Regularising Qualifications within the Mental Health Industry

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Issue Brief

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ISSUE BRIEF

Regularising Qualifications within the Mental Health Industry

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ABSTRACT

The MHA 2017 was a long time coming and a necessary revamp of the Indian State's engagement with the mental health infrastructure of India. The Act makes claims of ensuring patient-centric affordable health care. This piece would specially advocate for a policy mechanism which recognises a larger ambit of mental healthcare practitioners to create engagement with the mental health infrastructure of the country. The paper employs stakeholder interviews to substantiate claims and offer possible policy changes.

UNDERSTANDING THE MENTAL HEALTHCARE SPECTRUM

Mental Health Act [MHA], 2017 came into effect in May 2018 and repealed the Mental Health Act, 1987. This act was lauded for being patient-centric and ensuring that mental healthcare services were "available, affordable and accessible" (Mishra, A. & Galhotra, A. 2018). The act helps the Indian mental health legislation meet 68% of the WHO checklist for the given mental health legislation (Duffy, R. M. & Kelly, B. D., 2020). While the Mental Health Act 2017 (MHA, 2017) was a long time coming, and its decriminalisation of suicide was some critical improvements, this paper focuses on the patient-centric understanding of the bill.

The mental health spectrum is wide, requiring a policy understanding differentiating between mental health illness and mental healthcare. Mental health illness is diagnosed through clinical tests and has a clear prognosis involving medication and therapy but is not limited to the same. On the other hand, mental health care is the realisation of the need for life and mental health adjustment to better deal with ongoing stressors. However, it is critical to understand how the Indian Mental Health Act engages and fails to recognise regularising the myriad qualifications of mental health practitioners.

At present, education institutions in India train mental health practitioners for mental illness (psychiatrists, clinical psychologists, nurses) and mental health care (psychologists, counsellors, therapists, to name a few). Yet, no law currently recognises the ample ambit of mental healthcare practitioners. The MHA, 2017 only recognises clinical psychologists and psychiatrists as mental health practitioners, which only encompasses mental health infrastructure for mental illness.

There is a mismatch between education being provided and recognised practitioners by law within the field. This mismatch results in tangible costs for the industry, where many practitioners are actively involved in healthcare practice and have no regulation on their ambit and scope. Qualifications within mental healthcare practitioners are important because their education defines the scope of their ability as a practitioner. This vulnerability and lack of clear policy structure create conditions where the mental healthcare system is informal, and the ambiguity has tangible health and economic costs for patients.

Furthermore, patients become vulnerable because mental healthcare literacy continues to be low in the country. While there are no clear and systematised studies indicating nationwide numbers. Studies have shown that mental health literacy, even among adolescents, is very low, where depression was only recognised by 29.04%, and schizophrenia was recognised by 1.6% of the population subset (Srivastava, Chatterjee & Bhat, 2016).

Certificates and licenses are not mandatory, and people seeking mental health intervention are unaware that it is their prerogative to ask mental health practitioners about their qualifications, licensing or certification. With no regulation of qualifications in mental healthcare and the resultant varied ambit and scope of various practitioners, no recognition of private institutes and mental health centres which deal with mental healthcare and not mental illness, the complete mental healthcare industry is not regularised within the Indian policy system. This also leaves enough informality for non-qualified practitioners to crop up and create conditions which actively harm the healthcare of individuals seeking intervention.

Most private mental healthcare centres and therapeutic practitioners engaged in private practice are accessed by patients seeking preventive or immediate intervention to specific stressors in life. This whole industry lies outside the regulation of the Mental Health Act 2017. This leaves the patients uninformed, unprotected, and unaware of the benefits that would accrue from their chosen or given healthcare practitioners.

The study uses a mixed research design supplemented by primary and secondary data sources. The primary data sources include interviews and archival resources. Secondary sources include National Mental Health Survey, 2016, research papers, and review articles. Interviews were taken from a non-homogeneous sample of mental health practitioners from the country. The details for the semi-structured interviews, interviewees and questionnaires have been added as Appendix 1 for the reader's reference. Archival sources include the parliamentary debates and Mental Health Act, 2017, and Mental Health Act, 1987. These interviews from the field try to build on stakeholder conversations that have been missed in formulating the current Mental Health Act.

MENTAL HEALTH ACT, 2017

The Mental Health Act, 2017 is the first law to define mental illness "as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement or ability to meet the ordinary demands of life, mental conditions associated with abuse of alcohol and drugs." (MHA, 2017). Dr Heena Vijaykumar Gavit, MP from Maharashtra while discussing the MHA, 2017 in the Parliament spoke to the aims of the bill, it "seeks to remove the stigma attached to mental illness. It makes efforts to secure equal treatment for persons with mental illness just like people with other physical illnesses." (Lok Sabha Debates, 27th March 2017).

This Act also overturned the outdated 309 IPC, criminalising suicide in India. Through this Act, acute stress is attributed as the primary cause of mental illness until proven otherwise. Yet, the policy only seems interested in diagnosable and severe mental illnesses, which can result from various other causes. The law also ensured that electro-convulsive therapy (a clinical and surgical procedure where electrical currents are passed through the brain to stimulate seizures) is outlawed for all children and adults where the illness has progressed, it is mandatory to use anaesthesia for the therapy.

The bill creates Central, State and District Mental Health Authorities, which recognise and regulate three mental health practitioners: clinical psychologists, mental health nurses and psychiatric social workers. Only the following mental health professionals constitute mental health institutes that also come within the purview of the stated authorities. Specifically, the authority will be responsible:

1. Register, supervise and maintain a register of all mental health professionals
2. Develop all quality and service provision norms of such establishment
3. Maintain a register of mental health professionals
4. Train law officials and mental health professionals on the provisions of act
5. Receive complaints about deficiencies in the provision of services
6. Advise the Government on matters relating to mental health

SPECTRUM OF MENTAL HEALTH AND REQUISITE QUALIFICATION

Within the parliament, it was recognised that the bill is still not all-encompassing. Dr. Ratna De (Nag), MP for West Bengal, pointed out in the Parliament that the bill did not account for the shortage of mental health practitioners[1]. Shri Bhartruhari Mahtab also detailed the lack of infrastructure that the bill fails to address[2]. The lack of infrastructure and requisite mental health practitioners is exacerbated by the absence of accounting for the majority of the industry itself. While for mental illness, the Act accounts for the mental healthcare system by recognising the role and scope of psychiatrists and clinical psychologists, the same cannot be said for mental health care; thus, people are made vulnerable to prying and predatory systems in the informal sector with no scope for redressal. The MHA, 2017 does not recognise various mental health practitioners within the field, licensed professional Counsellor, Mental Health Counsellor, Psychologist, Psychotherapist, Psychoanalyst, Addiction and Religious Counsellor, and Art Therapist to name a few recognised within the industry.

While recognition of mental health practitioners beyond clinical psychologists is not present globally, UNHRC mentions only a clinical psychologist by name. The definition is still broad enough and encompassing, as "Mental health practitioners" mean a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care" (UNHRC, 1991). Giving enough space within policy to manoeuvre and recognise other mental health practitioners.

Snigdha Mishra (Interview 03), a founding member of the Bharatiya Counselling Association and a practising psychotherapist with 16 years of experience, developed the difference between a clinical psychologist and other trained professionals by pointing out that disability test administration, certification and care is the unique scope of a clinical psychologist. The spectrum of mental health is vast, and the progression of mental illness to disability is not always the case. The distress experienced, the disability felt, and the pathology together define the diagnosis of illness. Given such circumstances, a clinical psychologist might not be the right choice of practitioner for all people. Stated poignantly, "The Mental Healthcare Act, 2017 actually is a Mental Illness Healthcare Act…it does not cater to everyone with mental health issue but only patients suffering from a diagnosed and progressed mental illness, where medicinal intervention is necessary".

Interview 05, a trained counselling psychologist from TISS Mumbai with ten years of practice in Mumbai, pointed out that even patients suffering from mental health illnesses need an all-encompassing approach where diagnosis, medication, therapy and counselling are all needed for better health care. She further pointed out that counsellors are better equipped to care for people who need

1 - Dr. Ratna De (Nag), "There are about 4000 psychiatrists in India. Most of them are in private practice. So, there is a massive shortage of psychiatrists in the public sector. This will lead to a large number of people requiring treatment remaining undiagnosed." (Lok Sabha Debates, 27th March 2017)

2 - Shri Bhartruhari Mahtab, "The existing medical infrastructure is poor. Lack of specialists to treat mental disorders is another problem. India has just 0.1 psychiatrists for one lakh people compared to 1.7 for one lakh in China. Over 50 per cent of the mentally ill in India have no access to healthcare…While the intentions of the Bill are laudable, much of it will fall through the cracks unless appropriate infrastructure is set up."(Lok Sabha Debates, 27th March 2017)

mental health adjustment, which can result from illness, trauma or even stressors in life. It was clear from all these interviews that, at this time, the policy has not engaged with the complete scope of mental health requirements and the mental health care industry available.

Mental healthcare practitioners and the industry have tried to respond to these concerns by establishing the Counsellors Council of India in 2004, which provides licensing and certification to counsellors. This was further lent credibility through the Gramin Yuwa Vikash Samiti in 2011, but they are yet to scale their regulating abilities as the Central, State and District Mental Health Authorities.

PATIENT VULNERABILITY

With the prevailing rates of mental health illiteracy, most patients would not know what to expect from therapeutic intervention and which intervention would suit their immediate and underlying costs. Given the ambiguity of the field itself, mental healthcare is a spectrum and requires different interventions for different concerns, problems and illnesses the patient vulnerability exacerbates.

A truly patient-centric act needs to recognise within the policy itself the scope of mental health practitioners with varied qualifications. The same is not true for mental healthcare because mental illness is debilitating and can be intervened through third-party recognition. Most people seeking mental health adjustment, mental health intervention and preventive intervention are self-motivated, and clear policy ambits would empower patients and clients to make informed mental healthcare decisions. This policy intervention is needed to prevent tangible costs for patient health.

The economic vulnerability, even given the MHA 17 objective of accessible and affordable health care, is extremely high. A recent study shows that the average household income due to mental illness increases by 18.1% of household income, a burden further exacerbated by poverty. There are no government schemes where Mental illness is recognised as a disability and covers the entire healthcare cost. When only mental illness is recognised within the law, insurance policies do not cover the costs of mental healthcare. Furthermore, there is no impetus and given the lack of clarity within the industry, insurance companies would not want to enter given the informality within the sector.

MENTAL HEALTHCARE AND INFORMOLISATION

There is another worrying trend of this lack of recognition and regulation within the mental health sector: a booming system of social media psychologists. These people call themselves mental health practitioners with limited education, including Instagram influencers, religious healers, and life coaches. Most mental health practitioners agreed that these systems were in place because of the secrecy that shrouds the mental health system in India.

Interviewee 12 pointed out that most of these places resulted from two flaws within the industry itself, first, the lack of recognition that Indian social systems fail regarding support systems and second, because the industry within itself continues with many unethical practices. Patients identifying within

the LGBTQ+ community find it very difficult to find access to mental health practitioners who are Queer affirmative. These are tangible concerns of people seeking mental health intervention, who, with minimal awareness among people accessing the mental health industry people, fall prey to these predatory practitioners.

Snigdha Mishra (Interview 03), founding member of Bharitya Counselling Association and a practising psychotherapist with 16 years of experience, pointed out that her organisation does not intend to operate in a vacuum and believes in the need for 'Peer support communities'. They have robust training modules to better prepare communities with mental health adjustment, which might be required by people seeking mental health intervention. These communities sustain mental health-oriented community health programmes.

Another consensus among the interviewees was the presence of these informal mental healthcare systems was well-intended and was not always intended to be exploitative. One outlying interviewee (10), a clinical psychologist in training at RML Hospital, New Delhi, pointed out that sometimes these pop psychology-oriented health initiatives could be led by people who feed off the cult following they have been able to build for themselves. In such situations, the care of the person seeking mental health intervention is pushed to service inflated egos.

Most practising professionals who were interviewed pointed out that the only qualification that these mental healthcare popups present are listening skills, and without robust training and the ability to recognise when mental health professionals need to intervene, these well-intended communities can also create conditions where mental health concerns are exacerbated. The person's severity might increase on the spectrum because they are not receiving the appropriate care necessary.

CONCLUSION

There is an urgent need for a policy system within India to respond to these regulation concerns. Currently, the mental health industry is operating entirely in an informal system with tangible costs for patient care and access to affordable care. Policy needs to become informative and involve various stakeholders at the stage of policy creation. There needs to be a recognition that mental health is a spectrum, and preventive mental health intervention is starkly different from mental illness intervention. All mental health practitioners need to have a regulating body whose decision-making body gives representations to all stakeholders. The Government of India needs to recognise this body to define the qualification and scope of various mental health practitioners and spearhead mental health literacy programmes nationwide. There needs to be a three-pronged approach, where the first will be to reduce the stigma associated with mental health illness and increase mental health literacy, and the second will be to regulate the mental health industry and ensure the industry does not continue outside the ambit of policy and lastly, there needs to be a mental health policy where all the provisions of the Mental Health Act, 2017 can be fulfilled.

APPENDIX - 1

1.A: Semi Structured Interview Questions:

1. The regulation of qualification within the private sector for mental health practitioners continues to be a policy miss. How does this impact:

a. the discipline of Clinical psychology
b. the professionals practicing currently
c. people who access these private unregulated mental health care spaces

2. What would be the ideal qualifications for various patients, if they are to make an informed choice? What is the scope of various different qualifications within the mental healthcare?

3. After COVID-19 Online portals developed of people providing mental health safe havens and called themselves 'Empaths'. Given the burden on the healthcare system during the pandemic- did these spaces help? Did they have any tangible benefits?

4. These Empath run safe havens/Private health care healing centres- what are the risks and pitfalls of not differentiating them from the mental healthcare practice?

5. Any policy recommendations that you think would safeguard both the clients and the practitioners within the healthcare industry?

1.B Sampling and Sample Size

The paper employed a snowball sampling technique to interview 15 mental health practitioners and mental health practitioners in training.

Interviewee	Stakeholder	Experience
1	Counselor	7 years
2	Trained Social Worker	2 years
3 Snigdha Mishra	Psychotherapist	16 years
4	Social Worker	3 years
5	Counseling Psychologist	10 years
6	School Counsellor	4 years
7	Clinical Psychologist	6 years
8	Family Therapist	8 years
9	Training Counsellor	-
10	Training Clinical Psychologist	2 years
11	Addiction Specialist	1 year
12	Queer Affirmative Counsellor	5 years
13	School Counsellor	10 years
14	Psychotherapist	2.5 years
15	Empath	7 months

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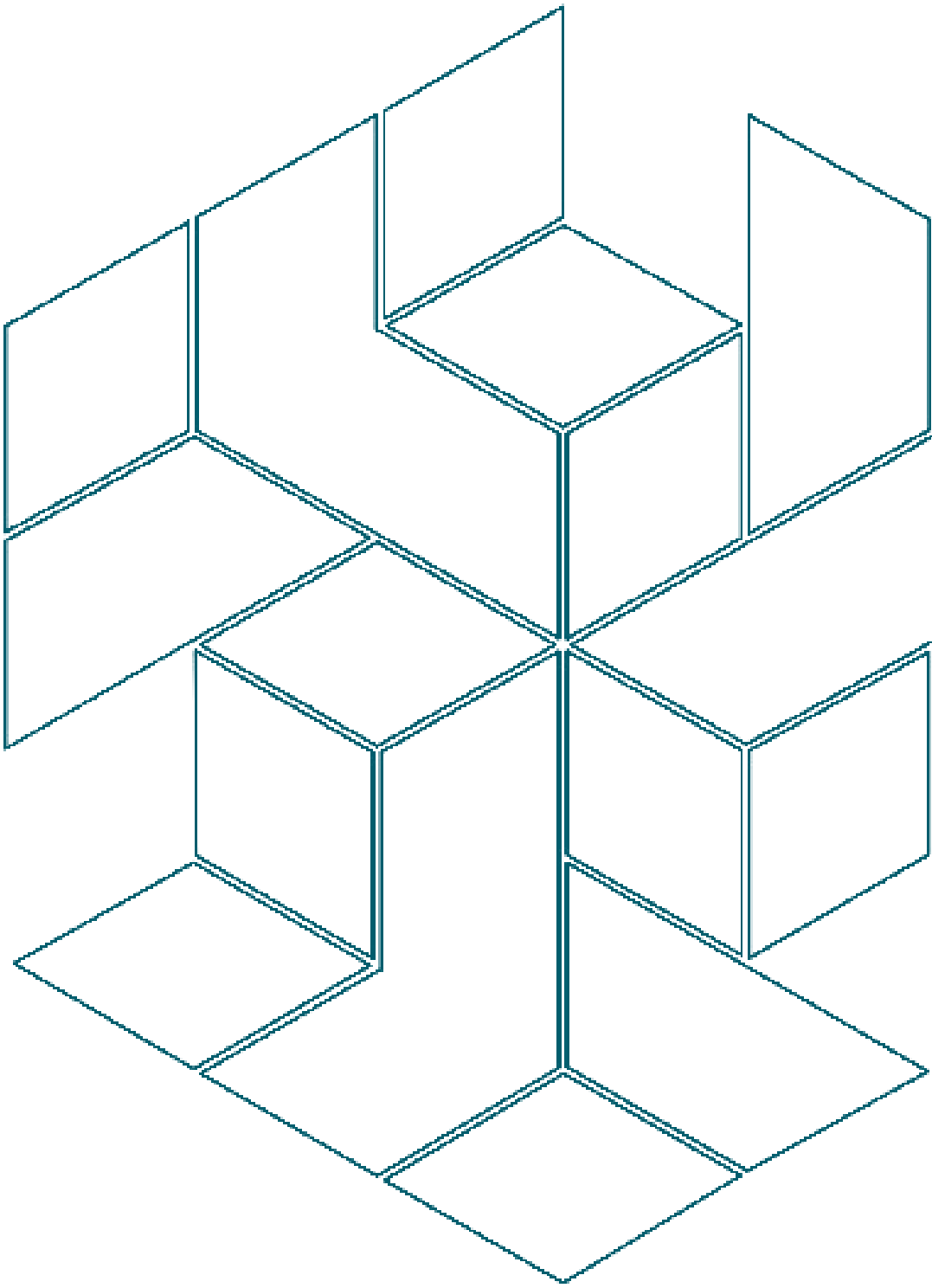

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