REVIEW ARTICLE

From uncertainty to solution: A narrative review on challenges of mental health professionals in India before, during and after the pandemic

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ABSTRACT

The current study presents a comprehensive narrative review examining the challenges faced by mental health professionals in India during the COVID-19 pandemic. Prior to COVID-19, India's mental health infrastructure was already under strain, characterized by a substantial treatment gap, scarcity of professionals, and a concentration of services in urban areas. The pandemic exacerbated these challenges, necessitating a swift transition to tele-counselling and online interventions, despite inherent limitations and ethical dilemmas. Increased cases of domestic violence, loneliness, and mood disorders during lockdowns highlighted the urgent need for effective mental health support. The paper discusses pre-existing issues such as stigma, lack of training institutes, and misconceptions about mental health in rural areas. It also explores innovative solutions, including the integration of spiritual and community leaders into mental health initiatives, to address the unique cultural context of India. The study underscores the urgent need for policy reforms, enhanced training, and collaborative approaches to bridge the treatment gap and ensure accessible mental health care in both urban and rural settings.

Keywords: Mental health, community health, pandemic, challenges

Mental Health in India Pre COVID

In India, an estimated 150 million people urgently need mental health interventions, yet only 8 psychiatrists exist for every 100,000 individuals. This stark reality highlights India's mental health crisis.[1] In 1954, the World Health Organization's (WHO) then-director general underscored the fundamental link between mental well-being and overall health. The WHO defines mental health as "*a state of well-being in which every individual realizes his/her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*".[2]

Galderisi et al.[3] proposed a new definition of mental health- "*mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with individual values of society. Basic cognitive and social skills; ability to recognize, express and moderate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium*." By use of the phrase "*dynamic state of internal equilibrium*," the authors are referring to various life events such as marriage or having a child that may require the individual to be flexible and search for a new state of equilibrium. The definition acknowledges that human beings may often experience emotions such as fear, anger and sadness and at the same time possess a resilient attitude which helps in restoring the state of equilibrium. Thus, a shift has occurred in the understanding of mental health, which now encompasses both positive and negative life experiences.

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Many African countries have not yet conceptualized a mental health policy and there are still a large number of countries where only a small percentage of the health budget is allocated for mental health.[4] Obstacles such as existing public health practices, scarcity of trained professionals and lack of access to mental health delivery have characterized the mental health scenario in India as well.[5]

The National Mental Health Survey (NMHS) conducted in 2015-2016 revealed the presence of a significant treatment gap. According to the survey, the treatment gap for mental illness ranged between 70%-92%. For majority of the cases, help was sought from a government facility. The survey also highlighted those severe mental illnesses were usually characterized by a long duration. Among those with a mental illness, at least half had some disability in major domains of life such as occupational, personal and social.[6] According to recent estimates, approximately 150 million people in the country require urgent intervention to address mental illnesses. Approximately 3.6-4.5 million people are in need of hospitalization in a psychiatric facility but there are only a maximum of 8 psychiatric beds available for every 1000 patients.[7] The treatment gap identified by the NMHS survey has been highlighted by other researchers as well. For the Indian mental health scenario, this has long standing consequences. There is a serious scarcity of mental health professionals (psychiatrists, clinical psychologists, psychiatric social workers). Add to this the fact that the practicing mental health professionals are concentrated in urban areas, which leads to existing government facilities being overburdened.[8] Despite multiple programmes such as the 1982 National Mental Health Program and the 1996 District Mental Health Program being implemented, the scarcity of professionals has not been addressed and thereby the treatment gap remains the same.[9]

Mental Health in India Post COVID

With the onset of SARS COVID-19 (Coronavirus Disease 2019) crippling the world, the field of mental health practice had to adapt. With COVID-19 causing a paradigm shift in traditional face to face mode of therapy to tele-counselling, this can pose challenges as well as advantages to the field.

In response to lockdowns, a surge in cases of domestic violence, loneliness and suicidal ideations along onset of mood disorders and distress resulting from substance addictions were noticed.[10,11] The toll on mental health of the population would increase with depression and anxiety symptoms among adolescents and intrafamilial violence,[12] economic struggles pushing more people below the poverty line and leading to higher risk of mental illness.[13,14,15,16] Fiorillo & Gorwood,[17] state the need to increase resources of mental health for the public stating a foreseen increase in demand as a response to trauma and isolation causing a rise in mood and other mental disorders as a result of COVID. Teleconsultations and tele-therapy cannot replace in-person interventions[18] however, they could be established and modified to assist the traditional mental health practices. Semo & Frissa,[19] and, Shah et al.[20] suggest lack of collaboration between different sectors of healthcare results in an inadequate number of mental health practitioners per requirement and suggest using front line healthcare workers during COVID to also combat this issue. Similar problems exist within the Indian context however, given the varied cultural differences and resulting hierarchies seen among the Indian population, community leaders, spiritual heads, and other trained individuals can collaborate with existing mental health practitioners in India to cater to wider populations and identify individuals at high risk. Identification can lead to planning and implementing better intervention protocols.

Challenges Faced by Mental Health Professionals Pre-Covid

India faces a critical shortage of mental health professionals, stemming from the lack of training institutes and insufficient policy prioritization of mental health.[21] Stigma remains a major barrier to seeking help, with individuals often accepting supernatural explanations for mental illness.[22,23] Public awareness is lacking, as demonstrated by limited knowledge of mental illnesses and high prevalence of stigma (74.61%). Mental health understanding in rural areas is particularly problematic, where belief in supernatural causes leads to reliance on faith healers.[24] This highlights the need for awareness campaigns tailored to deeply ingrained beliefs. Homelessness and mental illness have a bidirectional relationship,[25] with chronic

schizophrenia being a common contributor.[26] This can lead to abandonment due to reduced functioning and strained family relationships.[27,28]

Challenges Faced by Mental Health Professionals Post Covid

The pandemic accelerated the need for tele-counselling and online therapy, requiring new regulations and adaptations. Dherendra Kumar[29] a prominent Indian Psychiatrist notes challenges like technological barriers, the absence of physical cues, difficulty engaging children online, ethical dilemmas, and adapting assessments designed for in-person use. However, tele-counselling reduces geographic barriers, expands reach, broadens helpline services, and potentially creates more job opportunities. This offers a post-COVID opportunity for helplines to bridge accessibility gaps in India. Increased internet access in the post-COVID era allows for greater dissemination of mental health awareness and stigma reduction materials. However, India's mental health community remains hierarchical, with limited interdisciplinary collaboration. Awareness initiatives must be tailored to diverse audience attitudes for maximum impact. Community practice must address delayed help-seeking. Spirituality's mediating role in India suggests encouraging spiritual healing as an adjunct to, rather than a replacement for, therapy and medication. Jain and Jadhav[30] argue for decentralizing training to empower community figures (leaders, spiritual heads) for broader reach, stigma reduction, and timely intervention. The pandemic exacerbated unemployment, mental illness, and domestic violence, contributing to homelessness.[31] Mental health professionals must pivot towards training community leaders and NGOs for brief individual/group therapies. Existing homelessness initiatives can serve as models for future policies.

Ways of Tackling Some Challenges from the Pre-Covid Era into the Post Covid

Development of tele-counselling and online mental health services

India faces a vast mental health crisis, with 73 per 1,000 people afflicted and a 3.5% higher morbidity rate in urban areas.[32] This burden drastically outpaces the 0.5 mental health professionals per 100,000 population.[33,34,35] Inexperience and limited training are common issues for mental health practitioners due to accreditation and licensing problems and few higher-level educational opportunities.[36] Burnout among professionals is also a concern, driven by factors like long hours and poor working conditions.[37] The pandemic widened the treatment gap, leading to the rise of helplines like the national KIRAN line, which collaborates with clinical psychologists, psychiatrists, and social workers.[37] Their hierarchical triage system optimizes time.[37] Despite adaptation challenges like technical issues and reduced empathy, helplines increased access and reduced stigma.[38,39]

Inspired by China's model, India could direct internet searches related to suicide to prevention helplines with specialized content.[40] Studies in Rajasthan highlight the accessibility of mobile mental health services for lower SES populations, with limitations being network range and affordability.[41] Optimal contact frequency is twice weekly.[42,43,44] In emergencies, Assamese helplines alert families, prescribe medication, arrange hospitalizations, and coordinate home surveillance.[45] Tele-therapy requires specific competencies to handle technical gaps, first-time client rapport building, and emergency preparation.[46] Initiatives like SUNDAR in Goa demonstrate the power of training laypeople to deliver basic mental health interventions, extending reach to smaller communities.[47] This is especially advantageous for PTSD, alcohol abuse, and perinatal depression. Recent technology can even monitor social activity to predict emotional reactions and identify high-risk individuals.[48,49,50,51] China's 24-hour online counselling, self-help systems, free online books, and AI-powered risk monitoring program offer valuable models for India to adapt.[52]

Overcoming Barriers Caused by Stigma

The cultural norms in India contribute significantly towards a gender divide in mental health stigma, with women expressing significantly higher levels.[24] Despite assumptions that urban areas offer better mental health access, rural-urban differences in treatment-seeking exist.[53] Simply building facilities doesn't guarantee utilization, highlighting the need for strategies beyond

infrastructure. A generalized negative view of traditional healers exists,[54] but successful partnerships with these figures could greatly enhance mental health outreach. The 2012 "Great Push for Mental Health" initiative identified four global challenges: lack of unity within the mental health community, low visibility of mental illness, widespread stigma due to misinformation, and poor access to treatment and rehabilitation.[55] To address these in India:

- Indian television serials could provide significant mental health awareness by including helpline numbers and illness identification tips with their high viewership among older women.[56]
- Short advertisements and radio jingles featuring personal stories could challenge stigma.
- Community-driven efforts like those of the South African Depression and Anxiety Group (SADAG) offer models: talk shows, radio broadcasts in local languages, and collaborations with schools and religious centers.[57]
- Social media campaigns like "*Like Minds, Like Mine*", the #smashthestigma hashtag, and blogger-led mental health discussions help reduce stigma.[59]
- In Bangladesh, a TV show on autism positively shaped cultural and religious attitudes toward various social issues.[60] Careful media portrayals of mental illness can encourage help-seeking, offer hope, provide accurate information, and humanize those affected.[60]

Addressing stigma is especially crucial in the post-COVID era to support caregivers and ensure better intervention outcomes.[61]

Addressing Barriers Leading to Delayed Help through Enhancing Community Practice

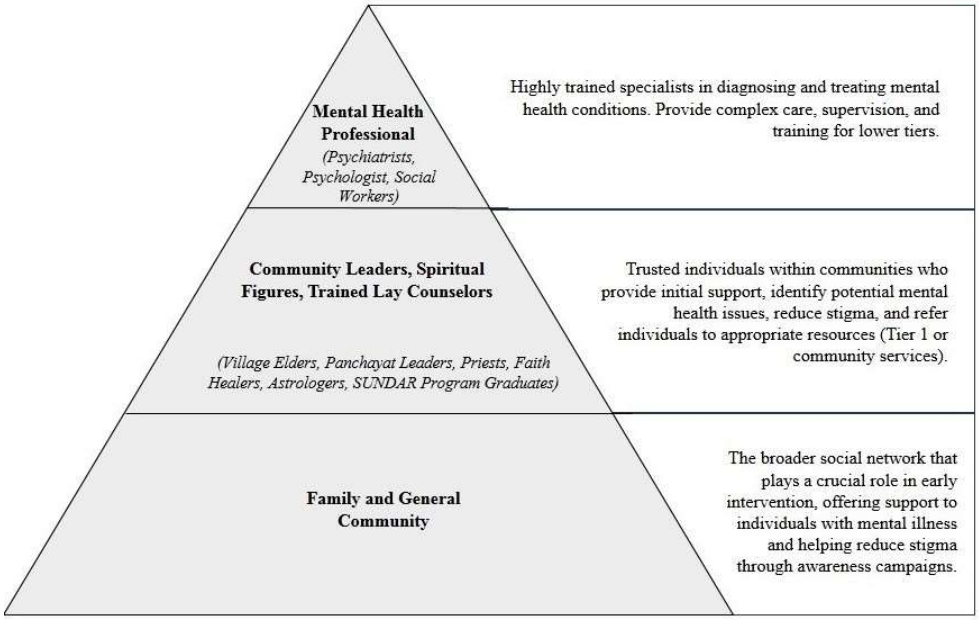
Addressing delayed help-seeking in India requires understanding cultural factors like reliance on traditional healers. In Bangladesh, the tribal group's reliance on local providers for affordability and spiritual treatments highlights similar patterns.[62] India's Muthuswamy Temple, known for spiritual mental illness healing, demonstrates the potential positive impact of environment, routine, and acceptance.[63,64] However, variability in outcomes and potential delays in seeking appropriate treatment must be considered.[65] Collaboration between mental health professionals and religious figures can be beneficial. Religious views can sometimes negatively influence patients, but often serve as a positive mediating factor.[66] Inter-referral between medical and spiritual caretakers promotes better treatment results and reduces stigma. Recognizing the role of community within a villager's identity is crucial, as cultural beliefs about mental illness are often supported by religious figures. Thus, community care models integrating religious healers, particularly at follow-up stages, would be advantageous.

Pastors and other faith leaders in lower-income communities are often primary mental health resources.[66] Providing them with training in psychological first aid, assessment, and prevention techniques would enhance their services. Integrating spiritual workers into the existing multidimensional treatment model, with appropriate certification and supervision, can bridge the treatment gap.[65] Initiatives like the Healthy Beginnings Initiative (HBI) demonstrate the success of utilizing clergy for health interventions.[67]

India's existing cultural reliance on spiritual guidance for mental health issues makes training faith leaders in basic screening and intervention strategies a promising approach to increase awareness and accessibility.[68] Cultural competence is vital; practitioners should incorporate Hindu philosophical concepts, astrological beliefs, and the importance of social support into their practice to resonate with clients.[69,70] Community practice in India faces a biomedical focus as a barrier, but NGOs have greater community reach and less stigma.[71] Incorporating community heads, spiritual healers, and students into NGO initiatives can improve their accessibility. Initiatives like the Child Developmental Centre in Chennai demonstrate how integrating mental health services into educational settings reduces stigma and provides students with valuable experience.[72]

Global examples offer additional models. In Afghanistan, training family members for domestic violence intervention demonstrates the power of lay counsellor models supervised by mental health professionals.[73] India's Tele-

Figure 1. Hierarchical Community-Based Mental Health Care Model in India



MANAS program emphasizes layman's terms over technical language to reduce stigma and trains local counsellors on symptom recognition and brief therapies.[74, 75] Vietnam's clinical trials on Supported Self-Management (SSM) for depression, culturally adapted and emphasizing patient responsibility, and show promise as a low-cost, community-based management option.[76]

Figure 1 illustrates the hierarchical community-based model describes the need for bridging India's mental health treatment gap. At the top, mental health professionals (psychiatrists, psychologists, social workers) provide training and supervision. The next level consists of community leaders, spiritual figures, and trained lay-counselors who extend reach, offering initial support, and identifying at-risk individuals. The base of this pyramid is the broader community, including families, where awareness campaigns can destigmatize mental health and encourage early intervention. Arrows indicating two-way collaboration between these tiers are essential. This model leverages existing trust with community figures, reduces the burden on specialized professionals, and addresses both stigma and lack of access.

Homelessness

It is hard to find a clear definition of being homeless in India given the number of people falling below the poverty line, 4.5 lakh houseless families, and those[77] living in kutcha housing (which is temporary, poor quality, inadequate standards), following a nomadic lifestyle based on their culture, occupants of emergency camps etc. Patra & Anand[78] advocate for a precise Indian-context definition and reliable estimation methods, alongside linking homelessness programs with the National Rural Employment Guarantee Act. That Act mandates work or unemployment allowance, focuses on women laborers, provides childcare, and prohibits gender-based pay discrimination.[79]

The COVID-19 pandemic highlighted the vulnerability of India's homeless. Banerjee & Bhattacharya[80] suggest NGOs' efforts could be augmented by repurposing school grounds as shelters and ensuring hygiene and mental health support. Health-seeking barriers include prioritizing basic survival needs, fear of service denial for lack of ID, and, for homeless children, fear of police or social services involvement.[78] Domestic violence can both cause and be perpetuated by fear of homelessness for women. This makes them vulnerable to abuse, exploitation, health risks, and exclusion from government programs.[81] Initiatives like Tamil Nadu's government-backed Emergency Care and Recovery Services (The Banyan) offer promising models. This 120-bed facility caters to homeless women with mental illness, providing crisis care and multidisciplinary treatment, alongside employment and reintegration opportunities.[82]

Inclusive Living Option services support long-term disability care and community re-entry. The Banyan's training programs in social work and community mental health address staffing needs, benefiting both service-seekers and students.[83] Prescilla[84] emphasizes skill training for homeless youth to ensure employability and advocates for a national policy framework. The National Urban Livelihoods Mission supports self-help groups, skill development, and shelters for the urban homeless.[85] Collaborations like that in Adilabad, where an NGO-run night shelter receives government funding, offer scalable models. *Sadak Chaap's* informal vocational training program for Mumbai's street children improves living conditions for them and others.[86]

Nair & Raghavan's[87] survey highlights the urgent need for outreach programs to educate the homeless about government schemes and eligibility. Accessible toilets, healthcare, and decentralized shelters are recommended. More *anganwadis* (child development centers) at construction sites are needed to provide nutrition.

Way Forward for Mental Health Professionals and Policy Makers

To enhance mental health care in India, several initiatives are recommended. First, there's a critical need for developing educational resources on tele-counselling. This includes books, materials, and courses focused on ethics, cultural considerations within India, and legal policies for online therapy. Integrating tele-counselling into all psychology programs is essential for training the next generation of therapists. Second, investment in digital phenotyping offers significant potential. By tracking smartphone data for markers of mood disorders, it enables large-scale screening. Prioritizing development and implementation of better online platforms is crucial, with funding dedicated to upgrading existing online intervention services for wider accessibility. Third, stigma reduction requires focused action. Support groups dedicated to tackling stigma should be formed with partnerships between mental health professionals, schools, and workplaces. To ensure effectiveness and safety, these groups need government funding, collaboration with registered mental health organizations, and adherence to stringent policies. Fourth, engaging spiritual and community leaders in rural areas is vital. Tailor-made courses for these leaders, along with well-defined triage policies, will extend mental health awareness and initial support within communities where formal services are often scarce. Finally, the absence of a regulatory board for NGOs poses ethical challenges for treatment and research within these organizations. Creating an official board to oversee NGOs will ensure compliance with ethical standards and safeguard the rights of those receiving services or participating in research.

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