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COMMENT

Alternative medicine under the Mental Health Care Act, 2017: Future implications and concerns

RAMDAS RANSING, SUJITA KUMAR KAR, VIKAS MENON

Abstract

In recent years, the Indian government has been promoting healthcare with an insufficient evidence base, or which is non-evidence-based, alongside delivery of evidence-based care by untrained practitioners, through supportive legislation and guidelines. The Mental Health Care Act, 2017, is a unique example of a law endorsing such practices. In this paper, we aim to highlight the positive and negative implications of such practices for the delivery of good quality mental healthcare in India.

Keywords: *mental health services, mental disorder, law, patient rights, India*

Introduction

On April 7, 2017, the Government of India approved the Mental Health Care Act (MHCA), 2017, "to provide for mental healthcare and services for persons with mental illness, and to protect, promote, and fulfil the rights of such persons during delivery of mental healthcare and services" (1). Section 2 (p) and (r), Section 18(10), and Section 34(1) (c) of the MHCA, 2017 include the provision of mental healthcare through the traditional systems of medicine such as Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH)(1). This inclusion was primarily intended to reduce the existing large treatment gap for mental illness ranging from 70% to 92% according to the National Mental Health Survey 2015-16, to provide integrative and holistic care, and to promote inter-disciplinary research for mental health (2).

Authors: **Ramdas Ransing** (corresponding author – ramdas_ransing123@yahoo.co.in) Associate Professor, Department Of Psychiatry, BKL.Walawalkar Rural Medical College, Sawarde, Ratnagiri 415 606 Maharashtra, INDIA; **Sujita Kumar Kar** (drsujita@gmail.com), Associate Professor, Department of Psychiatry, King George's Medical University, Lucknow 226 003, Uttar Pradesh, INDIA; **Vikas Menon** (drvmenon@gmail.com), Additional Professor, Department of Psychiatry, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Puducherry 605 006, INDIA.

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Currently, in India, AYUSH practitioners are often found to practise modern medicine (allopathic medicine) without adequate training in modern medicine (3,4). Hence, the chances that MHCA, 2017 will further promote such practices in the treatment of mental illness are high. This paper attempts to explore the potential benefits of inclusion of AYUSH systems in mental healthcare, the underlying factors that can promote undesirable mixed or "cross-pathy" practices, and some recommendations to prevent and reduce the potential adverse consequences on mental healthcare service delivery.

Potential benefits of inclusion of AYUSH under MHCA, 2017

AYUSH comprises the Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy systems. Ayurveda is a traditional Indian healthcare system based on the humoral principle of *Tridosha* (ie, three bioforces, *vata, pitta,* and *kapha*) for maintenance of good health including mental health (5,6). It is the most popular system among the traditional, complementary, and alternative medicine systems in India. Yoga is based on non-pharmacological interventional regimens (ie, postures (*asanas*), breath control (*pranayama*), and meditation (*dhyana*) for the treatment of common mental disorders, as well as the promotion of mental wellbeing and health (5,7). Similarly, the naturopathic principles focus on external and internal changes in five essential elements of life for the management of health conditions. Spirituality is encouraged in the naturopathy system of medicine(8). Unani is a Graeco-Arabic medical system based on the concept of humours (blood, phlegm, yellow bile, and black bile)(5). Unani treatment mainly includes regimental therapy, special diets, herbal medicines, and surgery. The priciples of diagnostics and treatment in the Siddha and Sowa-Rigpa system of medicine is similar to that of Ayurveda. The homoeopathic medical system is based on the principles of *"Similia similibus curentur"* (Like cures like). Animal, plant, mineral, and synthetic substances are examples of remedies (5).

It is important to note that, the AYUSH systems of medicine have provided a more holistic approach to the diagnosis and management of mental illness, as well as mental health

promotion, than western models of mental illness (6). For instance, there are some striking similarities between modern psychiatric models of gut dysregulation and depression and Ayurvedic perspectives (9). Therefore, the inclusion of AYUSH under MHCA, 2017 may encourage interprofessional collaboration between modern medicine and AYUSH psychiatry. Such collaboration may help to reduce the gap in mental healthcare, explore the potential benefits of AYUSH medicine or intervention (eg, Yoga), and establish a community of mental health practitioners (5).

Published literature suggests that some non-pharmacological interventions (eg, aspects of psychotherapy, Yoga) are effective in the management of common mental disorders(6). On the other hand, other previous reviews and meta-analysis have demonstrated that there is insufficient scientific evidence for AYUSH interventions (5). Since the majority of published studies are low-quality clinical trials, no firm conclusions can be drawn regarding the effectiveness of any category of AYUSH interventions (5). This is one of the main reasons for undesirable mixed or "cross-pathy" practice among AYUSH practitioners. In addition, there are other underlying factors that may promote undesirable mixed or cross-pathy practices for mental health in India as discussed below.

Underlying factors that may promote undesirable mixed or cross-pathy practice

Legislation

In India, a cadre of mid-level healthcare providers has been created to strengthen primary health centres (PHCs) and community health centres (CHCs) for provision of healthcare services. For this, the Indian government has started a bridge course for nurses and AYUSH practitioners/students, with the goal of allowing bridge course graduates to work as mid-level health care providers(10).

However, through permissive legislation (National Medical Commission Act, 2019 Section 32(1), MHCA, 2017), bridge courses, and creating a cadre of mid-level healthcare providers, the Government and policy makers have been consistently promoting modern psychiatry practices among AYUSH practitioners/ students (11–14).

Many AYUSH practitioners prefer to work under national programmes such as the National Health Mission (NHM) due to a lack of job opportunities in the private and public sectors. Furthermore, the government appoints them under such programmes due to a shortage of modern medicine practitioners in India. However, such AYUSH practitioners are often encouraged to prescribe allopathic medicines, in many states, despite the central government's lack of sanction for this practice (15).

Training

The AYUSH postgraduate syllabus (psychiatry equivalent subject) — AYUSH syllabus for mental health includes both AYUSH and modern psychiatry components(16–20). Therefore, the AYUSH postgraduate students are expected to learn the principles and diagnostic and therapeutic approaches of both these systems. The systems are based on different principles as shown below:

- The AYUSH component is based on a different understanding of mental illness in terms of etiopathogenesis and therapeutic procedures: Ayurveda, for instance, has *Antah Karana chatushtaya* [four internal faculties], *bhutas, grahas,* and pharmacopeia in Ayurveda.
- The modern psychiatry component includes the areas of basic and clinical sciences: eg. neuroanatomy, neurophysiology, clinical disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), and International Classification of Diseases (ICD) -10th Edition (ICD-10) technology (Electroencephalography, and Magnetic resonance imaging procedures (Electroconvulsive therapy), and modern medicines (antipsychotics or mood stabilisers).

The mixed syllabus has been prepared and approved by Indian universities and statutory bodies (16). The lack of confidence in the effectiveness of AYUSH care and ambivalence towards both AYUSH and the modern psychiatry component could be a reason for recommending this mixed syllabus (4). However, this ambivalence is creating a dilemma among AYUSH practitioners about whether to practise modern medicine or the AYUSH systems of medicine in future, along with the false assumption that they have been comprehensively trained in both AYUSH and modern psychiatry.

Mentoring and assessment

Completing both the AYUSH and modern psychiatry components of the syllabus without a mentor for modern psychiatry over three years of course duration could be frustrating for postgraduate AYUSH students (4,21). Also, modern psychiatry has only a small weightage in the postgraduate AYUSH examination (4). These factors have a negative impact on achieving an in-depth understanding of mental illness as well as of therapeutic processes. Furthermore, the absence or non-inclusion of modern psychiatry teachers in the mentoring and assessment of AYUSH postgraduates may have an impact on the quality of delivery of mental health services.

Evidence for interventions

There is little or no evidence supporting the effectiveness and safety of AYUSH interventions (3,22,23). However, some interventions (eg, yoga) can be used as a low-intensity intervention, adjuvant, or supportive treatment in some mental illnesses (7,24,25).

To sum up, supportive legislation, mixed syllabus during training, government encouragement, and insufficient or no

evidence in support of AYUSH medicine pushes AYUSH practitioners to treat a mental illness using mixed practices.

Potential public mental health consequences of inclusion of AYUSH in the MHCA, 2017

Currently, mental health services in India are patchy, underdeveloped, neglected, and difficult to access for the vast majority of people with mental illness (2). The inclusion of AYUSH in the fold of mental healthcare has added a new pathway, which may act as a barrier to accessing specialist mental health services, eg, people suffering from mental illnesses and their caregivers may prefer AYUSH services that currently lack evidence, causing a delay in seeking evidence-based mental healthcare.

Despite the insufficient evidence, the AYUSH system of medicine is widely accepted in India. The main reasons for this acceptance is the belief that AYUSH medicines have no side effects; that AYUSH care is linked with religion, tradition, or culture; and the promotional activities by non-institutionally qualified individuals and the government (3,26). On the other hand, modern psychiatric interventions are avoided due to adverse effects (eg electroconvulsive therapy), high cost of medicines, and stigma (27).

According to MHCA, Section 5(1), every person, except a minor, has the right to make an advance directive in writing on how they want to be cared for and treated for a mental illness or how they do not want to be cared for and treated for a mental illness(1). In our opinion, AYUSH inclusion may encourage people with mental illness to prefer non-evidence-based care using the advanced directive option under MHCA, 2017 and potentially delay evidence-based care(28). Further, it will add to the pre-existing barriers to mental health such as stigma, low mental health literacy, and inadequately trained human resources (AYUSH psychiatrists) (29,30). Also, the inclusion of AYUSH medicines with insufficient evidence in routine care will raise the overall cost of mental illness treatment.

The concept of illness, as explained to patients and their caregivers by these practitioners will differ from the explanatory model given by the modern system of medicine in several instances. For example, Ayurveda conceptualises the role of *bhutas* and *grahas* in the etiology of mental illness (18). The *bhutas* are external factors that contribute to mental illness. According to Atharvaveda, *bhutas* are mainly of two types: (a) *Drishya* (causative agents which can be seen) and (b) *Adrishya* (causative agents which cannot be seen or investigated)(31). However, these terms can create a lot of confusion and misunderstanding among patients (eg, *bhuta* can be misinterpreted as "ghost" or "demon') and their caregivers regarding the conceptualisation of the illness, which can subsequently influence the establishment of the therapeutic relationship, treatment adherence, and disease outcomes if they eventually access specialist mental healthcare services. The clinical notes mentioning the role of *bhutas* and *grahas* can increase the stigmatisation of mental illness (17,32). On the other hand, some modern psychiatry treatment modalities (eg, electroconvulsive therapy), diagnosis(eg, schizophrenia), and treatment facilities (eg, "mental hospital") are also associated with stigma (33,34).

Patient care requires a reasonable degree of understanding of illness, sound theoretical grounding, an etiology-oriented approach, and clinical skills. The published literature suggests that irrational prescriptions of allopathic medicine are quite common (up to 80%) among AYUSH practitioners due to inadequate or superficial understanding of these illnesses (4). Such irrational mixed prescriptions may not be therapeutically effective, or worse still, may be potentially harmful to the patient. For example, schizophrenia may be treated by an AYUSH doctor using antipsychotics. However, such practitioners may not be adequately trained to detect or manage the serious adverse effects of antipsychotic drugs or other psychiatric medications (eg, neuroleptic malignant syndrome : a life-threatening adverse reaction to antipsychotics characterised by altered mental status, fever, muscle rigidity, and autonomic dysfunction)(35). Further, the use of different or mixed diagnostic or classification systems (eg, ICD-10 or/and *Manasavikara Vargeekarana i*e Ayurveda classification of mental disorders) can affect estimation of epidemiology of mental illness (36).

AYUSH services and mixed practices are most likely to be accessed by the rural populations, poor, illiterate, and marginalised people due to their availability among less served regions (37). As they are the first point of contact for patients, an incorrect diagnosis using DSM-5 or ICD-10 or diagnosis with the AYUSH classification system could increase forensic and legal issues (eg diagnosing a major illness such as schizophrenia or bipolar disorders as minor illness, or vice versa, due to inadequate training in administration of DSM-5 or ICD-10 or AYUSH classification systems). Thus, the provision of good quality mental healthcare services without inequalities and discrimination as envisaged under MHCA, 2017 may be difficult to deliver (38).

The cost of unproven medicines will put an additional financial burden on different states' mental health services and people with mental illness. This will further affect the delivery of evidence-based care and the services of competent psychiatrists. The government may not be able to monitor the quality of such services. In future, despite early contact with the healthcare system, many people with mental illness may remain undiagnosed, untreated, or inadequately treated, contributing to poorer prognosis and outcomes.

Recommendations

In our opinion, the mixing of different systems of medicine could result in more harms than the expected benefits. Ideally, policymakers should discourage mixing different

systems of medicine through legislations and policies till sufficient evidence is available. Instead, the practice of different systems of medicine with clear inter-disciplinary boundaries must be encouraged.

Unfortunately, this could be a difficult task due to the large treatment gap for mental illness, human resource constraints (lack of adequate access to modern medicine /psychiatry), legislation (AYUSH degrees are approved by Indian universities and statutory bodies such as Central Council of Indian Medicine, and MHCA-2017), lack of political commitment to evidence-based mental healthcare, and social-cultural-political support to the AYUSH systems. Considering this, we would like to provide some alternative suggestions to prevent or reduce these adverse consequences:

- The government and policymakers should have their primary focus on the provision of evidence-based, quality care to patients with mental illness. They should promote acceptable practices and professional harmony across all systems of medicine.
- The AYUSH systems of medicine need more research and innovations to establish evidence of their effectiveness and safety.
- An integrated and collaborative system of referrals (eg, screening and referral by AYUSH practitioners after adequate training for detection of common mental disorders and the appropriate referral pathways) can improve access to care in mainly rural areas.
- The AYUSH therapies should be explored for evidence in a phase-wise manner (eg, preventing mental health problems, promoting positive mental health) through inter-disciplinary research and by establishing integrative centres on the All India Institute of Medical Science- Centre for Integrative Medicine and Research (AIIMS-CIMR model) (39).
- Both modern psychiatry and AYUSH teachers should be involved in the mentoring and assessment of AYUSH postgraduates.

To conclude, addressing the enormous mental healthcare treatment gap in India is essential. However, practitioners and policymakers should not attempt to reduce it by encouraging or discouraging the mixing of different systems of medicine without any scientific rationale or providing non-evidence-based healthcare models/ services/interventions in under-served rural and remote regions. Instead, adequate investment should be made for strengthening the individual systems of medicine through research and innovation.

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