly, the provision of mental healthcare from within the community, and secondly, the delivery of simple interventions by non-specialist healthcare providers. The National Mental Health Programme in India has emphasized the delivery of Mental Healthcare in Primary Healthcare and by all levels of healthcare workers. Thus, training non-specialist healthcare providers in the core competencies of managing common mental disorders would be the way forward considering the outreach, cost and continuity of care.

The barriers to improving mental health are a lack of awareness, the increasing burden of comorbid diseases, climate change, rise in workplace stressors, lack of robust implementation systems for regulations related to mental health and substance use, and many more. This warrants a greater emphasis on education, reduction of stigma, maintaining good mental health, and promotion and advocacy of mental health issues. In order to help permeate mental health related factors into the entire population, a collaborative approach should be adopted, ensuring service provision at all levels of healthcare.

The need of the hour is to consider the various steps and develop a roadmap that bridges the gaps in mental health services in our country.

The National Health Conclave 2021 brought together leaders from the government, research institutions, academia, industry, community and international agencies on one platform to find lasting solutions to the problem. The inclusion of service takers such as caregivers and individuals who have earlier suffered mental illness, represented by various Non-Governmental Organizations, has reinforced the perspective of "nothing about us without us". The stakeholders shared their thought processes for an integrated and lasting solution that would, in addition to mental illness, encompass the prevention of mental distress and promotion of mental health, thus ranging from mental illness to mental wellness.

Objectives and Expected Outcomes of the National Health Conclave, 2021

The National Health Conclave 2021 endeavours to be a national level think tank for paving a roadmap to address issues related to mental health and to discuss, deliberate and formulate strategies and recommendations on various issues that affect the mental health scenario.

It served as a platform for premier institutions and organizations to share and learn from experiences and best practices, and to understand the approaches required to combat the current and future mental health burden in India.

The outcome of the conclave presented in this white paper has been drafted from the proceedings of the conclave and is expected to aid in synergizing efforts of the public and private sectors in addressing mental health issues.

Executive Summary

Common mental disorders such as depression, anxiety, bipolar disorders, eating disorders, schizophrenia and substance use disorders are the leading cause of disease burden and disability affecting more than 10% of the global population. In India, one in seven individuals are affected by mental disorders; the availability of mental health services in the country is grossly inadequate. In this context, the National Health Conclave 2021 brought together leaders from the government, research institutions, academia, industry, community and international agencies on one platform to find lasting solutions. The conclave also engaged with the caregivers and individuals who have earlier suffered mental illness, represented by various Non-Government Organizations. The stakeholders shared their thought processes to arrive at an integrated and lasting solution that would in addition to mental illness encompass the prevention of mental distress and promotion of mental health, thus ranging from mental illness to mental wellness.

There are several barriers to the care of mental disorders in our country. The stigma associated with mental illness is a major obstacle in the development of mental healthcare services and ensuring a good quality of life with opportunities to those affected. The availability of standardised and quality care at an affordable cost is another important hurdle in mental healthcare that has not received adequate prioritisation. The integration of mental healthcare with primary healthcare still remains unaccomplished, leading to an increased burden and gap in treatment. This requires large-scale capacity-building of physicians and primary healthcare workers in basic mental healthcare. While specialised mental institutions and long-term care would be required for some cases, further efforts are needed regarding early discharge, rehabilitation and integration with family and community. Despite the provision of several laws and schemes, effective rehabilitation remains a challenge due to the involvement of multiple stakeholders and bias against those dealing with mental health issues.

Specific needs of different age groups and marginalised groups need special attention. Children growing up in today's globalised and complex world constantly face emotional challenges. Building skills for resilience by involving teachers and parents will help in the prevention of these emotional issues from developing into mental illness. Women are more likely to experience common mental health conditions than men, and their impact is more severe due to gender discrimination. Therefore, the provision of gender-sensitive mental health services is required in order to meet women's needs. Integrating mental health interventions with the national program for maternal and child health would go a long way in improving the coverage. Mental health issues faced by the elderly are traditionally seen as a part of ageing. Educating family members is the key to early identification and treatment. NGOs can play an important role, especially in rehabilitation and community-based activities.

Disabled people with mental illness and those with disabilities associated with mental health are more marginalized than others. The Rights of Persons with Disabilities (RPwD) Act, 2016, recommends effective measures to ensure that persons with disabilities enjoy their rights equally with others. Sensitisation of officials and stakeholders across all government departments is needed in order to create a conducive environment for the effective implementation of the act.

Prevention of disease is the first step in dealing with the burden of illness in a community. It works best when coupled with the promotion of good mental health practices. Several scientific studies have provided evidence of prevention at the community level. The Vidharbha model for suicide prevention involving community health workers, family and community has shown good results and can be replicated elsewhere. Similarly, workplace mental health programs can reduce stress among workers. Aligning our mental health promotion and practices with the religion and culture of our country will help in reaching the masses.

A significant step towards addressing the burden due to mental illness was the enactment of the Mental Healthcare Act, 2017, that attempts to address the rights of people with mental illness and bringing in general hospital settings under the purview of the Act. The act aims at upholding the patient's right to autonomy, confidentiality, dignity and access to mental healthcare. The role of the police and the judiciary besides the health system is important in ensuring the rights of those living with mental illness. The act needs to be backed by the right policies and programs.

The provision of mental healthcare at the community level remains the ultimate goal of improved access. The focus on wellness, with allocations for health and wellness centres under the Ayushman Bharat program, is an important step towards improving access to mental healthcare at the primary and community level. It is possible to provide good quality stigma-free mental healthcare coordinated and co-located with primary care. Trained mental health workers are needed in the community along with professionals in order to provide good mental health services. Inadequate coverage of mental illness under private health insurance schemes is a bottleneck in access that needs to be resolved based on standardisation. It is critical to include the training of existing human resources (including primary care doctors and health workers). The government should look at existing models of training and stakeholders engaged in capacity building to quickly upscale at the pan-India level. The existing curriculum in psychiatry also needs to be reviewed. The curriculum should adequately focus on a holistic model of community-based mental healthcare with the objectives that support mental health public policy, advocacy, principles of population management and destigmatizing mental illness.

Recommendations

1. Undertake sustained and vigorous nationwide mass media campaign targeted towards increasing awareness regarding mental illness and reducing the stigma associated with it.

2. Provide mandatory treatment to people with mental illness at the community level.

3. Implement standard treatment guidelines for mental illness for non-specialist settings in both public and private sectors.

4. Upscale the existing mental health capacity building models for primary care physicians and health workers involving institutions in the government and NGOs to expand the mental health services at primary care level.

5. Integrate telepsychiatry with the District Mental Health Program to increase access to mental health specialists.

6. Introduce life skills training as a compulsory subject for students at the middle school, high school and college levels.

7. Implement the Gatekeeper Training program for college students to act as the first responder for people under emotional distress to prevent suicide.

8. Incorporate community-based mental healthcare in the undergraduate medical education curriculum.

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Appendices

Appendix 1:
National Mental Health Act, 2017

According to the World Health Organization, health encompasses the composite union of physical, spiritual, mental, and social dimensions, which recognizes that "mental health and well-being are fundamental to the quality of life, enabling people to experience life as meaningful, and become creative and active citizens." Mental health is significantly different from general health, as in certain circumstances, people with mental illness may not be in a position to make decisions on their own. Mental illness can last for a protracted period and can have a lifelong impact which gradually results in a poor quality of life. Persons with mental Illness can find it difficult to obtain access to appropriate psychological counselling and treatment, as their families may try to hide their condition out of a sense of shame. This attitude not only harms patients but also leaves them vulnerable to exploitation, abuse, neglect, and marginalization.

India ratified the United Nations Convention on the Rights of Persons with Disabilities in 2007 (CRPD, 2006). This necessitated a review of the existing Mental Health Act to ensure compliance with the Convention. The existing act was the Mental Healthcare Act of 1987 which had been widely criticized for not recognizing the rights of a person with mental illness and paving the way for isolating these patients. The Mental Health Act 1987 provided legal provision for the healthcare of persons with mental illness requiring inpatient treatment. The lack of provision for an independent judicial/quasi-judicial review of the decision for compulsory admission was a major drawback of the old act. There was no provision to ensure that compulsory treatment was not restrictive of the patient's rights. This act was also only applicable to specialist mental hospitals and thus excluded the large proportion of people receiving mental healthcare in general hospital settings from being considered under the purview of the act.

In compliance with the Convention, the new Act is firmly rooted in the rights of people with mental illnesses. In March 2017, the Lok Sabha in a unanimous decision passed the Mental Healthcare Act 2017. It had been passed in the Rajya Sabha in August 2016, and was approved by the Honourable President of India in April 2017. The act defines "mental illness" as a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment or ability to meet the ordinary demands of life, including mental conditions associated with the abuse of alcohol and drugs. This act replaced the previous Mental Healthcare Act of 1987, and makes a presumption of equality for mental healthcare decisions in the eyes of the law for people with mental illnesses, unless an individual has an impaired decision-making capacity. The new act also upholds the patient's right to autonomy, confidentiality and dignity. Access to mental healthcare has become the right of every citizen. The law presumes that everyone with mental illness is capacitous for mental healthcare (until proved otherwise) and enshrines the right to protection from cruel, inhuman and degrading medical treatment.

The capacity for decisions on mental healthcare is articulated in the Act as the ability to understand relevant information, (or) appreciation of consequences of decisions (or) ability to communicate the decisions (Section 4 of this Act). Mental healthcare for a capacitous individual can only be provided subject to informed consent. A capacitous individual is the sole decision-maker for her/ his mental healthcare, irrespective of the mental illness or risks involved. Unlike in many other jurisdictions, a capacitous individual cannot now be forced inpatient treatment for mental health in India, even when the risks related to mental health are high. Even at times of incapacity, the patient's choice must be adhered to. To ensure that patient choice is respected even in individuals with impaired capacity, this law uses three tools: advance directives, nomination of representatives and supported decision-making.

Advanced directives are legal documents in which the person with mental illness will specify what actions are to be taken for their mental health if they are no longer able to. To enforce the will of the advanced directive, nominated representatives will be appointed. The nominated representative's authorization is required for the treatment of the person with mental illness and hence will have full control over the decisions, even when they are not a family member.

Every citizen of India now also has the right to access State-provided mental healthcare. Discrimination due to mental illness in any sphere of life is illegal (including for insurance purposes). There are several other multifarious provisions provided under this act such as emergency mental healthcare, prohibiting unmodified (without anaesthesia) Electroconvulsive Treatments (ECT) and prior approval by the Mental Health Review Board for ECT in minors. The duty of the police in assisting patients and family to provide safety and protection has been clearly stated. This Statute also prohibits discrimination to access mental healthcare on grounds of sexual orientation. Admission into a mental health establishment can be either independent or supported. The former is voluntary and the latter only when the person with mental illness has passed a severity threshold, judged by two independent mental health professionals. Such admissions must be duly reported to the mental health review boards. Mental health review boards are quasi-judicial: lead by a judge, they have the power to approve/disapprove a supported admission. In addition to this, they also must do mandatory independent reviews and appeals by patients and nominated representatives, are entrusted with responsibilities of review of advance directives, review of nominated representatives, approvals of extensions of supported admission, and ECTs for minors and psychosurgeries.

Involvement of the judicial system in protecting the rights of patients with mental illness is a welcome step, but increasing the legalized approaches to care on the already vast backlog of cases in our judicial system will need much planning, allocation of resources and manpower. Although the law has included mental illness under the purview of health insurance, several challenges hinder its implementation. The mental health picture in India is not very progressive compared to the rest of the world, and the understanding of the concept is underdeveloped. There are several other factors that need to be addressed before the act can be implemented to its full potential. The new mental health act has garnered mixed opinions amongst mental health professionals and they need to be heard. The act requires some changes in order to optimize itself to the current scenario and improve mental healthcare in India.

Appendix 2:
Session Proceedings

Session 1:
Barriers to the Care of Mental Disorders and Solutions

Several references to various types of Mental Illness (MI) are seen throughout history. Due to its complicated aetiology and peculiar symptoms, mental illnesses were poorly understood in the past. Even today, the organization and functioning of the human brain, one of the most complex structures in the universe, is still a mystery. Mental illness has also been misinterpreted likewise due to its complexity. However, with advances in technology and research, our knowledge of mental health is growing at a steady pace. Mental healthcare has also advanced considerably but has been insufficient in handling the burden.

There are several barriers to the care of mental disorders in our country such as stigma, lack of effective utilisation of scarce financial resources, lack of mental health professionals, poor utilisation of non-specialist human resources, lack of intervention of mental healthcare in the primary care systems, poor involvement of other (non-health) related sectors, paucity in evidence based indigenous research, and limited use of technology.

Mental illnesses are now recognised to have a 'bio-psycho-social' (biological, psychological, social and environmental) aetiology. Several centuries ago, mental illness was attributed to demonic possession, witchcraft or angry gods. Sadly, several people still believe this today in many developing countries. When some things are misunderstood, they lead to prejudice, stereotypes and stigma. Stigma involves negative attitudes or discrimination against someone based on a distinguishing characteristic such as a mental illness, health condition, or disability. The stigmatized individual experiences social distancing, fear, rejection and ill-treatment from others in the society. The stigma becomes an obstacle in the development of mental healthcare services and in ensuring a good quality of life for those with mental illness. Stigma leads to deprivation of rightful opportunities for healthcare, housing, employment, socialization, and marriage. Unfortunately, there is a paucity of evidence-based research regarding stigma and its interventions. Stigma can affect mental health professionals themselves from other health professionals. Several methods have been proposed, such as mass educational support programmes, cognitive and mindfulness therapy, and psycho-education to reduce external and internal stigma. This phenomenon needs to be understood in the personal as well as the social context. Considering the wide impact of stigma associated with mental illness, the underlying mechanisms related to stigma must be addressed, and efforts must be made at all possible levels to remove this.

The second half of the 20th century witnessed great advances in our understanding of the epidemiology and aetiologies of mental illnesses. Much has also been learned about the efficacy and effectiveness of various treatments - somatic, psychotherapeutic and social. A significant challenge for psychiatry is the incorporation of this new knowledge into the daily work of clinicians. One approach to increase the use of evidence-based treatments is the development and implementation of standard treatment protocols (STP). The benefits of this can be the implementation of 'best practice' psychiatric treatment; the education of psychiatrists, other physicians and other mental health professionals; provision of information to the patient and family; reduced cognitive burden on the mental health professional; improved funding of psychiatric services; identification of 'gaps' in the research base and promotion of more effective research; increased recognition of the scientific basis of the treatment of mental illnesses. Ultimately, standard treatment protocols will enhance the 'reach' of treating mental illness amongst health professionals. Without standard treatment protocols, there can be economic implications such as the improper use of available resources, and financial burden on patients and families. Clinicians and researchers experience pragmatic difficulties in forming and implementing STP in India for several reasons including 'copy-pasting' STPS from other countries with varied cultures, different economical and biological makeup, overworked busy practitioners who cannot implement it fully, and low indigenous research. The advantages in the use of evidence-based guidelines in the treatment of patients are considerable and their use will increasingly contribute to improvement in the quality of care available to patients.

The human rights-based approach to mental health is not a new concept. Some examples from history are the penal orders to remove the chains binding the "insane", deinstitutionalisation of people in asylums and reintegrating them into the community while providing them the right of dignity and autonomy. Every individual has the right to receive appropriate mental healthcare. Human rights and mental health have a bidirectional relationship. Human rights violations can negatively impact mental health. Conversely, respecting human rights can improve mental health. Dealing with ethical issues related to rights in black and white terms can lead to difficult situations. Legislative oversight on human rights contain several grey areas on the management of people with mental illness. The prime difficulty arises when the person with mental illness has lost the capacity to make a decision for himself or herself, which is likely the scenario in a severe mental disorder. They cannot provide consent and usually refuse any sort of treatment. The newer Mental Healthcare Act, 2017, has put in place some legislation on how to go about approaching this issue. Involvement of the judicial system and approving legal documents such as an advanced directive and nominated representatives are the key steps of the act. But are these steps suited to and adequate for our country? A lot of debate has stemmed from this question. Human rights must be viewed from a holistic humanistic point of view, and a global right of the person should be kept in mind. Rights, while respecting the individual, must also be viewed through the lens of the familial, societal and cultural perspectives.

Mental illness is a public health problem. Mental illnesses, like all other illnesses, have multiple morbidities. Primary healthcare is the first level of contact of individuals, the family and the community with the national health system, the closest and easiest form of care available, located near people's homes and within their communities. With increasing awareness of mental illness, many patients with mental illness are approaching the primary health worker. Specialized psychiatric institutions are located in major cities and towns, a long way from where people live. Patients here can become isolated, removed from their emotional and social support networks and no longer in a position to maintain their daily living activities, compounding the financial difficulties they already face. Integration ensures that the population as a whole has access to mental healthcare, ensuring early detection and providing better health outcomes. Responsibility for public healthcare in India lies with the national and state governments. Several policies emphasize the need for consolidated services in the existing healthcare paradigm. These include the National and District Mental Health Programme, the revision of the National Health Policy which specifies the inclusion of mental health in general health services since 2002 and recently added the National Mental Healthcare Act of 2017. Mental healthcare in primary settings is much more likely to be effective and long lasting with support. A strong secondary level is also needed for referrals and supervision. Diploma courses for health professionals can train our primary care workers in this subject. Strong informal community mental health services and support groups can complement and strengthen the services of primary healthcare services.

Due to the chronicity and severity of various mental disorders, institutionalisation and long-term care and their subsequent reintegration into the community is of vital importance. During the age of enlightenment, there was widespread deinstitutionalisation due to human right issues. With the improvement in pharmacotherapy, patients have improved symptomatically, but a small proportion of them require long-term stays in hospitals due to suboptimal responses to treatment, significant disability and the need for institutionalisation. Many of them have longer stays in the hospital in a state of confinement because rehabilitative facilities are not available. Ironically, there are several barriers to discharging long stay patients with mental illness who have already been admitted. Large institutions, inadequate psychosocial interventions, long distances and unavailable families perpetuate the chronicity of stay in centres. Most long-stay patients aspire to a normal life, and the hospital atmosphere is not suited to address their aspirations and emotional needs. A prolonged stay in itself can hinder mental health recovery. Mental hospitals have worked on the reintegration of long stay patients using their staff, support of other government departments and partnerships with NGOs. However, the healthcare sector alone may not be able to address the challenges of providing a better living for all long-stay persons with mental illness. In India, family is a key component of mental healthcare, as they are involved in decision making, treatment seeking, providing finances, monitoring medications and marriage. In patients with long stay treatment without family support, the role of

family needs to be taken by the government agencies to facilitate rehabilitation and reintegration. Providing employment opportunities and disability benefits can certainly work toward rehabilitation.

Due to the exponential growth in technology, particularly information and communication technologies, a vast number of people have access to the internet and smartphones nowadays. There is a tremendous opportunity to use this technology in mental healthcare. There is a widespread deficit of treatment resources for mental disorders such as trained professionals and specialised mental health establishments. To bridge this gap, technology has paved the way for 'tele-psychiatry'. Tele-psychiatry is derived from telemedicine and has been defined as the "use of electronic communication and information technologies to provide and support clinical psychiatric care" Though this term is intended to include all modalities of communication such as telephone, fax, e-mail, the internet, still imaging, and live two-way audio-visual communication, in effect, the term is often equated with the provision of psychiatric services via telecommunication systems, which enable two-way interactive "real-time" communication between patients and providers. Telepsychiatry was originally conceived to help the rural population with no access to specialist treatment. In developed countries, telepsychiatry has proven to be a success story providing high quality mental healthcare, but its effectiveness still needs to be seen in the low and middle-income developing nations. The use of telepsychiatry can not only improve mental healthcare but also reduce the costs of care significantly. However, there are several limitations that needs to be addressed for this use. Standardisation of telepsychiatry protocols, data privacy, confidentiality and consent issues, lack of video communication systems, lack of high bandwidth internet in rural centres due to poor funding, lack of training in the use of these technologies, lack of information among the people regarding telehealth services, and the reimbursement of fees by insurance companies are some of them. Telepsychiatry can revolutionise mental healthcare in India. It can become easy & cost effective for people to access mental healthcare.

Consensus Points:

- Stigma related to mental illness is the biggest challenge to accessing mental health services. Considering the wide impact of stigma on people with mental illness, the underlying mechanisms related to stigma must be addressed, and efforts must be made at all possible levels to remove it. A sustained awareness campaign using mass media is needed to increase awareness regarding mental illness and reduce the stigma associated with it. Opportunistic intervention (awareness) by general practitioners and other health professionals would also be helpful.

- Country/region specific standard treatment guidelines that are simple and feasible for non-specialist setting are required in order to upscale the availability of treatment. The use of generic drugs and rational drug use will reduce the economic burden of treatment and improve resource utilisation.

- Rehabilitation of people with mental illness with their family and community should be prioritised. Rehabilitation requires multi-sectoral support for providing employment opportunities and disability benefits. Increased awareness of such support among the stakeholders and patient families/community will help in effective rehabilitation. Compulsory community level treatment by the community health workers will improve the outcome and rehabilitation.

- Integration of mental health with primary healthcare still remains unaccomplished, leading to increased disease burdens and gaps in treatment. Large-scale training programs are needed for primary care physicians and health workers. Leveraging capacity building should be a policy priority for integrating mental healthcare with primary care.

- Technology has provided great opportunities for improving access to mental health treatment. Telepsychiatry provides an opportunity to reach out to the last person. Artificial intelligence (AI) based decision support systems (DSS) for non-specialist settings has tremendous potential for improving availability and access to treatment. Integrating telepsychiatry with the District Mental Health Programme can act as the first step in expanding the reach of specialist mental healthcare.

Session 2:
Mental health across life span and in special settings

Presentation and Discussion

We imagine childhood as a carefree time, but age alone offers no shield against the emotional hurts, challenges, and traumas that many children face, especially in today's globalised world. Children deal with problems ranging from adapting to a new classroom or online schooling to bullying by peers or even struggles at home. Adding to that, the uncertainties that are part of growing up in a complex world can be anything but carefree. The ability to thrive despite these challenges arises from the skills of resilience. All children are capable of functioning through challenges and coping with stress. Resilience is the ability to bounce back from stress, adversity, failure, challenges, or even trauma. It is a skill that children develop as they grow. Resilient children are more likely to take healthy risks because they don't fear falling short of expectations. They are curious, brave, and trusting of their instincts. They know their limits and they push themselves to step outside of their comfort zones. This helps them reach for their long-term goals and it helps them solve problems independently.

Parents can help children build resilience and confront uncertainty by teaching them to solve problems independently. Children need to experience discomfort so that they can learn to work through it and develop their own problem-solving skills. Without this skill-set in place, children will experience anxiety and shut down in the face of adversity. Ideas for building resilience in children include encouraging healthy risk taking; showing acceptance of mistakes and losses; asking questions to encourage independent thinking; praising accomplishments in the right way; defining and discussing emotions; promoting optimism and positive thinking; encouraging interaction with others; showing that it's okay to ask for help; helping them build positive relationships with their friends and other adults; teaching them to be independent in their actions and thoughts; encouraging them to understand, express and manage their emotions; and building their confidence by taking on challenges and allowing them to learn from them if they fail.

A woman's mental health and wellbeing may be greatly affected by a combination of biological, social, psychological, environmental and economic factors. Women are more likely to experience common mental health conditions than men, and while rates remain relatively stable in men, prevalence is increasing in women (McManus et al, 2016). Young women are a particularly high-risk group, with over a quarter (26%) experiencing a common mental disorder, such as anxiety or depression – almost three times more than young men (9.1%). Women often face gender-based discrimination, abuse and violence. Presence of untreated mental illness makes women more susceptible to violence and abuse whereas violence and abuse puts them at higher risk of developing mental illness. The untreated mental health illness and domestic violence faced by pregnant mothers impact the child even during pregnancy and later affects their developmental outcomes, cognitive and neurological development. It can also lead to neglect of the child.

Despite the clear relationship between gender-based violence, trauma, and poor mental health, the link is rarely reflected in the support available to women with mental health problems. A women's contact with mental health services could also at times be re-traumatising, for example through restraint or observations, often by male members. Women with multiple needs, many of whom have faced extensive violence, abuse, poverty and inequality, are often deeply traumatized and can face other challenges alongside poor mental health, such as addiction and homelessness. Yet, the services are not always well set up to meet women's needs or be flexible to respond to where women are in their lives.

The 'treatment gap' for mental disorders is large all over the country, but especially so among elderly and the socially disadvantaged. Some of the key factors affecting the mental health of elderly include lack of participation in meaningful activities, discrimination, physical health failings, relationships and poverty. Geriatric mental health issues are often seen as part of aging by the community. The role of family is critical in the care of elderly population. Even within the family, the onus of taking care of the elderly lies on the

shoulders of youth. Therefore, it is critical that the youth in the family have adequate knowledge and ability to distinguish between mental health and aging issues. Provision for training of youth in early identification and seeking care will help in strengthening the mental healthcare of the elderly.

While the government or public services are the key providers of care for these populations, NGOs working at the community level can be of great support in early identification, treatment, rehabilitation and prevention of mental illness among the elderly. However, NGOs at times may not have a standard protocol for such interventions. Therefore, it is important that specialists are engaged in the capacity building of such NGOs to provide standard care and support.

Several NGOs are working on primary prevention activities from suicide prevention to provision of treatment in community clinics, increasing awareness and providing community-based rehabilitation. NGOs are arguably better placed to approach and win the trust of local communities, establish ties with them and locate their programs in and for the community.

Adults with disabilities more often report depression and anxiety, reduced healthcare access, and health-related risk behaviours than do adults without disabilities. Disabled people with mental illness and those with disabilities associated with mental health are more marginalized than any other marginalized group of people. With the passing of the Rights of Persons with Disabilities (RPwD) Act, 2016 there has been a paradigm shift from the medical model to the social model, and the fact that disability is an evolving concept and dynamic in nature. The Rights of Persons with Disabilities (RPwD) Act, 2016, requires governments to take effective measures to ensure that the persons with disabilities enjoy their rights equally with others. The act also provides benefits such as reservation in higher education, government jobs, land allocation, poverty alleviation schemes, etc. The barriers to implementation of the act can be broadly classified into attitudinal barriers and environmental barriers. Attitudinal barriers are more likely to lead to deprivation of rights of people with disabilities. There are functional challenges such as assessing employability of people with disabilities. Further, the attitudes of co-workers and employers leads to discriminatory behaviour. Strict adherence to the act and general awareness regarding the right of people with mental illness and disabilities would help in their rehabilitation.

Disasters and humanitarian crises have a profound impact on the mental health of the affected population. Mental illness is closely associated with poverty, wars, and other humanitarian disasters, and in some cases, leads to suicide, one of the most common causes of preventable death among adolescents and young adults. The COVID-19 pandemic is a major health crisis of our 21st century. Rapid transmission of the COVID-19 virus resulted in the enforcement of regional lockdowns to prevent spread of the disease. Isolation, social distancing, and closure of educational institutes, workplaces, and entertainment venues compelled people to stay in their homes to break the chain of transmission. A review published in The Lancet said that the separation from loved ones, loss of freedom, boredom, and uncertainty could cause a deterioration in an individual's mental health status. Both children and adults had issues such as difficulty in concentration and attention, avoiding activities that they enjoyed in the past, changes in eating and sleeping habits, emotional outbursts and irritability. With elderly people being dependent on the young for their needs, self.isolation can critically damage a family system. Doctors, nurses, and paramedics working as a front.line force to fight the COVID.19 outbreak may be more susceptible to develop mental health symptoms. Fear of catching a disease, long hours, unobtainability of protective gear and supplies initially, patient load, unavailability of effective COVID.19 medication, death of colleagues after exposure to COVID.19, social distancing and isolation from their family and friends, and the dire situation of their patients are likely to impact the mental health of health workers.

Understanding the effects of the COVID.19 outbreak on the mental health of various populations are as important as understanding its clinical features, transmission patterns, and management. Spending time with family members including the children and the elderly, involvement in different healthy exercises and sports activities, following a schedule/routine, and taking a break from traditional and social media can all

help to overcome mental health issues. Public awareness campaigns focusing on the maintenance of mental health in the prevailing situation are urgently needed.

The 20th century facilitated a fast-forward from tertiary prevention to secondary prevention of various psychiatric disorders. The psychiatric morbidity in patients is in the prime ages — the second and third decades — and in the most crucial phase of his or her development and maturity (educational, occupational, marital, and social identity); and in most cases, they leave a significant disability and remark on the personality. The only way this can be stopped is primary prevention. Though this sounds an impossible goal to achieve at present, there seems to be some hope with more and more evidence coming in favour of epigenetics and neuroplasticity.

As we all know, the goal in primary prevention is preventing the occurrence of a particular illness and reducing its prevalence in the community. The best results in terms of primary prevention will be in the case of infectious diseases, where the etiological factors are well defined and identified. Also, in those with non-infectious aetiology, serious attempts are being made to achieve primary prevention; stopping smoking to prevent lung cancer and providing dietary supplements of iodine to prevent goitre and thyroid disease are two examples. The same is true in the case of public awareness camps on obesity and exercise, with the goal of reducing the incidence of diabetes, an area of major concern for WHO in the 21st century. Many developmental risk factors are not disorder-specific, but may relate to many maladaptive outcomes.

Different combinations of risk factors may lead to the same disorder and no single cause may be sufficient to produce a specific negative outcome. The notion of generic and inter-related risk factors has led to a strategy of targeting multiple factors simultaneously.

Lack of objectivity, questionable diagnostic validity, and absence of laboratory confirmatory tools are a few significant drawbacks in the classificatory system of psychiatric disorders. Any plan for primary prevention should be clear about what needs to be prevented. Among psychiatric disorders, the efforts at primary prevention should focus first, perhaps, on illnesses such as bipolar disorder, schizophrenia, OCD, dementia, etc., where the boundaries are not very diffuse and biological aetiology is more in acceptance. Eradicating dementias secondary to vitamin deficiencies can be an achievable practical goal. The highly discussed prevention-related findings for anxiety, depression in childhood and adolescence, suicide, substance abuse, and eating disorders are not conclusive and provide little evidence that incidence is lowered. Primary healthcare staff should be adequately supervised, monitored and supported by mental health specialists (professional at/of secondary level) if integration is to succeed. The mental health professional should be available to discuss difficulties in management and to provide advice on interventions to be carried out by primary care staff. Effective referral links between primary, secondary and tertiary levels of care need to be in place. It is recommended to develop and coordinate a collaborative network in order to provide mental health services.

Consensus Points:

- As a part of growing up in a complex world, children and adolescents face several challenges such as stress, adversity, failure, or even trauma, and their ability to overcome these challenges arises from the skills of resilience. Parents and teachers can play a major role in building life skills. Life skills training should be a part of the curriculum at middle school, high school and college levels. Parents should also be sensitized to identify needs in children and seek advice. Mass media can play a major role in generating awareness.

- Women are more likely to experience common mental health conditions than men and their impact is more severe due to gender discrimination and domestic violence. Risk of depression is also higher. Therefore, provision of gender sensitive mental health services is needed. One of the ways to achieve this would be piggybacking mental health interventions on the national program for maternal and child health, as maternal healthcare for a happy mother and happy child. The involvement of husband and family is also critical for the success of any mental health intervention for mothers.

- Mental healthcare provided through the government for the elderly population should be the priority. There is a need for effective integration of mental health screening and management for elderly with the NCDs programs at the primary care level. Mental healthcare for the elderly can be further strengthened by greater involvement of NGOs, especially for rehabilitation and community-based activities.

- Disabled people with mental illness and those with disabilities associated with mental health are a highly marginalized group. Effective implementation of the Rights of Persons with Disabilities (RPwD) Act, 2016 can be promoted by educating and sensitising officials and stakeholders across all government departments towards the rights of people with disabilities and the need for creating a conducive environment for effective implementation of the act.

Session 3:
Mental Health Promotion and Prevention

Presentations and Discussion

Prevention is better than cure is an age old saying. Prevention of diseases is the first step to deal with the burden of illness in a community. Several scientific studies have time and again provided empirical evidence that mental illness and its disabilities can be prevented altogether if specific evidence-based approaches are employed on a mass scale. Along with prevention we now know that having good mental health can lead to a better quality of life and satisfaction in people. Healthy mental health practices should be promoted amongst the people so that they can better take care of their mental health. In dealing with mental illness, prevention should also be coupled with the promotion of good mental health practices. Prevention focuses on identifying risk and causative factors to avoid illness, whereas promotion aims at enhancing the ability of the individual to achieve psychosocial wellbeing and coping with adversity. Both of these concepts overlap and together will prevent mental illnesses from occurring..

India is a vast country with a population of 1.37 billion, second only to China. Together they comprise 40% of the total population of the world. According to WHO and its 194 member nations, there are 8 lakh suicides annually, so it can be said these 2 countries amount to 40 % (or more) of those deaths. Suicide is a complex human behaviour with multiple interacting determinants. It is the second common cause of death in the young population second to road traffic accidents. Farmer suicides account to 10 % of all the suicides in India. This is an alarming problem and there is a need for a 'collaborative' model between mental health professionals, staff workers, government and non-health sectors such as family, and the media in aiding prevention of suicide. The prevention strategies followed by countries include a combination of the suicide awareness programmes for public and health professionals, screening programs for suicide prevention at the primary healthcare level, Gatekeeper (individuals who regularly interact with potential suicidal persons) training for teachers, peers , support staff, restriction of access to means of suicide such as OP compounds, follow-up care, suicide hotlines/helplines, using the media for responsible reporting, and pharmacotherapeutic and psychological strategies. Stigma, lack of human and financial resources and deficiency of indigenous research are some of the limitations in effective prevention. During the 90s, in the region of Vidharbha (home to approximately 3.4 million cotton farmers, 90% of whom were struggling with debt), farmer suicides reached epidemic proportions.

Absence of social support, uncertainty of agricultural enterprise, rising costs, weather changes, easy access to poisons all compounded to an increased rate of suicide. A community-based suicide prevention programme was initiated. Community health workers with mental health training were deployed into the villages for screening and psychoeducation. Depression and substance use disorders were identified and promptly managed. Involving the wives helps to solve economic problems, involving children to participate in community weddings, removing the system of dowries, promoting self-employment and teaching farmers about proper agricultural practices were some of the methods employed by the programme. It was a huge success and farmer suicides were reduced more than 90%. The Vidharbha model is the best example of effective suicide prevention in India. Plans to employ these techniques on a national scale should be undertaken.

'Culture' is an abstraction, reflecting the total way of life of a society. It is a precipitate of the group's history and an expression of its adaptation to the physical environment. It refers to the shared patterns of beliefs, feeling and behaviour and the basic values and concepts that members of the group carry in their minds as guides for the conduct. Besides social relationships, economics, religion, philosophy, mythology, scriptures, technology and other aspects of living contribute to the culture. Culture is constantly in the process of change and it is transmitted from one generation to the next. All societies have it though their styles vary from one group to another. Culture uniquely influences the mental health of people living in a given society. Mental health problems, from presentation of illness to course and outcome, at every stage are influenced by cultural issues. Most of the psychiatry practice in India is guided by the western concepts of mental health and illness,

which have largely ignored the role of religion, family, eastern philosophy, and medicine in understanding and managing the psychiatric disorders. Understanding the cultural milieu of the patient helps in establishing a good therapeutic relationship. Training of psychiatrists and raising their cultural competence is neglected in India. They should be aware of the local cultural organization, world views and values, etic-emic differences, linguistic concepts and idioms of distress. Religious beliefs are protective factors for suicide. Beliefs of rebirth and karma can have profound effects on dealing with death and loss. A more holistic approach is needed to evaluate a patient with a mental disorder, rather than a mechanistic and deterministic approach followed by western psychiatry. Aligning our mental health promotion and practices with the religion and culture of our country, will help in reaching the masses.

Humans are social beings. Being connected to others and the feeling of relating to others is essential. There is widespread consensus in the public health and epidemiology literatures that social connectedness causally protects and promotes mental health. Models that specify the bidirectional relationship are also common among clinicians; the loss of social connectedness is frequently described as a consequence of mental illness. Indeed, a key diagnostic criterion of major depressive disorder is that symptoms 'cause clinically significant distress or impairment in social, occupational or other important areas of functioning'. Social capital is a multidimensional concept that includes both structural ('objective') and cognitive ('subjective') components. Mounting evidence suggests that subjective appraisals of social relationships (e.g., self-reported social support or belonging), or 'complex' operationalisations of social capital (where both structural and cognitive elements are present), are more strongly associated with psychological health than purely objective measures (e.g., whether a person lives alone). In some nations, public health policy has begun to incorporate lessons from this work by emphasizing the importance of social relationships and social support for mental health and wellbeing. The mental health landscape in India is highly stigmatized with public, structural and self-stigma. Stigma can affect social connectedness by isolating the individual from the group. Joint families are reducing in number, the role of elders in social connectedness is changing, and improvements in technology lead to vast networks of virtual spaces which can make people distrust each other, leading to loneliness.

Corporate sectors are the biggest contributors to the economic stability of the country. They are the largest platform to provide employment to the general public. They help people grow as professionals and improve their lifestyle in exchange of their contribution for the financial growth of their companies. It requires a lot of physical and mental investment which becomes challenging for the employees. Sometimes these challenges act as motivators and sometimes they take the shape of stressors due to the pressures encountered by demanding jobs. This is bound to have an impact on a person with mental illness. WHO has defined mental health as a state of wellbeing and is not only the absence of a mental disorder. Stress at the workplace can lead to mental health problems. The sources of stress for working professionals are heavy workload, lack of cooperation from colleagues or neighbours, and negative community attitude. The prevailing psychiatric symptoms in corporate sector are found to be associated with perceived increased stress levels at work, dysfunctional interpersonal relationships, increased job pressure, greater responsibility without authority, and feelings of insecurity, career problems and pressure for production. However, it is not clear that these factors act as a cause or effect of the psychiatric symptoms. Employers experience expensive consequences of mental illness through absenteeism, lower productivity, disability, accidents and the inappropriate use of medical services. Companies should be well equipped to identify the early signs of job-related stress symptoms. The screening for mental health can be integrated in the periodic health examination system in the industry and the industry management can be urged to set up a multidisciplinary committee to oversee the implementation of occupational mental health and health promotion programs. Employee Assisted Programs should be made and implemented in consultation with mental health professionals. They should be open to collaborations with the mental health professionals to provide the required assistance to their employees and should be able to outsource them to seek help for medication and intensive psychotherapy to manage job-related stress and psychiatric symptoms. An open empathic inclusive environment should be promoted in the office, where confidential information is respected and there is no discrimination against people in the LGBTQI community or against people with disabilities.

Consensus points:

- The only way to stop wide ranging psychiatric morbidity in patients in the prime ages is through primary prevention-preventing the occurrence of a particular illness and reducing its prevalence in the community. In dealing with mental illness, prevention should also be coupled with promotion of good mental health practices.

- There is strong evidence to show the impact of community-based suicide prevention programme. The Vidharbha model used community health workers with mental health training for screening, psychoeducation and prompt management of depression and substance use disorders. The Vidharbha model can be employed at the national scale for effective suicide prevention. Similarly, Gatekeeper Training can be undertaken to create a pool of first responders for the emotional distress.

- Mental health problems, from the presentation of illness to course and outcome, are influenced by cultural issues at every stage. Therefore, the role of religion, family, philosophy, and traditional medicine is important in understanding and managing psychiatric disorders. Aligning our mental health promotion and practices with the religion and culture of our country will help in reaching the masses.

- Stress at the workplace can lead to mental health problems. The screening for mental health can be integrated in the periodic health examination system in the industry and the implementation of occupational mental health and health promotion programs.

Session 4:
Policy and Regulations: Shortcomings and Solutions

Presentations and Discussion

Health is now widely acknowledged to include both physical and mental health. Especially in country like ours, persons with mental illness constitute a vulnerable section of the society and are subject to discrimination. Families bear the financial and emotional burdens of providing treatment to relatives with mental illness. Mental illness should be treated like any other illness and the environment should facilitate recovery and rehabilitation. Primary healthcare is the essential healthcare universally acceptable to all individuals. The Mental Health Act of 2017 aims to protect, promote and fulfil the rights of persons from mental illness during the delivery of mental healthcare. The principle reflects a paradigm shift from a social welfare concern to a human rights issue.

Provision of mental healthcare at the community level remains the ultimate goal. However, for achieving this, mental healthcare should be treated as a basic need such as safe drinking water. There is ample evidence show the effectiveness of community-based interventions and guidelines based on the same. Workers at the primary care level can assertively screen for mental illnesses and mental issues, diagnosis and even manage the most common psychiatric morbidities. We need to set up structures where effective mental health can be provided in a systematic continuous manner. Ensuring follow-up of care is the single biggest challenge that we face in the country.

The Government of India launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community. The district Mental Health Program was added to the Program in 1996. The objectives of the program are:

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future;
2. To encourage the application of mental health knowledge in general healthcare and in social development;
3. To promote community participation in the mental health service development; and
4. To enhance human resources in mental health sub-specialties.

The program had variable success based on the state level mental health leadership. States that accorded higher priority to mental health, saw better outcomes. The District Mental Health Program based on the Bellary model has served a purpose in providing services, training and IEC activities at district level. However, it needs to reach sub district level at the primary health centre level and within the community, and attempt to remove the stigma for better utilisation of services.

The Mental Healthcare Act 2017 and Rights of Persons with Disabilities Act 2016 make provisions for reservation in employment. However, the proportion of persons with disability is estimated to be much higher than the provisions made in the Act.

Mental Health has received the right impetus in the 2021 budget that emphasizes the idea of wellness with allocation for health and wellness centres. It gives the necessary institutional ecosystem needed to address this dimension. A holistic approach is required for measuring national development, not just as part of monetary income or capita income or national production, but as a measure of wellness. Mental health is not just linked with the sociological or psychological disorders alone but also linked with economic factors for treatment, loss of wage/employment due to disability. The economic recession is also pushing many people into mental illness. Therefore, adequate information and the right framework is needed for formulating economic policies that can support wellness. The issue of inadequate coverage of mental illness under health insurance have been highlighted. This is mainly due to lack of clarity regarding the nature of illness that is scientifically substantiated so as to arrive at the parameters for reimbursement. Such guidelines need to be

developed urgently.

Newer models of care that lay emphasis on quality, sustainability and recovery are being developed. These holistic models of community based mental healthcare are aspirational and should become part of the curriculum. This includes high quality services that encompass the protection of human rights, a public health approach with the promotion of recovery, journey of service users, the evaluation of effectiveness based on evidence and service user goals, development of a wide network of community support services and incorporation of service users and expertise in service planning and delivery. All are different levels of care ranging from resource groups to generic community services and community mental health.

In the Medical Council of India (MCI) curriculum, the learner should acquire the competencies pertaining to psychiatry that are required to be practiced in the community and at all levels of the healthcare system. Among the objectives, about half the objectives mention public health goals and three emphasize the key importance of mental health in the country. It also mentions that the learner should play an assigned role in the implementation of national health programs effectively and responsibly, and they should be able to organize and supervise the desired managerial and leadership skills. In terms of the syllabus, a general guideline is that during the training period, efforts should be made to discuss mental health problems. However, in the actual curriculum itself, there is only a brief mention of public and community psychiatry, healthcare reform and psychiatric rehabilitation. There is also no mention of public health in the actual practical skills teaching session. A psychiatry milestone project in the USA monitors the progress of each candidate reaching new milestones, and some of the training requirements including performance requirements, are related to public mental health. Similarly, the guidelines in Canada explicitly emphasize the diverse role that physicians fulfil in society including that of communicator, collaborator, manager, health advocate and professional, thereby focusing on the public health aspects of mental health. An increased focus on community care is also required. The objectives of a curriculum of this kind should be to support mental health public policy, advocacy, principles of population management, remove stigma, etc.

Past experience has shown that during disasters, there is a rush of professionals for expert psychiatric care. Like chronic health conditions, mental health problems can be long term in nature, especially severe mental disorders. Severe chronic mental disorders can go through a lot of relapse and recurrence. Therefore, the sustainability of available mental health services needs to be strengthened during the disaster and the immediate post disaster situation.

Consensus points:

- Mental health is not just linked with the sociological or psychological disorders alone but also with economic factors for treatment, loss of wage/employment due to disability. Therefore, adequate information and the right framework is needed for formulating economic policies that can support wellness.

- The issue of inadequate coverage of mental illness under health insurance have been highlighted. This is mainly due to lack of clarity regarding the nature of illness that is scientifically substantiated so as to arrive at the parameters for reimbursement. Such guidelines need to be developed urgently. At the very least, admission for mental illness should be covered under all health insurance schemes.

- The curriculum for higher education in psychiatry should have a greater focus on the holistic model of community based mental healthcare. The objectives of a curriculum of this kind should be to support mental health public policy, advocacy, principles of population management and destigmatizing mental illness.

- Mental illness is closely associated with humanitarian disasters, and in some cases, leads to suicide. Past experience has shown that during disasters, there is a rush of professionals for expert psychiatric care. We need to strengthen the sustainability of available mental health services during the disaster and the immediate post-disaster situation.

Appendix 3
Organising Committee and Secretariat

Organizing Committee

Organising Chairperson:
Dr. Alexander Thomas, President, Association of Healthcare Providers – India and Prof. K. Srinath Reddy, President, Public Health Foundation of India

Organizing Secretary:
Dr. Sandeep Bhalla, Honorary Advisor, Public Health Foundation of India

Joint Secretary:
Dr. Jagadish A, Indian Psychiatric Society

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Appendix 4
Conclave Agenda

National Health Conclave 2021

Mental Health - "From Distress to Wellness"

Friday & Saturday, 12th - 13th March 2021 | 3:00 - 6:00 PM

Day 1: 12th March 2021

Welcome Address and Inauguration **(3.00PM – 3.15PM)**	
Keynote Talk **(3.15PM – 3.30PM)**	**Prof. K Srinath Reddy** President, Public Health Foundation of India, New Delhi

	Panel Theme	Topic	Speaker
		Introduction of Panellist and Chair-person's note	
1.	Barriers in care of Mental Disorders and Solutions **(3:30PM -5:00PM)**	**Pace-setter talk** **Dr. Shekhar Saxena,** Professor of Practice of Global Health, TH Chan School of Public Health, formerly Director of Mental Neurological and Substance Use division of WHO	
		Mental illness and stigma: A major public health problem	**Dr. Raghuraman** Professor of Psychaitry and Head, Department of Psychiatry, M.E.S Medical College, Perinthalmanna, Malappuram, formerly Professor, NIMHANS
		Practical difficulties in diagnosis and standardisation of treatment protocols	
		Ethics in management of mental illness, implications of right based management	**Dr. Bharat Watvani** Founder Shraddha Rehabilitation Foundation, Mumbai
		Role of primary care systems and non-specialist care in mental health	**Dr. Santosh Chaturvedi** Senior Professor of Psychiatry, formerly Dean, Behavioural Sciences, NIMHANS
		Mental health long term care: Institutionalisation and reintegration/community care	**Dr. R.Thara** Vice-chairman and Formerly, Director, SCARF, Chennai
		Innovative, technology-based solutions for mental health/ Tele-psychiatry	**Dr. Savita Malhotra** Formerly, Dean, PGIMER and Professor and Head, Department of Psychiatry, PGIMER Chandigarh

	Panel Theme	Topic	Speaker
		Introduction of Panellist and Chair-person's notes	
2.	Mental health across life span and in special settings **(5:00PM-6.30PM)**	**Pace-setter Talk** **Dr. Gautam Saha,** President elect, Indian Psychiatric Society)	
		Mental health in Humanitarian settings: COVID-19	**Dr. Amresh Srivastava** Professor Emeritus, Psychiatry, Western University and Adjunct Scientist in the Lawson Health Research Institute, London, Ontario, Canada
		Child and adolescent Mental Health care, newer challenges: Role of schools in resilience building	**Dr. Harish Shetty** Psychiatrist at Hiranandani Hospital, Mumbai
		Women mental health: special challenges in the face of discrimination, abuse and disadvantages: Alignment of Maternal and Child health services for better MH outcomes	**Dr. Prabha Chandra** Professor of Psychiatry and in-charge of Peri-natal Psychiatry services, NIMHANS)
		Geriatric MH care: barriers and solutions: Role of NGOs in old age care: shared responsibilities	**Dr. S C Tiwari** Professor of Psychiatry, Head, Department of Geriatric Mental Health, KGMU, Lucknow
		Mental Health in disabled individuals: barriers and solutions	**Dr. S K Nambi** Dr Nambi's Clinic, Chennai
		Military mental health: challenges and solutions	**Dr. Kaushik Chatterjee** Professor of Psychiatry and Head, AFMC Pune

Q&A and Summary

Day 2: 13th March 2021

	Panel Theme	Topic	Speaker
		Introduction of Panellist and Chair-person's note	
3.	Mental health Promotion and Prevention **(3:30PM -4:30PM)**	**Pace-setter talk** **Dr. B N Gangadhar,** Former Director, NIMHANS	
		Suicide: need for collaborative care: Vidarbha model to prevent farmers suicide	**Dr. P B Behere** Professor of Psychiatry, Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences, Wardha, Maharashtra, India

		Yoga and traditional methods for MH care	**Prof. Ajit K Dalal** Retired Professor of Psychology, University of Allahabad
		Role of Nutrition and lifestyle changes in maintaining MH care	
		Social connectedness as a mental health determinant and role of family interventions	**Anna Chandy** Social Psychologist and counsellor, Trustee, TLLLF
		Sustainable infrastructure for prevention of mental distress	**Dr. Sainath**
		Workplace mental health: How occupational safety measures can align to MH care	**Dr. Kersi Chavada** Consultant Psychiatrist, P D Hinduja Hospital, Mumbai

Q&A and Summary

	Panel Theme	**Topic**	**Speaker**
		Introduction of Panellist and Chair-person's remarks	
4.	Policy and Regulations: Shortcomings and Solutions **(4:30PM -6:00PM)**	Pace-setter talk **Justice N Kumar**, Sitting Judge of Kerala	
		Mental health care as a component in comprehensive primary health care: Challenges faced in Implementing community Psychiatry in India	**Dr. Mohan Issac** Clinical Associate Professor of Psychiatry, The University of Western Australia
		National Mental Health Program, critical appraisal and solutions	**Dr. Rajesh Sagar** Professor of Psychiatry, AIIMS New Delhi, Secretary, Central Mental Health Authority, New Delhi
		MHC Act 2017, RPWD Act 2016, critical appraisal and solutions	**Dr. Suresh Badamath** Professor of Psychiatry, In-charge Head of Community Psychiatry, NIMHANS
		Economic commitments for better MH outcomes and insurance coverage of mental disorders: Reasons for resistance and solutions	**Dr. Sachin Chaturvedi** Director General, Research and Information System for Developing Countries (RIS)
		Higher education in mental health: how postgraduate training in psychiatry can be aligned for public mental health outcomes	**Dr. Pratap Sharan** Professor of Psychiatry, AIIMS New Delhi
		Mitigating Psychological distress in disasters: Lessons from COVID-19	**Dr. Nimesh Desai** Former Director, IHBAS, Delhi

Q&A and Summary

Glimpses of the National Health Conclave 2021



Inauguration and Lamp Lightening Ceremony



Welcome and Introduction Address were given by Dr. Alexander Thomas, President, Association of Healthcare Providers India (AHPI), Chairman, Organizing Committee and Dr. Sandeep Bhalla, Honorary Advisor, Training Division, PHFI, Organizing Secretary. The opening remarks were given by Dr. Megha Khobragade, Assistant Director General, Director General Health Services (DGHS), Government of India and Vote of Thanks by Dr. Jagadish A, Joint Organizing Secretary.















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