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**Title**: Alternative Medicine for Mental Health Care under the Mental Health Care Act, 2017: Future implications and concerns

**Short Title:** Alternative Medicine and Mental Health Care

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**Abstract :**

In recent years, the Indian government is promoting insufficient or non-evidence-based health care and delivery of evidence-based care through untrained practitioners through supportive legalizations and guidelines. Mental Health Care Act, 2017 is a unique example of endorsing such practices. In this paper, we aimed to highlight the both pros and cons of such practices on the delivery of mental health care in India.

**Main text (Includes 1 Figure and 1 Table)**

**1.0 Introduction:**

On 7th April 2017, the Government of India has approved the mental health care act (MHCA), 2017, to provide mental health care services and protect, promote, and fulfill people's rights with mental illness during the delivery(1). MHCA, 2017 also had a provision to provide mental health care through the traditional systems of medicine such as Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH)(1). Though, this inclusion was primarily aimed to reduce the existing large treatment gap for mental illness (existing: 70 % to 92%), to provide integrative and holistic care, and to promote inter-disciplinary research for mental health (2).

Currently, in India, AYUSH practitioners often practice modern medicine (allopathic medicine) without adequate training in modern medicine(3,4). On this account, there are high chances that MHCA, 2017 will further promote such practices for mental illness. This report attempts to explore the underlying factors that can promote such undesirable practices, and some recommendations to prevent and reduce their potentially adverse consequences on mental health care service delivery (Figure 1.0).

**2.0 Underlying factors that may promote mixed or cross-pathy practices (Table 1.0 and Figure 1.0):**

1. **Legalizations :**
   1. Government and policymakers are promoting modern psychiatry practices among AYUSH practitioners/ students through permissive legislations, bridge courses, and creating the cadre of mid-level health practitioners (Table 1.0) (5) (6).
   2. AYUSH practitioners working under national programs such as the National Health Mission (NHM) are encouraged or forced to practice modern medicine (7).
2. **Training:** 
   1. **AYUSH postgraduate syllabus** (psychiatry equivalent subject)**:** AYUSH syllabus for mental health includes both AYUSH and modern psychiatry component (8). The AYUSH component provides a different understanding of mental illness in terms of etiopathogenesis and therapeutic procedures (e.g., *Antah Karana chatushtaya* [four internal faculties], *bhutas, grahas*, pharmacopeia). On the other hand, the modern psychiatry component includes the areas of basic sciences (neuroanatomy, neurophysiology), clinical disorders (DSM-5 or ICD-10), technology(EEG, MRI), procedures(ECT), and modern medicines (antipsychotics or mood stabilizers). This mixed syllabus has been prepared and approved by Indian universities and statutory bodies (8). The lack of confidence about the effectiveness of AYUSH care and ambivalence towards both AYUSH and the modern psychiatry component could be a reason for recommending the mixed syllabus (4). However, this ambivalence is creating a dilemma among AYUSH practitioners whether to practice modern or AYUSH care in the future, along with the false assumption that they were comprehensively trained in both AYUSH and modern psychiatry.
   2. **Mentoring and assessment**: Completing both the AYUSH and modern psychiatry components of the syllabus without a mentor for modern psychiatry in three years is exhaustive for students. Also, modern psychiatry has a small weightage in post-graduate examination (4). These factors are affecting an in-depth understanding and the therapeutic processes for mental illness.
   3. **Evidence for Interventions:** There is little or no evidence about the effectiveness and safety of AYUSH treatment (3,9,10). Some interventions (e.g., yoga) can be used as a low-intensity intervention, adjuvant, or supportive treatment in some mental illnesses (11–13).

Supportive legalizations, mixed syllabus during training, government encouragement, and insufficient or no –evidence for AYUSH medicine exhort the AYUSH practitioners to treat a mental illness using mixed practices.

**3.0 Consequences on public mental health:**

Currently, mental health services are patchy, underdeveloped, neglected, and challenging to access in India for the vast majority of people with mental illness(2). AYUSH inclusion has added a new pathway to care, which may act as a barrier to accessing specialist mental health services. In India, the AYUSH system of medicine is traditional, complementary, and well accepted. It is widely believed that AYUSH medicines are without any side effects and often linked with Indian culture or religion (3,14). On the other hand, allopathic psychiatry medicines are often linked with adverse effects (15). This may encourage people with mental illness to prefer non-evidence-based care using advanced directive under MHCA, 2017, and potentially delay evidence-based care. Further, it will increase the pre-existing barriers for mental health such as stigma, mental health literacy, financial burden (due to inclusion of non-evidence-based AYUSH medicines), and inadequately trained human resources (AYUSH psychiatrist) (16,17).

The concept of illness explained to the patients, and their caregivers by these practitioners will differ from the explanatory model given by the modern system of medicine in several instances; as an example, Ayurveda conceptualizes the role of *bhutas* (can be misinterpreted as ghost or demon) and *grahas* in the etiology of mental illness (18). It can create a lot of confusion and dilemma among the patients and their caregivers regarding the conceptualization of the illness, which subsequently influence the establishment of the therapeutic relationship, treatment adherence, and disease outcomes when they eventually access specialist mental health care services. The clinical notes mentioning the role of *bhutas* and *grahas* can increase the stigmatization of mental illness (19,20).

Patient care requires a reasonable degree of understanding of illness, sound theoretical grounding, an etiology-oriented approach, and clinical skills. 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, potentially harmful to the patient. For example, Schizophrenia can 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 antipsychotics (e.g., Neuroleptic malignant syndrome or neutropenia). Further, the use of different or mixed diagnostic or classification systems (e.g., ICD-10 or/and Manasavikara Vargeekarana i.e. Ayurveda classification of mental disorders) can affect estimation of epidemiology of mental illness(21).

AYUSH services and mixed practices are most likely to be accessed by rural, poor, illiterate, and marginalized people due to their availability among less serviced regions (22). As they are the first point of contact with patients, an incorrect diagnosis using DSM-5 or ICD-10 or diagnosis with AYUSH classification system could increase forensic and legal issues (e.g. diagnosing the 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 of mental health care services without inequalities and discrimination envisaged under MHCA, 2017 may be difficult to deliver (23).

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 health care system, many people with mental illness may remain undiagnosed, untreated, or inadequately treated, contributing to poorer prognosis and outcomes.

**4.0 Recommendations:**

In our opinion, the mixing of different systems of medicine could be more harmful than the expected benefits. Ideally, the 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 an adequate number of modern medicine psychiatry), legal boundaries (degrees are approved by Indian Universities, MHCA-2017, and statutory bodies), lack of political commitment, benefits of stepped care models, and social-cultural support to AYUSH system. Considering this, we would like to provide some alternative suggestions to prevent or reduce these adverse consequences. First, 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 medicines. Second, the AYUSH system of medicine needs more research and innovations to establish evidence for their effectiveness and safety. Third, an integrated and collaborative system of referrals (e.g., 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. Fourth, the AYUSH therapies should be explored for evidence in a phase-wise manner (e.g., Preventing mental health problems, promoting positive mental health) through the inter-disciplinary research and establishing the integrative centers (AIIMS-CIMR model)(24).

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

**Abbreviations:**

CT: Computed tomography

EEG: Electroencephalography

AIIMS: All India Institute Of Medical Sciences

CIMR: Centre for Integrative Medicine and Research

ECT: Electroconvulsive therapy

MBBS: Bachelor of Medicine and Bachelor of Surgery

PHCs: Primary Health Care centers

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

ICD-10: International Classification of Diseases (ICD) -10th Edition

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**Table 1:** Factors promoting mixing of different systems of medicine for mental health care

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| --- | --- |
| **AYUSH Post-graduation in Psychiatry (Current status)** | * Ayurveda (Mano Vigyan Avum Manas Roga)(18,19) * Unani : Moalijat (Nafasiyatt)(25) * Siddha : Sirappu Maruthuvam(26). * Homeopathy: Homeopathy psychiatry(8) |
| **Legal framework** : | |
| 1. MHCA act, 2017 | **Role of AYUSH practitioners** in mental health care establishment:   * Medical practitioners (chapter 1, section 2-n), * Medical officer in charge (chapter 1, section 2-m), * Mental health professional (chapter 1, section 2-r)(1).   \*Government may designate any medical officer having knowledge and experience in psychiatry as a psychiatrist. |
| 1. NMC Act, 2019 | **Mid-level health care practitioners:** NMC can grant a license to other practitioners (e.g., Nurse, AYUSH) those who have received training as mid-level practitioners (6). |
| 1. AYUSH Acts (Indian Medicine Central Council Act, 1970 and Central Council of Homoeopathy Act, 1973) | **Ambiguous term:** Modern practice(27,28). |
| **Academic factors:** | * Mixed post-graduate AYUSH psychiatry syllabus : * **Bridge course for AYUSH practitioners: e.g.,** Maharashtra University of health sciences: One-year training in modern medicines |

Figure 1: Underlying factors promoting undesirable practices among AYUSH practitioners and their consequences

