



INDIAN ASSOCIATION FOR
CHILD AND ADOLESCENT
MENTAL HEALTH (IACAM)

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TECHNICAL REPORT

Research & Compilation of Project

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE MAPPING: INDIA

2024





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MESSAGE



Dr. Zoya Ali Rizvi
Deputy Commissioner - Adolescent Health
Ministry of Health & Family Welfare, Government of India

India's adolescents constitute a significant portion of our population representing both a vital demographic and critical human capital for national development. Their health and development must be supported through responsive systems that address not only their physical well-being but also psychosocial and emotional needs.

The Rashtriya Kishor Swasthya Karyakram (RKSK) a flagship programme for adolescents under the National Health Mission adopts a holistic approach to adolescent health, focussing on six strategic priorities: nutrition, sexual and reproductive health, mental health, substance misuse, non-communicable diseases, and injuries and violence. The programme delivers services through community-based platforms like Peer Education Programme and Adolescent Health & Wellness Days (AH&WDs) supported by ANMs/ASHAs, and through facility-based care at Adolescent Friendly Health Clinics (AFHCs), ensuring adolescents—especially in underserved areas—have access to appropriate information, counselling, care and get need based timely referral.

Further, Weekly Iron & Folic Acid Supplementation (WIFS) aims at reducing the prevalence of anemia among school going adolescents and out of school adolescent girls to breaking the intergenerational cycle of anemia. Menstrual Hygiene Scheme is implemented with an objective of creating awareness on menstrual hygiene among the adolescent girls and improving the accessibility to sanitary napkins. Complementing these efforts, School Health and Wellness Programme (SHWP)—a joint initiative of the Ministries of Health and Education—reaches the school-going adolescents with health promotion activities across eleven thematic areas, including mental health and emotional well-being. These programmes together strengthen facility, community and school-based systems to advance adolescent health and wellbeing holistically.

The Child and Adolescent Mental Health (CAMH) Service Mapping in India, led by a team of the Indian Association for Child and Adolescent Mental Health (IACAM) in collaboration with UNICEF provides a critical overview of the current mental health ecosystem for young people. It will be instrumental in guiding future programme designs, and support convergence to ensure that mental health is treated not as an afterthought but as an essential pillar of adolescent health.

I commend all contributors to this important initiative and hope the findings serve as a catalyst for stronger, more integrated adolescent health responses across the country.

MESSAGE



Dr. Vivek V Singh, Chief of Health a.i., UNICEF India

India has the largest population of adolescents in the world, 253 million strong and growing. Our adolescents are the backbone of our future, embodying the promise of a vibrant and progressing nation. India's commitment to adolescents is unequivocal. We recognize that ensuring their health- physical, mental and emotional wellbeing is vital to achieving our national and international development goals, including the Sustainable Development Goals (SDGs).

The increasing burden of mental health disorders such as anxiety & depression is a common concern among adolescents and are on rise along with self- harm tendencies and suicides. It is important to have specific interventions at national & subnational level for addressing the mental health and psychosocial support of the youths and adolescents particularly addressing the drivers of mental health including family systems and pressure, academic pressure and competition and, relationship conflicts.

The mapping of child and adolescent mental health service in India by Indian Association of Child and Adolescent Mental Health provides a comprehensive compilation of all the policies focusing on child and adolescent mental health. The mapping also provides good insight on child and adolescent mental health service covering all six pillars of health system strengthening – governance, financing for mental health, information systems, drugs and logistics, service delivery platforms and human resource. It highlights existing challenges and provide constructive recommendations to address the same for improving the mental health and emotional wellbeing of children and adolescents in India.



PREFACE

The strength of the community is reflected in its commitment to care for its youngest members; by prioritizing their mental health today, we lay the groundwork for a resilient tomorrow.

The pressing need for a comprehensive service mapping of child and adolescent mental health in India emerges from the alarming mental health crisis affecting this population subset. The ever-increasing 436 million children & adolescents represent a vital asset for our future society. However, despite significant advancements in physical health, the mental health services for children have lagged considerably, often relegated to a deprioritised status in the health policy discussions. The infrastructure to support their mental well-being remains severely inadequate.

Mental health issues among children and adolescents are frequently left unidentified and untreated until the effects convert the distress into dysfunction. This treatment gap is exacerbated by poor help-seeking behaviour compounded by stigma and lack of awareness. There is a concerning trend toward dismissing adolescents' problems as a normal part of growing up, often obscuring the reality of their experiences and allowing their concerns to fester without support.

Children and adolescents are typically unable to seek help independently, as they rely on their families for access to services, incapacitating their rights and exacerbating their struggles. Families often face systemic barriers of the additional cost of care, loss of daily wages to attend repeated appointments, lack of holistic care wherein early identification, awareness and caregiver support are main prerogatives. Furthermore, the absence of adequate infrastructure, unqualified manpower and the heavy burden on frontline workers, who are often overwhelmed by high service loads, compromise the quality of care provided.

Additionally, certain vulnerable populations face double discrimination, complicating their access to mental healthcare. These groups include orphaned, abandoned, and missing children, children of sex workers, abused, neglected and exploited children, children in conflict with the law, children out of school, those affected by HIV/AIDS, children of veterans, those impacted by natural calamities/manmade disasters, and those with parents with mental health conditions including substance use disorders, and children with disabilities. These marginalized children are often left behind, as the existing service infrastructure fails to address their unique and contextually sensitive needs. Their mental health issues are not only under-represented in data, but the existing literature and population and culture-specific care standards are often non-representative or absent altogether, leaving this group unaddressed.

The diversity of issues facing children and adolescents requires a nuanced understanding of their unique mental health needs. With limited literature on the subject, varied prevalence rates, and manifestations of mental health issues across regions, it is difficult to gauge the full extent of the problem. This lack of clarity underscores the need for comprehensive research and data collection to inform effective policy and programmatic responses.

Therefore, there is an urgent need for a service mapping exercise that would help in understanding the supply-side infrastructure in place for addressing the mental health needs of children and adolescents in India. By addressing the revealed gaps, we can take a crucial step toward providing children and adolescents with the mental health care they deserve, ensuring that they can grow into healthy, resilient adults who contribute positively to society.

ACKNOWLEDGEMENT ---

This collaborative effort has been pivotal in shaping our understanding of the current landscape of child and adolescent mental health services in India. This initiative, aimed at identifying systemic gaps and optimizing the utilization of existing resources, was led by the team of the Indian Association for Child and Adolescent Mental Health (IACAM) in collaboration with UNICEF.

We express our sincere gratitude to UNICEF's Regional Office for South Asia (ROSA), for undertaking this monumental task and extending their generous financial and technical support, and for providing the service mapping tool, meticulously tailored to meet the contextual needs of the eight members of the Child and Adolescent Mental Health South Asia Regional Network (CAMHSAN)—namely, Nepal, India, Pakistan, Bangladesh, Sri Lanka, Maldives, Bhutan, and Afghanistan. This tool was instrumental in guiding our mapping exercise and informing primary data collection.

Our deep gratitude goes to Ms. Jyothi Ravichandran, Specialist for Mental Health and Psychosocial Support and Dr. Syed Hubbe Ali, Health Specialist at UNICEF ICO. Their unwavering support and insightful contributions were critical in synthesizing the country report and enhancing our understanding of the field.

Acknowledgment is due to Dr. Mangesh Gadhari, Health Specialist; Dr. Md Ziaul Matin, Health Specialist at UNICEF ICO; and Dr. Vivek Singh, Chief, Health, A.I at UNICEF ICO for their dedicated efforts in securing necessary permissions from government bodies and key stakeholders. Their continuous support ensured that we captured a diverse range of voices reflecting the realities of legislative and policy infrastructures.

We appreciate Dr. Henal Shah, Professor at the Department of Psychiatry, Nair Hospital, Mumbai, and Treasurer of IACAM for her adept management of project finances. Her organizational skills ensured smooth financial operations throughout the project.

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ABBREVIATIONS

Abbreviations	Full Description
ADHD	Attention Deficit Hyperactivity Disorder
AFHC	Adolescent Friendly Health Clinics
AI	Artificial Intelligence
AIIMS	All India Institute of Medical Sciences
AIOTA	All India Occupational Therapists' Association
ANM	Auxiliary Nurse Midwife
ASD	Autism Spectrum Disorder
BPL	Below Poverty Line
CAMH	Child and Adolescent Mental Health
CAMHSAN	Child and Adolescent Mental Health South Asia Regional Network
CAP	Child and Adolescent Psychiatry
CARA	Central Adoption Resource Authority
CBT	Cognitive Behavioural Therapy
CGC	Child Guidance Clinic
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CICL	Children in Conflict with Law
CIP	Central Institute of Psychiatry
CNCP	Children in Need of Care and Protection
CWC	Child Welfare Committee
DAWBA	Development and Well-Being Assessment
DDRS	Deendayal Disabled Rehabilitation Scheme
DEIC	District Early Intervention Centre

(Contd.)

Abbreviations	Full Description
DH	District Hospital
DM	Doctor of Medicine
DMHP	District Mental Health Programme
EHS	Employees' Health Scheme
EML	Essential Medicines List
EMRS	Eklavya Model Residential Schools
FGD	Focus Group Discussion
FMG	Financial Management Group
HA	Health Assistant
IACAM	Indian Association for Child and Adolescent Mental Health
ICDS	Integrated Child Development Services
ID	Intellectual Disability
IGNDPS	Indira Gandhi National Disability Pension Scheme
IHBAS	Institute of Human Behaviour and Allied Sciences
ILO	International Labour Organization
IRDAI	Insurance Regulatory and Development Authority of India
JJ	Juvenile Justice
LGBRIMH	Lokopriya Gopinath Bordoloi Regional Institute of Mental Health
MFCG	Model Foster Care Guidelines
MH	Mental Health
MHCA	Mental Healthcare Act
MHPSS	Mental Health and Psychosocial Support
MHRD	Ministry of Human Resource Development
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare

(Contd.)

Abbreviations	Full Description
MSW	Master of Social Work
NAHS	National Adolescent Health Strategy
NALSA	National Legal Services Authority
NAPDDR	National Action Plan for Drug Demand Reduction
NCERT	National Council of Educational Research and Training
NCPCR	National Commission for Protection of Child Rights
NEP	National Education Policy
NGO	Non-Governmental Organization
NHM	National Health Mission
NHRC	National Human Rights Commission
NIMHANS	National Institute of Mental Health and Neurosciences
NLEM	National List of Essential Medicines
NMBA	Nasha Mukh Bharat Abhiyaan
NMHP	National Mental Health Programme
OCD	Obsessive Compulsive Disorder
OPD	Outpatient Department
OTC	Over the Counter
PDF	Post-Doctoral Fellowship
PGIMER	Post Graduate Institute of Medical Education & Research
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PM-JAY	Pradhan Mantri Jan Arogya Yojana
POCSO	Protection of Children from Sexual Offences
RBSK	Rashtriya Bal Swasthya Karyakram
RKSK	Rashtriya Kishor Swasthya Karyakram

(Contd.)

Abbreviations	Full Description
RPwD	Rights of Persons with Disabilities
SHC	Sub-Health Centre
SIPDA	Scheme for Implementation of Persons with Disabilities Act
SLD	Specific Learning Disability
SMILE	Support for Marginalised Individuals for Livelihood and Enterprise
SOP	Standard Operating Procedures
ST	Scheduled Tribes
TCP	Tertiary Care Programme
UHWC	Urban Health and Wellness Centre
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UPHC	Urban Primary Health Centre
WHO	World Health Organization



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EXECUTIVE SUMMARY

The well-being of children is paramount in fostering a healthy society, particularly in India, which houses the largest population of children and adolescents globally. Thus, there is an urgent need for prioritizing Child and Adolescent Mental Health (CAMH) within the broader context of health policy and social development. With over 436 million children aged 0-18 years in India, neglecting their mental health can have profound implications not only for individual growth but also for societal sustainability.

In this regard, the work was undertaken to understand the mental health services in India. However, mapping of CAMH services in India posed a challenge due to the diverse contexts present in India in terms of the rural-urban divide in various states, uneven distribution of trained mental health resources, infrastructure in different states and so forth. Despite existing frameworks like the National Mental Health Policy (2014) and the National Health Policy (2017), which aim to integrate mental health into primary healthcare, significant barriers to their implementation and uptake remain. These contribute to a significant treatment gap constituted by insufficient institutional capacity, inadequate community outreach, maintaining low levels of public awareness and stigma surrounding mental health issues, and a lack of evidence and data ecosystem to track evolving mental health trends, service uptake and well-being outcomes at a population level.

The mapping exercise employed a systematic approach – of primary and secondary data to gather information from various stakeholders involved in CAMH services. Key informants included healthcare providers, educators, and social workers who provided insights into existing services and challenges faced in delivering effective mental healthcare. The survey utilized a tailored tool developed by UNICEF & CAMHSAN to evaluate multiple domains critical to CAMH service provision:

- Policy and Legislation
- Financial resource allocation
- Service Availability
- Medication & Treatment Modalities
- Human Resources
- Data and Health Information System

The findings from the mapping exercise revealed some gaps in CAMH services in India. The country has made notable strides in establishing policies aimed at enhancing mental health services. The Mental Healthcare Act (MHCA) of 2017 provides a rights-based framework; however, it lacks comprehensive provisions tailored specifically for children and adolescents, which limits its effectiveness in ensuring that their unique mental health needs are met. Many existing programmes have certain limitations to effectively tackle the unique challenges faced by children and adolescents, primarily due to shortcomings in the implementation process such as poor capacity building of human resources in delivering psychosocial support focusing on children and adolescents, lack of structures of accountability like supportive supervision for the specialised and non-specialised workforce, etc. Additionally, the absence of robust data collection systems restricts effective monitoring and evaluation of CAMH services. Without improved data systems, it becomes challenging to understand service utilization patterns and inform policy decisions that could enhance care delivery. Finally, there is a strong need to allow for interdisciplinary collaboration among various stakeholders involved in child welfare, social justice, child protection, and legal systems, mental healthcare providers,

educators, social workers, and families. This calls for the development of a robust continuum of care model with integrated approaches that could more effectively address the multifaceted needs of children and adolescents struggling with mental health issues.

To address the challenges and gaps identified in the mapping exercise, several key recommendations are made. First and foremost, there is a pressing need to identify child and adolescents' mental health concerns and their drivers. This would lead to the development of targeted policies that ensure alignment with international standards and would create a more integrated approach to mental health and psychosocial care. In addition to policy directives, it is crucial to increase financial investment in CAMH services for their operationalisation, realisation and sustainability - adequate funding to ensure proper staffing, comprehensive training, and infrastructure development. This investment will foster a robust support system capable of addressing the mental health needs of children and adolescents effectively.

Promoting public awareness is another vital component of the strategy to operationalise increased financial investment in CAMH services, as it would further inform advocacy initiative in service users and stakeholders, respectively. For service users, increased awareness fosters a deeper understanding of their rights and available resources, empowering them to advocate for their needs and participate more actively in shaping the services they receive. Such initiatives help re-build understanding and acceptance within communities, encouraging families to seek help without fear of judgment.

Improving data collection systems is imperative for advancing CAMH services. Enhanced data systems will also facilitate a better understanding of service utilization patterns, which is critical for resource allocation. Lastly, collaboration among various stakeholders for creating integrated service delivery models that address the multifaceted needs of children and adolescents is vital. Establishing interdisciplinary collaborative and integrated approach among psychiatrists, psychologists, paediatricians, social workers, teachers, and educators, child protection functionaries, legal workforce, police and families will ensure a holistic approach to mental healthcare that recognizes the interconnectedness of various factors affecting young people's well-being.

In India, child and adolescent mental health is addressed primarily within the systemic framework of general healthcare, women and child development, youth affairs, social welfare and education. Many policies, programmes, and laws exist, but their implementation at ground-level is uneven. The existing gaps may be reduced through targeted policies, increased resource allocation, public awareness initiatives, improved data systems, and collaborative efforts among stakeholders. Then only, children and adolescents can be equipped with the necessary support to thrive. Therefore, investing in CAMH is not merely an investment in individual well-being, it is a commitment to ensure sustainability and prosperity of the society at large.



INTRODUCTION

In the tapestry of community well-being, the child shall always stand as a singular unit of urgency. Their need of nurturance, trust, autonomy, initiative, competence, support, & generativity to navigate the conundrum of identity, to contribute meaningfully to society and to foster quality life must take precedence. This is imperative because this sensitive, yet critical period of rapid growth and development lays the foundational aspects of a child's physical health and mental capabilities - neglecting which can have lasting consequences not only for the child but also for the society at large. Though strides have been made in promoting physical health among children, their mental well-being has often been relegated to the periphery. The immediate and formative nature of their experiences act as a reminder that they do not have the luxury of waiting for tomorrow to receive what facilitates their development and perception of the world. Therefore, calling for a commitment to prioritize their needs, rights, narratives, and voices.

India has the largest population of over 436 million children and adolescents (United Nations, 2024), requiring prioritization of the developmental needs of the population. Being the most populated country, with 1.45 billion individuals (India Demographics, 2024), India has approximately 30 % of its population in the age group of 0-18. The Global Burden of Disease (2021) estimated that 14% of the adolescents aged 10-19 in India experienced a mental disorder – 13.4% of them being boys and 13.9% girls. The National Mental Health Survey (2015-16), reported that about 7% of adolescents aged 13 to 17 experienced mental disorders, translating to an approximate 8 to 11 million adolescents requiring mental healthcare at any given time. An Indian meta-analytic study on the prevalence rate of child and adolescent psychiatric disorders reported that 6.46% of community children and 23.33% of school children and adolescents have psychiatric disorders (Malhotra & Patra, 2014). It is imperative to understand that most of the prevalence studies conducted after or before this review cater to different parts of India with distinct socio-cultural settings, making generalization difficult. Additionally, the under-representation of cultural perspectives on mental health and the underreporting of mental health concerns compared to diagnosed disorders further constraints the relevance of these prevalence studies. Zhou et. al (2020) in a systematic review of *Child and Adolescent Mental Health Policy in Low-and Middle – Income Countries*, stated that lack of public awareness and associated stigma, inadequate institutional capacity, lack of reported data and resources act as significant barriers in the mental health systems of these countries.

Though the focus on maternal health, infant and early child mortality, immunization, and nutrition have significantly contributed to the improvement of physical health, little emphasis is given to the Child and Adolescent Mental Health (CAMH) in India (National Commission on Macroeconomics and Health, 2005). This inadequacy underscores the insufficient attention given to CAMH issues in the country, revealing a vicious cycle between lack of information and services. Therefore, by investing in their holistic well-being, India stands to leverage its demographic dividend as a competitive advantage considering that their needs are given due consideration in the policy and social fabric of the country.

Though India has made significant strides in addressing child and adolescent mental health through policies and programmes: the National Mental Health Policy (2014), National Health Policy (2017), National Mental Health Programme (NMHP) (1982), District Mental Health Programme (DMHP) (1996), Rashtriya Kishor Swasthya Karyakram

(RKSK)(2014) are some of the pivotal policy frameworks that aim to systematically target adolescent mental health. Efforts under the comprehensive primary health services under the aegis of Ayushman Bharat's Health and Wellness Centre Scheme have further augmented the early preventive care. There are challenges to interdisciplinary and multi-stakeholder collaboration, even though promising multisectoral mental health and psychosocial support (MHPSS) programmes such as the convergent School Health & Wellness Programme by the Ministries of Health & Family Welfare and Education have been implemented.

It is important to note that even though there is increasing recognition of the importance of convergent action to address mental health needs of children and adolescents, there is a lacuna in identifying the drivers of mental ill-health and factors contributing to well-being, leading to poor prioritisation of interventions that address social and structural determinants of mental health and psychosocial well-being. Challenges of existing reactive interventions are compounded by poor implementation and monitoring mechanisms, absence of systems to replicate effective and impactful programmes and services, and data and information systems with limited range of population level metrics of mental ill-health and well-being.

Therefore, to systematically understand these gaps and extend recommendations for strengthening the mental health service delivery system including optimum utilisation of existing systemic resources, a mapping exercise was conducted by the Indian Association for Child and Adolescent Mental Health (IACAM), a founding member of the Child and Adolescent Mental Health South Asia Regional Network (CAMHSAN), with support from UNICEF. This initiative aimed to assess the availability and utilization of existing Child and Adolescent Mental Health (CAMH) services across the country. To support this effort, UNICEF developed a tailored service mapping tool designed specifically for the contextual needs of the eight South Asian member countries of CAMHSAN.

METHODOLOGY

The scope of the exercise was to examine CAMH services for 0–19-year-olds via the UNICEF service mapping survey tool. It examined inter- and intra-healthcare services, community levels programmes, population centric services extending beyond the health-sector, services that focused on family and caregivers, the financial and human resource allocation and other relevant domains. Considering the contextual, geographical and socio-demographic diversity of the country the mapping exercise was designed to gain information from the following sources:

- Secondary research: The existing literature and policy framework of the country, wherein major policies, legislations, schemes, programme, operational and implementation guideline documents, and monitoring tools, pertaining to children and adolescents, union budget reports, Insurance Regulatory and Development Authority of India documents, National Human Rights Commission reports, Keshav Desiraju Indian Mental Health Observatory review and analysis reports, the global burden of disease reports, country report of the WHO Mental Health Atlas, research articles, commentaries on India's CAMH services, and other allied reports and scientific literature was reviewed. The READ approach to document analysis given by Dalgish, Khalid, & McMahon (2020) was used to study the aforementioned documents, adopting a systematic procedure for gathering documents and understanding information systems in the context of health policy studies, be it at local, national or global level. The steps consist of –

R- Read materials: it helped in outlining the parameters which established the nature of documents considering the availability of time and scope of inquiry, determining the criteria for topic, sources, and timeframes; defining document types inclusive of formal documents, grey literature, and informal documents.

E- Extract data: Guided the extraction of relevant and appropriate data for the mapping exercise.

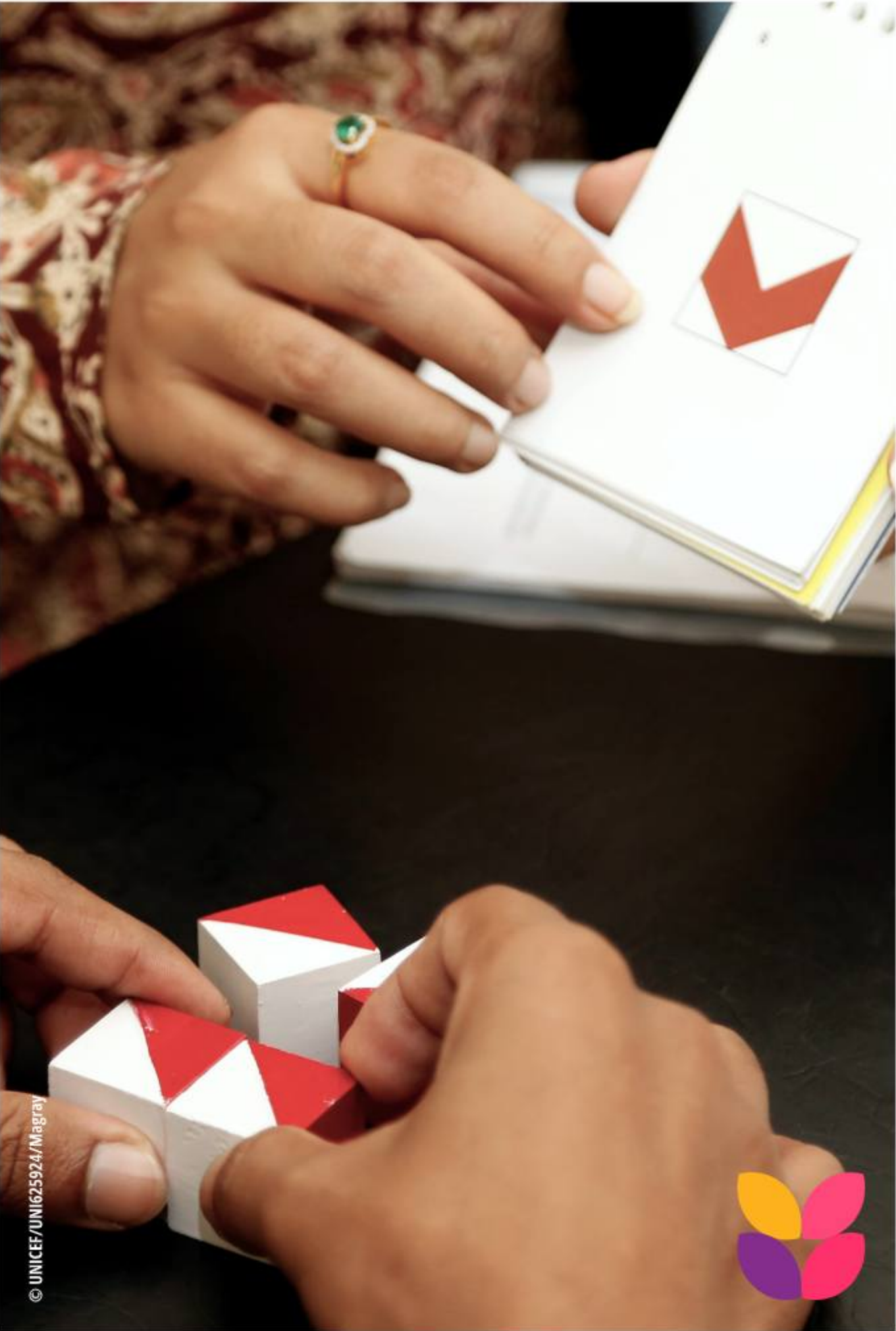
A- Analyse data: It ensured reflexivity, and accorded structure to the findings

D- Distil findings: Guided the process of comparing data against field examples to ensure robustness.

A specialized tool was developed by UNICEF for the study incorporating insights from the eight member countries of CAMHSAN—namely, Nepal, India, Pakistan, Bangladesh, Sri Lanka, Maldives, Bhutan, and Afghanistan to cater to the unique contextual needs of South Asian nations. It guided & facilitated the data collection through three primary methods: desk review, in-depth interviews and FGDs. Based on the tool, format for the Interview Guide and FGDs was prepared focusing on the following six key domains to critically identify the service planning, strategic resource allocation, and prioritization of needs:

- CAMH Policy and Legislation
- Financing for CAMH services
- CAMH Services
- CAMH Medication and Treatment Modalities
- Human Resources for CAMH services
- CAMH Data and Health Information Systems

Though the survey ensured scientific rigor during the data collection and collation phases, the information presented in the report is limited in terms of representation, given the scale of the country. Furthermore, the lack of available data and information systems could have potentially omitted certain existing CAMH services and initiatives such as those provided by community-based organisations.



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CAMH POLICY AND LEGISLATION

India's contribution towards addressing child and adolescent mental health has evolved significantly over the decades and is increasingly shaped by both national legislation and international frameworks. The trajectory has its formal origin in the establishment of Child Guidance Clinics (CGCs) in the 1930s and the formation of the Indian Council for Mental Hygiene in the 1940s. A significant advancement occurred in the late 20th century with the expansion of Child Guidance Clinics within the general hospital psychiatry units across the country. Following the pivotal shift made by the Mental Health Act of 1987, the National Mental Health Policy introduced in 2014 emphasized a rights-based approach to incorporate mental health into primary healthcare systems effectively.

The Mental Healthcare Act (2017) further advanced the rights-based approach by decriminalizing suicide and ensuring access to services, thereby aligning in principle with the international human rights treaty, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), 2006. The CRPD has been the guiding principle towards creating inclusive mental health services in the country since its ratification by India in 2007. Additionally, the former National Charter for Children underlines the framework necessary to safeguard children's rights and well-being, highlighting the immediate need for identifying and providing for the unique challenges faced by the young individuals. Programmes like RSKS recognized this need and subsequently worked towards building integrative services.

In the absence of a mandated legal framework addressing the unique mental health needs of the demographic in the country, the following existing legislations, policies, programmes, schemes, have provisions that touch upon certain aspects of child and adolescent mental health in the country.

Table 1: Overview of CAMH Policy & Legislation Framework in India

Programmes/Schemes/Policy/Legislation	CAMH Specific Provisions
MENTAL HEALTH	
Mental Healthcare Act (MHCA) (2017)	<ul style="list-style-type: none"> ● Definition of Minors ● Nominated Representative ● Informed Consent ● Admission Procedures ● Separate Accommodation ● Non-Separation Policy ● Decriminalisation of Suicide ● Rights of Minors ● Review Mechanism ● Age-Appropriate Treatment; and ● Mother-child units for inpatient treatments

<p>National Mental Health Programme (NMHP), (1982) and District Mental Health Programme (DMHP), (1996)</p>	<p>To decentralise mental healthcare.</p> <p>The DMHP is the component of the NMHP which has been sanctioned in 767 districts. Over 173,000 SHCs, PHCs, UPHCs, and UHWCs have been upgraded to Ayushman Arogya Mandirs to provide mental health services (Government of India, 2024) - prevention, promotion, long-term care, general psychotropic & psychosocial interventions; life skills in schools; and a non-school Child/Adolescent Mental Health Programme.</p>
<p>National Tele Mental Health Programme (2022)</p>	<p>To improve quality access to mental health counselling and care services.</p> <ul style="list-style-type: none"> ● 53 Tele MANAS Cells for mental health services (Government of India, 2024).
<p>School Health Programme under Ayushman Bharat</p>	<p>Training and Resource Material: Health and Wellness of School-going Children</p> <ul style="list-style-type: none"> ● Specific 'Emotional Well-being and Mental Health module ● Specific module on Interpersonal relationships ● Specific module on Substance abuse ● Specific module on promotion of safe use of the internet (Government of India, 2024).
<p>National Mental Health Policy (NMHP) (2014)</p>	<p>Focus on -</p> <ul style="list-style-type: none"> ● The mental health needs of vulnerable groups such as orphans with mental illnesses, children of persons with mental illnesses, and children in custodial care, and ● Awareness and psycho-education programmes (Government of India, 2014a). ● All modules to develop competencies in social-emotional and executive functioning, such as self-awareness, empathy, problem solving, decision-making, critical thinking, etc., to be applied by adolescents to life's challenges.

HEALTH

<p>National Adolescent Health Strategy (IAHS)/ Rashtriya Kishor Swasthya Karyakram (RKSK) (2014)</p> <p>6 programmes under RKSK - nutrition, sexual and reproductive health, non-communicable diseases, substance misuse, injuries and violence, and mental health</p>	<p>To provide health information, commodities, and services to meet the health and well-being needs of 253 million adolescents (10-19) - male/female, rural/urban, married/unmarried, in/out-of-school, with special focus on marginalised and underserved groups, enabling them to realise their full potential and rights.</p> <ul style="list-style-type: none"> ● To provide community-based health promotion, prevention and curative services ● To engage field service providers (ASHAs, ANMs, AWWs, & NYKS volunteers) ● Primary drivers- outreach by counsellors, facility based-counselling, Adolescent Friendly Health Clinics and social and behavioural change communication ● Recruiting, training, and supervising peer educators in the age group of 15-19 years ● Capacity building to improve access in treatment seeking and identification (Ministry of Health and Family Welfare, 2014a).
<p>Rashtriya Bal Swasthya Karyakram (2013)</p>	<p>An initiative by National Rural Health Mission to improve the overall quality of life of children (0-18) through early detection of 56 birth Defects, Diseases, Deficiencies, Development Delays and Disability (4Ds). Screening via mobile health teams and community outreach (Ministry of Health and Family Welfare, 2014b). For early identification District Early Intervention Centres (DEIC) are established in district hospitals to extend services for children up to 6 years of age.</p>
<p>National Action Plan for Drug Demand Reduction (NAPDDR) (2018, 2023)</p>	<ul style="list-style-type: none"> ● Emphasis on the need of targeted prevention programmes for children and adolescents. ● Aims to integrate drug education in school curricula. ● Community based engagement. ● Intersection with mental health (Ministry of Social Justice and Empowerment, 2023).

HUMAN RIGHTS

<p>National Charter for Children (2004)</p>	<p>To secure every child's inherent right to be a child and enjoy a healthy and happy childhood by addressing the root cause that negates health growth and development, and to make the society at large aware about their role as a community to protect children from all forms of abuse by strengthening family, community, and nation (Government of India, 2004).</p>
<p>United Nations Convention on the Rights of the Child (UNCRC) - MHCA, 2017 & RPwD, 2016</p>	<p>India is signatory to the UNCRC; the MHCA and RPwD aligns with these principles by ensuring that minors receive appropriate care and that their rights are protected</p>
<p>National Commission for Women</p>	<p>Works at the intersection of women's rights and empowerment, while focusing on their mental health and recognizing its crucial link with gender-based violence, social stigma, and systemic inequalities with adolescent girls, adult women and elderly women. It advocates incorporating mental health services into women's welfare schemes and collaborates with mental health professionals to provide counselling, legal aid, and crisis intervention. It underlines the need for mental health professionals in prisons across the country. Through helplines, public seminars, and awareness efforts like podcasts, it creates space for dialogue on these issues (National Commission for Women, 2023). In cases involving girls under 18, NCPCR often takes the lead or collaborates with the commission. By supporting women in their roles as mothers, caregivers, and professionals, the NCW indirectly strengthens the mental health environment for children and adolescents, contributing to better developmental and emotional outcomes.</p>

<p>National Human Rights Commission</p>	<p>It advocates for the human rights of persons with disabilities. On 10th October 2023 the commission issued an advisory on mental health to the Union and State governments to promote the rights of persons with mental health issues and disabilities. The advised recommendations focus on the -</p> <ul style="list-style-type: none"> ● Implementation of existing laws and policies ● Infrastructure and amenities ● Human resources ● Outreach and community services ● Rehabilitation of recovered patients ● Services of the states ● Mass awareness and sensitisation
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CHILD PROTECTION

<p>Mission Vatsalya Vehicle for effective implementation of the Juvenile Justice Act, (2015)</p>	<p>To ensure the safety, security, and well-being of children in vulnerable situations by providing protection, care, and rehabilitation services. It is a fully resourced scheme by the Government of India.</p> <p>Through this mission's rights-based approach the Ministry of Women and Child Development focuses on-</p> <ul style="list-style-type: none"> ● The juvenile justice programme for children in need for care and protection and children in conflict with the law. ● The integrated programme for street children, ● The scheme for assistance to child-care homes, ● Preventing child abuse, exploitation, and abandonment while strengthening systems for foster care, adoption, and family reintegration, and ● Lays out response and mitigation measures and places importance on mental health and psychosocial support for children in vulnerable circumstances.
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	<p>It is a centrally sponsored scheme with cost-sharing between the Government of India and states. It addresses the functioning of statutory bodies, strengthening community-level support, promoting preventive measures against child vulnerability, fostering collaboration with state authorities and civil society organizations for effective implementation, and raising public awareness about child rights and available protection services (Manoharan, 2018). Furthermore, it focuses on strengthening service delivery mechanisms via Child Welfare Committees (CWCs) and Juvenile Justice Boards (JJBs), upscaling institutional care, emergency and outreach services and training and capacity building. The scheme views institutions as the last resort in compliance with the law.</p>
<p>Mission Shakti Scheme aimed at strengthening interventions for women and girls' safety, security & empowerment.</p>	<p>Through sub-schemes under this mission the Ministry of Women and Child Development focuses on -</p> <ul style="list-style-type: none"> ● Services to women victims of Gender-based Violence (GBV) including the One Stop Centres ● Nutrition for pregnant and lactating mothers and children 0-6 years ● Beti Bachao Beti Padhao (BBBP) scheme to promote the survival, protection and education of the girl child, and ● Palna-Creche provides a safe and secure place for children of working women.

SOCIAL WELFARE	
National Policy for Children (1974, 2013)	<p>National Policy for Children (1974) provided comprehensive services for children's physical, mental, and social development, recognizing their rights up to 14 years of age.</p> <p>National Policy for Children (2013) recognized children up to 18 years of age and expanded upon the aforementioned principles by assuming a comprehensive multisectoral approach focusing on equality, non-discrimination and the intersections of health, education, protection, and participation (Government of India, 2013b).</p>
National Youth Policy (NYP)(2014) New NYP Draft (2024)	<p>The policy's goals include skill development, youth participation, quality education, healthcare, fitness, and social justice (Government of India, 2014b).</p>
DISABILITY	
Rights of Persons with Disabilities Act (RPwD), 2016	<p>The act identifies 21 disabilities that include intellectual disability, mental illness, autism spectrum disorder, and specific learning disabilities. It is not child and adolescent specific, but has provisions for-</p> <ul style="list-style-type: none"> ● Free inclusive education, community life ● Protection from Abuse & Exploitation ● Social Security, Rehabilitation ● Respect for evolving capacities of children with disabilities ● Right to preserve their identities and express themselves ● Non-Separation from Parents ● Early detection - to identify 'at risk'; to deliver suitable pedagogical measures (Government of India, 2016).

EDUCATION

<p>Right of Children to Free and Compulsory Education Act, 2009 (6-14 years of age) *</p> <p><i>*Article 21A, that guarantees all children between the ages of 6 and 14 have the right to free and compulsory education, was added to the constitution by the 86th Amendment, 2002. Subsequently in 2009 the Right to Education Act was enacted to describe the details of the article.</i></p>	<p>Recognises the right of children aged 6-14 years to free and compulsory education and for competent authorities to ensure that children are admitted, attend, and complete elementary education (Department of School Education and Literacy, 2021). The act also ensures minimum norms for elementary schools, prerequisites for surveys to identify the needs of children who need education, prohibitions on harassment and barriers to admissions, minimum standards for appropriately trained teachers, and requirements for curriculum development.</p>
<p>National Education Policy (2020) (All age groups)</p>	<p>Ensures high-quality education to all. It aims to prepare students to meet national and global challenges; developing cognitive skills; make education inclusive, holistic, flexible, and accessible. It emphasises the need for mental health education and support systems in schools (Government of India, 2020).</p>
<p>UMEED Guidelines (2023) Ministry of Education</p>	<p>Developed by the Indian Ministry of Education to enhance student mental health and prevent self-harm. These are evidence-informed and in alignment with the National Education Policy's (2020) focus on holistic education.</p> <p>UMEED: Understand, Motivate, Manage, Empathise, Empower, Develop</p> <p>Objectives:</p> <ul style="list-style-type: none"> ● To enhance Sensitivity and Support ● To establish School Wellness Teams ● To promote positive school environment ● To build capacity for suicide prevention ● To implement immediate response measures for supporting students at risk ● To foster community and parental engagement ● Appraisals of actions taken by schools (Ministry of Education, 2023)

<p>Ministry of Tribal Affairs and Ministry of Minority Affairs</p>	<p>Eklavya Model Residential Schools (EMRS): to provide quality education to scheduled tribe (ST) students in remote areas to ensure access to middle and high-level education.</p> <p>The ministry of tribal affairs pre-matric and post-matric scholarships, efforts to facilitate school admissions for scheduled tribe girls, vocational training centres for tribal youth, and establishing ashram schools are some of the other initiatives undertaken by the ministry of tribal affairs. The Ministry of Minority Affairs programme –</p> <ul style="list-style-type: none"> ● PM VIKAS – to provide an education bridge programme for school dropouts from minority and artisan communities, it also offers open schooling for 8,10, and 12. ● Free Coaching and Allied Scheme: to help community candidates improve their skills and capabilities. <p>The ministry also has several scholarship schemes to facilitate access for better education.</p>
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PROTECTION - Constitutional Provisions-Focusing on Their Specific Needs and Vulnerabilities

Table 2: Provisions & Frameworks on the Protection of Children & Adolescents

Article	Provisions
Article 15(3) of the Constitution of India	Allows the state to make special provisions for women and children, recognizing that they require additional support to ensure their well-being and development.
Article 23 of the Constitution of India	Prohibits trafficking in human beings and forced labour, safeguarding children from exploitation and ensuring their right to a life free from coercion.
Article 24 of the Constitution of India	Explicitly prohibits the employment of children below the age of 14 in factories and hazardous occupations, thereby protecting them from dangerous work environments that could harm their health and development.
Article 21 of the Constitution of India	Right to life and personal liberty, which encompasses the right to a safe and secure environment for children.
Article 21(A) of the Constitution of India & RTE, 2009	Ensures free and compulsory education for children between the ages of 6 to 14 and prohibits discrimination, physical punishment, and mental harassment of children.

PROTECTION - Acts on the Protection of Children & Adolescents

Table 3: Acts on the Protection of Children & Adolescents

Legal Provision	Target Area	Objectives and Intent
Protection of Children from Sexual Offences (POCSO) Act (2012)	Children up to 18 years	<p>Aims to protect children from offences of sexual assault, harassment, and pornography and provides for special court trials for such offences. Ensures child-friendly procedures during trials.</p> <ul style="list-style-type: none"> ● Meticulously defines various forms of sexual abuse and related terms ● Recognizes forms of abuse that were previously ignored, such as sexual assault by a person in a position of trust or authority (Government of India, 2012).

Child Labour (Prohibition and Regulation) Amendment Act (2016)	Children below 14 years	Prohibits the employment of children under 14 years old and regulates the working conditions of adolescents between the ages of 14 and 18. Provides for stricter punishments, lays out state action plans. Is in compliance with the International Labour Organization (ILO) conventions (Government of India, 2023a).
Juvenile Justice (Care and Protection of Children) Act (2015)	Children in conflict with law (up to 18 years)	Aims to care and protect for children in need and those in conflict with law. It covers- <ul style="list-style-type: none"> ● Apprehension, detention, & prosecution ● Rehabilitation and social reintegration ● Adoption ● Penalties ● Child-friendly adjudication ● Establishments of institutions to support the act (Government of India, 2015b).
The Prohibition of Child Marriage Act (2006)	Girls under 18 and boys under 21	Enacted to replace the Child Marriage Restraint Act of 1929. It lays out the age of marriage, punishment mandates, provisions related to voidability of marriage, return of gifts and injunctions (Government of India, 2006).

DIGITAL AND ONLINE SAFETY

Table 4: Acts/Policy & Legislations Focusing on the Digital & Online Safety of Children & Adolescents

Acts/Policy & Legislations	Provision
Digital India Act (Draft)	A forthcoming legislation targeting to protect children from online dangers (cyber bullying, unauthorised sharing of personal information). Will replace the existing Information Technology Act, 2000.
Digital Personal Data Protection Act (2023)	To provide for the processing of digital personal data. Provisions that protect children's online interactions and data privacy cover: parental consent, prohibition on targeted advertising, protection against detrimental effects, rights of data principles and grievance redressal (Government of India, 2023b).

National Cyber Security Policy (2013)	Prevention and proper investigation structure for cybercrimes. appropriate legislative framework for enhancing enforcement capability. It aims to create awareness about cyber security in society (Government of India, 2013a).
Other Acts/Legislations	POCSO Act, 2012 (Addresses Child Pornography, sexual offences are acknowledged irrespective of the medium, encompasses situations of online grooming and provisions for digital evidence gathering); IPC; Data Protection Bill 2021 (Mahawar, 2022)

ADOPTION AND FOSTER CARE

Table 5: Adoption and Foster Care Provisions for Children & Adolescents

Acts/Policy/Guidelines & Legislations	Provision
Juvenile Justice (Care and Protection of Children) Act (2015)	Provides legal foundation for adoption and foster care - establishes procedures for circumstances when biological parents cannot provide for the child. Emphasises the need of child-centric approaches guided by the Best Interest principle in all decisions related to care (Government of India, 2015b).
Central Adoption Resource Authority (CARA)	Established under the Ministry of Women and Child Development - regulates domestic and inter-country adoption (Central Adoption Resource Authority, 2024a).
Model Foster Care Guidelines (MFCG) (2024)	<p>Outlines the requirements for foster care under the Mission Vatsalya scheme.</p> <p>The guidelines are based on the provisions of the Juvenile Justice (Care and Protection of Children) Act (2015), the JJ Model Rules (2016), and the Adoption Regulations (2022) (Central Adoption Resource Authority, 2024b).</p>

ACCESS TO LEGAL SERVICES (Other than JJ Act, 2015 and POCSO, 2012)

Table 6: Acts & Schemes Ensuring Access to Legal Services with Respect to Children & Adolescents Rights

Acts & Schemes	Provision
Commissions for Protection of Child Rights Act (2005)	Established the National Commission for Protection of Child Rights (NCPCR) at the national level and State Commissions for Protection of Child Rights at the state level (Government of India, 2005).
Legal Services Authorities Act (1987)	Provision of free legal services to ensure that no one is denied access to justice - children are included as beneficiaries under this act (Government of India, 1987).
NALSA (Child-Friendly Legal Services for Children) Scheme (2024)	Enhance access to legal services for children-focused on providing free legal aid and assistance. Emphasises the establishment of child-friendly legal procedures and mechanisms, including specialised training for legal service providers to handle cases involving minors sensitively (National Legal Services Authority, 2024).
NALSA (Legal Services to Persons with Mental Illness and Persons with Intellectual Disabilities) Scheme (2024)	Necessary legal support and representation in various legal matters, including guardianship, property rights, and access to healthcare services. It emphasises the appointment of specialised legal aid counsellors trained to understand the unique challenges faced by these individuals (National Legal Services Authority, 2024).

CONSENT AND HEALTHCARE

Table 7: Healthcare Ethics Pertaining to Children and Adolescents

Healthcare Ethics	Legal Provision
Confidentiality of healthcare services and records	The Medical Council of India's Code of Ethics Regulations safeguards patient confidentiality by allowing disclosure only in specific situations: under court orders, when there is a serious risk to an individual or community, or in cases of notifiable diseases (Medical Council of India, 2002).
Informed Consent	The legal age for giving consent in India is 18 years, however, children aged 12 years and above can provide informed consent for medical examinations but not for procedures (Kaushik, Narang, & Agarwal, 2010). As older children and adolescents are in the process of developing competence, they can assent to treatments when they understand implications (Kaushik, Narang, & Agarwal, 2010).

<p>Prescription of medications or other medical treatments</p>	<p>Primarily governed by the MHCA, 2017, which highlights the importance of involving minors in discussions about their treatment when appropriate. With respect to treatments like ECT, it necessitates a careful balance between regulatory requirements, parental authority, patient autonomy, and the urgent need for effective treatment.</p>
<p>Involuntary treatment orders</p>	<p>The MHCA allows for the involuntary admission of the minors if two psychiatrists, or one psychiatrist and one mental health professional, independently evaluate the minor to conclude that admission is paramount and is in the best interest of the child as without it healthcare needs would not be met and has subsequently ruled out and/or deemed all community-based alternatives as unsuitable. The act also emphasizes the role of the nominated representative to ensure that the minor's best interests and rights are intact.</p> <p>In emergency situations, where there are no guardians/parents from whom consent can be sought, the practitioner can proceed to save the life of the child (Section 92 IPC).</p>
<p>Participating in Experimental trials</p>	<p>National Ethics Guidelines for Bio-Medical Research (2017) involving Children states that investigators must seek to involve children in discussions about research and obtain their assent for participation.</p> <ul style="list-style-type: none"> ● Children between 7 and 12 years old must provide oral assent in the presence of a parent or legal representative. ● Children between 13 and 18 years old must provide written assent. ● Any research that is to be conducted in adolescents must be submitted and reviewed by an EC in agreement with the current national guidelines. ● Utmost attention to confidentiality, anonymity and socio-cultural sensitivities. ● Parental consent to be waived by the EC in studies wherein permission would interfere with the validity of the study results (only applicable to research which is of low risk) (Indian Council of Medical Research, 2017).
<p>Related Provisions</p>	<p>Mental Health Care Act, 2017 (Decision making authority primarily with the Nominated Representative), Rights of Persons with Disabilities Act, 2016, and JJ Act, 2015 list provisions that also elaborate on the rights of individuals in healthcare.</p>

Despite the extensive range of policies, legislation, and programmes that directly or indirectly address various aspects of mental health for children and adolescents, there is a lack of uniformity in the written service standards regarding the required number of service providers per population or facility across different regions.

While many of these policies and strategies have outlined detailed implementation plans, India's mental health budgeting does not clearly delineate funds for specific programmes and their respective domains. Further details on mental health financing can be found in the CAMH financing report.

Additionally, although there are established indicator tools available to track and monitor the implementation of these policies, there is a notable absence of reported data or review reports. This gap hinders our understanding of policy outreach and the quality of the reporting indicators and tools.

CURTAILED ROLE OF CIVIL SOCIETY ORGANISATIONS IN THE MENTAL HEALTH LANDSCAPE

Other than the government-led initiatives, there are an exhaustive number of child and adolescent networks and associations present across the country. In continuation of their focus on care and outreach, these networks and organisations, specifically user-carer networks, are rarely consulted or invited to participate in the formulation and implementation of relevant policies and legislation. Furthermore, these networks/community-based organisations are often excluded as delivery partners, despite a significant deficiency in human resources within the sector. This oversight also means there are no regulatory processes to ensure quality of mental healthcare delivered by community-based organisations and no resources are made available for their capacity building in alignment with national policies and mandates. As an exception, multiple stakeholders were involved and consulted in the drafting of the MHCA (2017), indicating a possibility of the representation of the voices of these advocacy groups. The Ministry of Social Justice and Empowerment (MoSJE) also collaborates with Civil Society Organisations to enhance mental health services, some of the key avenues of engagement include-

- Deendayal Disabled Rehabilitation Scheme (DDRS): It provides financial assistance to voluntary organisations delivering services for the rehabilitation of persons with disabilities, encompassing mental health conditions. Eligible organisations that support projects on special schools, vocational training centres, and community-based rehabilitation can receive up to 90% of the project cost (Vikaspedia, n.d.).
- Nasha Mukta Bharat Abhiyaan (NMBA): Launched to create awareness about ill effects of substance abuse, with primary focus on youth, educational institutions, and communities. It involves Civil Society Organisations to foster community participation and ownership (Observer Voice, 2024). The National Health Mission of India underlines the role of civil societies in facilitating community based monitoring in the following three roles- a) as members of monitoring committees b) as resource groups for capacity building and facilitation, and c) as independent agencies to collect information.
- Support for Marginalised Individuals for Livelihood and Enterprise (SMILE): An umbrella scheme comprising sub-schemes for the comprehensive rehabilitation of transgender persons and individuals engaged in begging. It seeks support from State Governments, Urban Local Bodies, Civil Society Organisations, and Community-Based Organisations to extend rehabilitations, medical facilities, counselling, education, skill development, and economic linkages (Ministry of Social Justice and Empowerment, n.d.).

Through these, the MoSJE actively supports and strengthens civil society collaborations to promote well-being. But the absence of a specific CAMH policy in the country speaks volumes about the participation and representation of the impending needs of the growing demographic and the organisations that represent their voices.



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FINANCING FOR CAMH SERVICES

The implementation and allocation of the aforementioned policies, programmes, and initiatives can be better understood in relation to the overall budgetary allocation for mental health.

UNION BUDGET FOR MENTAL HEALTH 2024-2025

The proposed union budget for the financial year 2024-25 is INR 48,20,512 crores, an increase of 7% compared to the previous financial year 2023-24 (Keshav Desiraju India Mental Health Observatory, 2024).

Table 8: Mental Health Budget Allocation 2024-25

Budgetary Allocation (2024-25)	Amount in Rupees (crore)	Mental Health Allocation in Rupees (crore)
Union Budget	48,20,512	1,614
Total Health Budget for Ministry of Health and Family Welfare (MoHFW)	90,659 (2% of the Union Budget)	1,314* (Direct Expenditure under MoHFW & MoSJE** Budget)
Total Budget for Ministry of Social Justice and Empowerment (MoSJE)	14,225 (0.3 of the Union Budget)	300 (Indirect Expenditure 2% of MoSJE Budget)

*Non-inclusive of all direct expenditure due to lack of available data

**Direct expenditure is inclusive of allocations made to National Action plan for Drug Demand Reduction (NAPDDR) under MoSJE

The budgetary allocations for direct expenditure for mental health are made to -

- I. National Institute of Mental Health and Neurosciences, Bengaluru (₹ 850 crore),
- II. Lokpriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur (₹ 60 crore), and
- III. National Tele-Mental Health Programme (₹ 90 crore) (Keshav Desiraju India Mental Health Observatory, 2024).

The above allocations reflect that the funding towards Mental Health Institutions increased by 16%, majorly because of increased allocations to NIMHANS by 18% and decreased funding to TELE Manas by 33% (Keshav Desiraju India Mental Health Observatory, 2024).

National Tele Mental Health Programme launched in October 2022, is a two-tier system inclusive of state TELE-Manas cells and mental health professionals at DMHPs to extend specialist care at secondary level (Keshav Desiraju India Mental Health Observatory, 2023). Services are provided across 53 TELE Manas and till date they have managed approximately 12 lakh calls (Ministry of Home Affairs, 2024).

For the 2024-25 financial year, the budget estimate of T-MANAS was 90 crores, a decrease of 32% from the previous financial year, the drop in allocation could be attributed to the capital costs that were being invested in the first two years of the initiative (Keshav Desiraju India Mental Health Observatory, 2024).

It is difficult to ascertain the funding allocation for NMHP as it has been subsumed under Tertiary Care Programme (TCP). However, the expenditure for the TCP witnessed an increase of 27% (369 crores) from 2023-24 (290 crores). This growth indicates the potential for tertiary mental healthcare in the country, where the National Human Rights Commission highlighted the deplorable conditions of government mental health institutions and the absence of dedicated cadre for the field (National Human Rights Commission, 2023).

The funding sanctioned for 767 districts under DMHP, has not been detailed in the budget estimate statement and is likely to be merged with the 'Flexible Pool for RCH & Health System Strengthening, National Health Programme and National Urban Health Mission' (Keshav Desiraju India Mental Health Observatory, 2024).

This year the National Action Plan for Drug Demand Reduction (NAPDDR) (2018, 2020) has been included within the direct allocation head for mental health because the MHCA (2017) includes mental health conditions associated with the use of alcohol and drugs in its definition. An allocation of 314 crores has been made to NAPDDR (Keshav Desiraju India Mental Health Observatory, 2024). The utilisation history of the NAPDDR has been below optimal levels despite availability of funds (Keshav Desiraju India Mental Health Observatory, 2024).

The earmarked proportion for mental health (2024-25), under the National Programme for the Welfare of Persons with Disabilities is 615 crores, a 17% increase from 2023-24, under the indirect expenditure allotment (Keshav Desiraju India Mental Health Observatory, 2024). The allocations for specific schemes are as follows:

- I. Deendayal Disabled Rehabilitation Scheme is allocated 165 crores as compared to 130 crores in 2023-24 (Keshav Desiraju India Mental Health Observatory, 2023).
- II. The scheme for implementation of Rights of Persons with Disabilities Act (SIPDA) (2016) has been allocated 135 crores as compared to 150 crores in 2023-24. It has been reported that from the past 5 years the scheme has seen a steady decline in allocation, probably because of poor fund utilisation (Keshav Desiraju India Mental Health Observatory, 2023).

A positive development has been the inclusion of mental health in the Economic Survey 2023-24 (Government of India, 2024). It explores and examines the productivity losses, rising healthcare costs, and economic development due to mental health issues and extends policy recommendations to adopt holistic community-based approaches for the mentioned concerns (Keshav Desiraju India Mental Health Observatory, 2024).

DMHP'S CONTRIBUTION TO MENTAL HEALTH FUNDING PROVISIONS

The DMHP is financed through the National Health Mission (NHM). The DMHP falls under the *Flexible Pool for Non-Communicable Diseases, Injury, and Trauma*, the fourth financial component of the NHM. The Financial Management Group (FMG) is the designated fiscal body of the NHM that manages planning, budgeting, accounting, reporting, and management of internal controls. To facilitate better financial management the state and district have been mandated to set up FMGs at both levels to enable effective fund management (National Health Mission, n.d.). Approval for funding under the NHM is contingent on the State Project Implementation Plans (PIPs), which is a consolidated report inclusive of the drafts of the District Health Action Plan for the DMHP and other health expenditures by the state government (Fernandes, 2021). After submission to the MoHFW and revisions and approvals, the final approved budgets called the Record of Proceedings are released and split between the central

and the state government bodies (Fernandes, 2021). The pertinent issue remains the lack of transparency and certainty with respect to how the states finance the DMHP for the following period of 5 years. Historically they have been criticised for their low allocations (Fernandes, 2021; Ginneken et al., 2014).

GOVERNMENT FUNDED SCHEMES

In addition to the DMHP programme, the following government schemes contribute to mitigating the financial barrier to accessing mental health services in the country:

Ayushman Bharat (Pradhan Mantri Jan Arogya Yojana (PM-JAY))

Policy overview: Flagship health insurance scheme that aims to provide health coverage to economically vulnerable families, offers up to 5 lakhs per family per year for secondary and tertiary hospitalisation (Singh, 2019).

Coverage: It includes coverage for mental illnesses, offering 17 packages that encompasses various mental health disorders inclusive of substance use disorders, but coverage is limited to public sector hospitals only and is primarily applicable to inpatient services (Singh, 2019). The scheme's implementation varies across states as some have opted out in favour of their own initiatives.

Central Government Health Scheme (CGHS)

Policy Overview: It provides comprehensive healthcare services to central government employees, pensioners, and their dependents through empanelled private and government hospitals.

Coverage: It includes certain mental health services besides medical treatment. Beneficiaries can access outpatient consultations, inpatient care, and medications for mental health issues, but the extent of coverage depends on the type of mental health disorder and the treatment required.

Other Government Schemes:

Niramaya

This health insurance scheme provides affordable coverage for people with autism, cerebral palsy, mental retardation, and multiple disabilities (The National Trust, 2023).

Sahyogi

The scheme sets up caregiver cells to train and create a skilled workforce of caregivers for people with disabilities and their families (The National Trust, 2023).

Gyan Prabha

The scheme encourages people with autism, cerebral palsy, mental retardation, and multiple disabilities to pursue educational and vocational courses (The National Trust, 2023).

Employees' Health Scheme (EHS)

The scheme has been designed to provide healthcare services to central government employees and their families. It covers a range of medical treatments, including some mental health services, but the specifics can vary. The scheme primarily focuses on inpatient care, with limited provisions for outpatient mental health treatment, the coverage is less comprehensive as compared to other physical conditions.

Besides the above-mentioned schemes, there are certain state specific schemes that extend mental health insurance. Though there is no specific CAMH policy or programme, the PM CARES for Children scheme supports children who have lost both parents, a legal guardian, adoptive parents, or a surviving parent due to the COVID-19 pandemic. It ensures sustained protection and well-being through health insurance, educational empowerment, and financial support for self-sufficiency until they reach 23 years of age (PM CARES, 2021). Under this scheme, children and adolescents receive financial support up to ₹10 lakhs, health insurance coverage of ₹5 lakhs, and scholarships for education (PM CARES, 2021).

MENTAL HEALTH INSURANCE IN INDIA

The existing data states there is a reported treatment gap as high as 84% with approximately 150 million Indians in dire need of mental healthcare services. However, out of them, nearly 30 million seek treatment (Murthy, 2017). The estimated economic loss to India due to mental illness is estimated to be around USD 1.03 trillion between 2012 and 2030 due to loss of productivity (Avula et al., 2024). The underlined disparity between the mental health service needs and treatment seeking behaviour could be potentially attributed to the lack of financial resources and the unequal distribution of the existing ones, appropriate healthcare and insurance policies in the country. Although the extended government services offer either free of cost or subsidised mental healthcare, the primary service delivery model, that is, DMHP, is understaffed and overburdened to meet the demand of services (Fernandes & Varma, 2021). This situation has led to 80% of the health financing being private, a major percentage of which is funded by out-of-pocket expenditure, approximately a monthly average of INR 1000-1500 (Kumar et al., 2019). Yadav et al. (2023) used data of the National Sample Survey (NSS) on 'Persons with Disabilities in India Survey' conducted during July–December 2018 and revealed that 18.1% of the monthly consumption expenditure is spent on mental health as a result of which 20% of the households are pushed from non-poor to poor status calling for an immediate need of financial protection.

MHCA (2017), in its intent to promote access to mental healthcare provides mental health insurance coverage to reduce the aforementioned barriers. MHCA (2017) section 21 clause 4 states, *'Every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness'* (Government of India, 2017). This provision prompted the Insurance Regulatory and Development Authority of India (IRDAI) to issue a circular (IRDAI/HLT/MISC/CIR/128/08/2018) that mandated all insurers to comply with the said domain and were instructed to mention on their respective websites their underwriting philosophy and approach with regard to offering insurance for mental illness (IRDAI/HLT/MISC/CIR/129/06/2020) (IRDAI, 2018 & IRDAI, 2029). Due to poor compliance and increasing complaints, a revised circular re-issuing the mandate was released in 2022 following which an expert committee (IRDAI/HLT/ORD/Gen/73/03/2023) was formed to ensure effective implementation and supervision (IRDAI, 2023).

Avula et al. (2024) analysed the following 30 health insurance companies for their mental health policies to understand the (i) coverage, (ii) waiting period, (iii) treatment of substance use-related disorders, (iv) coverage for self-harm or suicide, and (v) coverage for outpatient consultation diagnostics and prescription expenses.

Table 9: Classification of Insurance Companies

Standalone Insurance Companies	General Insurance Companies (Private)	General Insurance Companies (Public Sector)	Insurance Companies not covering mental illness
Care Health Manipal Cigna Niva Bupa Health Aditya Birla Health Start Health and Allied	Go Digit Bajaj Allianz Cholamandalam Bharti AXA HDFC ERGO Future Reliance SBI Navi ICICI Lombard Liberty Gen Raheja QBE Magma HDI Gen Universal Sompo	National Insurance The New India The Oriental The United	Kotak Mahindra Zuno Shriram Gen Iffco Tokio Gen Tata AIG Gen Acko Royal Sundaram

(Avula et al., 2024)

- 22 out of 30 companies provide coverage for mental illness, with a significant variation in the use of definitions and diagnostic codes (Avula et al., 2024).
- 11 companies offer outpatient mental healthcare services, but coverage levels and conditions vary and are often mostly limited to premium policies, discount rates, or certain specific plans, pharmacy and diagnostics (Avula et al., 2024).
- All insurers universally exclude coverage for suicide or self-harm incidents (Avula et al., 2024).
- Only 2 insurance companies cover alcohol and psychoactive substance use disorders (Avula et al., 2024).
- Waiting periods for mental illness coverage range from 24 to 48 months, with some companies offering flexibility (Avula et al., 2024).
- Out of the 235 policies reviewed, a significant proportion of 51%, that is 119 policies do not offer any coverage for mental illness (Avula et al., 2024).
- 93.3% (28 companies) of the companies cover individuals with >40% disability, they cover individuals who have intellectual disabilities, mental illness, specific learning disability, speech and language disabilities and autism spectrum disorder, etc (Avula et al., 2024). However, the total sum insured for these benchmark disabilities is restricted to 10 lakhs (Avula et al., 2024). Other mental health conditions covered by insurance companies are-

Table 10: Additional Mental Health Provisions of Insurance Companies

Mental Health Conditions	Coverage by Companies
Schizophrenia	All Companies
Mood Disorders	All Companies
Anxiety Disorders	All Companies, emphasis on phobic disorders and ICD
Specific Personality Disorders	Consistently covered by all companies, but only Bharti AXA and Oriental Insurance cover Anankastic Personality Disorder
Mental Retardation	All Companies
Pervasive Developmental Disorders	Manipal Cigna, Future Generali
Hyperkinetic Disorders	Manipal Cigna, Liberty Insurance

(Avula et al., 2024)

In addition to government schemes and insurance coverage, disability certification given to individuals with a benchmark disability of at least 40% for mental illness including autism, intellectual disability and specific learning disorder, is crucial for accessing benefits and services provided under the RPwD Act. Other social welfare measures of the government include, but are not limited to, tax deductions for caregivers, concessional loans, and employment support with reservations. Additionally, vocational training programmes, housing support, travel & rail concession for persons with disability and their caregivers are also available (Swarupa, 2020).

National Handicapped Finance and Development Corporation offers schemes for education and training of persons with disabilities to enhance employability and self-sufficiency among persons with disabilities. Furthermore, states in India have their own disability pension schemes. For instance, Haryana provides pensions based on the level of disability, offering ₹ 2,500 per month for individuals with 100% disability, which includes mental illness as one of the qualifying conditions. Similarly, in Delhi, the disability pension is ₹ 2,500 per month for individuals with a minimum of 40% disability.



R

Rapport Formation and Reflective Listening
 (संक्षेप संस्थापन एवं विचारशील होकर सुनना)
 बच्चे के साथ गूढ़ संबंध (rapport) बनाने की प्रक्रिया को संक्षेप संस्थापन
 निम्नलिखित तरीके से सुनना।

समायोजन के लिए यह ध्यान रखना महत्वपूर्ण है कि हर बच्चे के लिए सुनना एक ही तरह की रचनात्मकता लागू नहीं होती है। आपको हर बच्चे के साथ अलग तरीके से बातचीत करनी पड़ेगी। सामान्य रूप से, सामने वाले बच्चे के द्वारा ही बातचीत के दौरान आपको संक्षेप संस्थापन के अर्थ क्या चाहिए, इसलिए यह सुझाव है कि पहले से किसी भी प्रकार की अनुमति को ध्यान में रखकर बातचीत न करें।



A

Assessment
 (मूल्यांकन)

(इसके बारे में मॉड्यूल-6 में विस्तृत जानकारी दी गई है)
 बच्चे की मानसिक समस्या की गंभीरता का मूल्यांकन करना।



P

Prioritization
 (प्राथमिकता)

(इसके बारे में मॉड्यूल-7 में विस्तृत जानकारी दी गई है)
 किस समस्या पर सबसे पहले ध्यान देने की आवश्यकता है यह सुनिश्चित करना।

I

Intervention
 (हस्तक्षेप)

(इसके बारे में मॉड्यूल-8 में विस्तृत जानकारी दी गई है)
 बचाव या हस्तक्षेप करना - बच्चे की तनाव की स्थिति को कम करना और
 हिम्मत देना।

D

Disposition
 (मनोवृत्ति)

(इसके बारे में मॉड्यूल-9 में विस्तृत जानकारी दी गई है)
 बच्चे की तनाव की स्थिति को कम करना और
 हिम्मत देना।



CAMH SERVICES

This section intersects with other components of the CAMH mapping exercise, yet it serves to provide a clear overview of the child and adolescent mental health (CAMH) services available in India. According to the available records, there are three centrally run mental health institutes (National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur, and Central Institute of Psychiatry (CIP), Ranchi), and approximately 44 remaining state run mental hospitals, and 398 Department of Psychiatry in various medical colleges across the country (Government of India, 2023d; Press Information Bureau, 2014).

A range of child and adolescent mental health services are currently being offered across the country. Most of these facilities provide a combination of outpatient and inpatient services as a basic component of care. However, several centres, particularly those housed within premier institutes offer a more specialized service dissemination profile. For instance, the Central Institute of Psychiatry (CIP), Ranchi offers in-patient and out-patient units, along with community outreach through the Erna Hoch Centre for Child and Adolescent Psychiatry. Similarly, NIMHANS, Bangalore houses two distinct inpatient facilities dedicated to children and adolescents, in addition to specialty clinics like the Swatantra Clinic which caters to children in need of care and protection (CNCP) and those in conflict with the law (CICL). Their community CAMH service project provides promotive, preventive, and curative care, reaching both urban and rural populations through direct service delivery and capacity building of childcare workers across schools, anganwadis, and community-based organizations. The Tele MANAS which is coordinated by NIMHANS provides free multilingual, 24/7 mental health support through toll-free helplines and a mobile application.

Other premier institutes like AIIMS Delhi, PGIMER Chandigarh, and IHBAS Delhi provide regular outpatient and inpatient care, and run specialty clinics focused on child and adolescent disorders. The behavioural addiction clinics such as those at AIIMS focus not just on treatment but also public health initiatives and training. Community outreach is a shared priority across, with some institutes like PGIMER and Topiwala National Medical College, Mumbai even leveraging telepsychiatry and/or telemedicine services for extended access, particularly during emergencies. Learning disability clinics, autism testing and intervention centres, remedial education units, and dynamic intervention schools (e.g., at BYL Nair Hospital, Mumbai) further expand the range of specialized care that is beginning to take root.

While the services offered across these institutions showcase a developing landscape of CAMH infrastructure, it must be emphasized that they reflect only a fraction of what potentially exists or should exist in the country. Institutes listed here are illustrative and not exhaustive as many services remain undocumented or underreported. Most State Medical Colleges feature a Department of Psychiatry that provides both outpatient and in-patient services for children and adolescents. However, these services are predominantly delivered by tertiary healthcare centres, underscoring a critical gap in access to community-based preventive, promotive and rehabilitative mental healthcare for children and adolescents. Moreover, the National Human Rights Commission has highlighted the deplorable conditions of the state-run mental healthcare institutions, suggesting a gross oversight by multiple stakeholders involved. The state of affairs captured by the commission infringes upon the human rights of persons with mental health issues and disabilities (National Human Rights Commission, 2023).

This paints a grim picture of a system where both accessibility and dignity in care are compromised. The uneven distribution of CAMH services across different healthcare levels and regions, coupled with poor implementation of inpatient and outpatient guidelines, and inhumane conditions presents significant challenges. Additionally, the lack of integrated approaches and standalone initiatives without provisions for scalability, such as effective implementation of decentralization of services, strengthening national flagship programmes with last-mile reach, task shifting, incorporation of digital platforms, public-private partnerships, policy integration- further complicate the landscape of child and adolescent mental health in India.

In light of these complexities, there is a pressing need for an intensive and systematic mapping exercise that goes beyond a mere listing of institutions. This must include identifying the full spectrum of services being offered across public and private sectors—whether they are implemented as envisioned, what their human and infrastructural resources look like, their outreach and effectiveness metrics, how their services are monitored and supervised, and whether successful models are being adapted in other settings. Crucially, such adaptation must be accompanied by the incorporation of local cultural knowledge and context-specific systems to ensure efficacy and sustainability in diverse environments.

Alongside these institutional efforts, various government programmes have also been instrumental in shaping the broader landscape of CAMH service delivery in India, particularly through school, community, and healthcare platforms.

Table 11: CAMH Services under Government Programmes

Government Programmes	CAMH Services
DMHP (Under NMHP)	Over 173,000 SHCs, PHCs, UPHCs, and UHCs have been upgraded to Ayushman Arogya Mandirs to provide mental health services - prevention, promotion, long-term care, general psychotropic & psychosocial interventions; life skills in schools; and a non-school Child/Adolescent Mental Health Programme.
RKSK	Recognizes mental health as a key priority for adolescent health in India, encompassing all genders, urban/rural areas, in/out of school, and vulnerable groups, through Adolescent Friendly Health Clinics, community interventions, facility-based counselling, and social behaviour change communication.
Support, Advocacy, and Mental health interventions for children in Vulnerable circumstances And Distress (SAMVAD), Ministry of Women and Child Development, Government of India	<p>A National Initiative and Integrated Resource for Child Protection, Mental Health, and Psychosocial Care</p> <ul style="list-style-type: none"> ● Located in the Department of Child and Adolescent Psychiatry, NIMHANS ● Child and Adolescent well-being through transdisciplinary and integrated approaches- ○ Training and capacity building, research, and mentoring for child services

	<ul style="list-style-type: none"> ○ Collaborations with National Institutes to ensure integration ○ Innovative research ○ Affecting policy change ● Increasing geographical coverage to percolate child protection and mental health awareness to grassroots levels
The National Council of Educational Research and Training (NCERT)	<p>Manodarpan (COVID & beyond) - An initiative that provides mental health support to students, teachers, and families. It includes:</p> <ul style="list-style-type: none"> ● Helpline for tele-counselling ● Webinars to raise awareness ● Live interactive session <p>School Health Programme -</p> <ul style="list-style-type: none"> ● Module on "Emotional Wellbeing and Mental Health" ● Training and resource materials on health and wellness for school-going children <p>PRASHAST - helps teachers identify children who are not developing typically -</p> <ul style="list-style-type: none"> ● PRASHAST-1: for regular teachers for first level preliminary screening. ● PRASHAST-2: for special educators, further referred to assessment camps.
Ayushman Bharat School Health & Wellness Programme	<p>Joint initiative by the Ministries of Education (MoE) and Health & Family Welfare (MoHFW) to promote health and wellness in schools from 2020.</p> <ul style="list-style-type: none"> ● Provides information, psychological support, commodities, and services to school children. ● Help children develop the skills to respond to real-life situations ● Two teachers in each school are designated as Health and Wellness Ambassadors. They are trained to deliver health promotion and disease prevention information to students through interactive activities ● Life-skill based education ● NCERT in partnership with UNESCO New Delhi developed 11 animated videos to raise awareness among children and teachers

<p>Central Board of Secondary Education</p>	<p>Promotion of Life Skills and Mental Health in Schools, 2024 - A Curricular Practice that intends -</p> <ul style="list-style-type: none"> ● To foster self-confidence, eco-sensitivity and a lifelong learning mind-set among students ● To collaborate with Expressions India to establish the online Adolescent Peer Educators Leadership Programme. ● To develop Life Skills and Well-being Centres in the school
<p>Nasha Mukh Bharat Abhiyaan (NMBA), Ministry of Social Justice and Empowerment (MoSJE)</p>	<p>NMBA, a nationwide initiative launched by the Ministry of Social Justice and Empowerment (MoSJE) on August 15, 2020, to combat substance abuse and promote awareness about dangers of drug use across India. As of August 15, 2023, the programme has expanded to cover all districts across India.</p>

Most of the CAMH specific services (Table 14) under government programmes have been implemented since COVID-19 outbreak with the exception of RKSK launched in 2014 and DMHP in 1982. These programmes are overlapping in their objectives to develop mental health outcomes of children and adolescents in school, community and healthcare settings, pointing to shared goals and diversified approaches to reaching the target population. However, the monitoring and evaluation mechanisms, capacity building protocols, outreach, and impact require renewed and immediate attention. In addition to these, few non-governmental organizations and independent societies add to the existing pool of service availability, thereby advancing access.

CAMH SERVICES UNDER NON-GOVERNMENTAL ORGANISATIONS & INDEPENDENT ORGANISATIONS

Given India's vast network of NGOs and independent organisations working in mental health and/or its intersection with various stakeholders, the absence of a centralized online or offline repository of registered organisations makes it difficult to account for their efforts, objectives, and impact. Most of them primarily engage in capacity building, awareness initiatives, advocacy, accessibility, and care by leveraging community and health system resources to provide mental health and psychosocial support across all age groups.

However, very few focus specifically on child and adolescent mental health. Although the NITI Aayog's NGO DARPAN portal, launched in 2017, serves as a digital platform for voluntary organizations to register and interface with the government, its scope remains limited. The portal facilitates registration and recognition of voluntary organizations, including those working in mental health and child welfare, thereby enabling them to access government schemes, yet it does not capture the scope, quality, or outcomes of their CAMH-related interventions.

Despite these efforts, there is a lack of structured coordination among aforementioned services, raising critical concerns about their long-term sustainability and systemic integration. No standardized set of guidelines exists to develop a systemic framework for CAMH services. While the National Health Policy (2017) emphasises the importance for a structured referral mechanism to ensure continuity of care from primary to tertiary levels, specific standardized referral protocols for mental health continue to remain absent. However, policies and legislations addressing school-

based mental health services and protocols for reporting abuse and neglect acknowledge the importance of coordinated care regimes. These frameworks recognize the complexities of psychosocial risk factors and emphasize the need for an integrated approach to address mental health issues among children and adolescents.



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CAMH MEDICATION AND TREATMENT MODALITIES

CAMH is a critical area with varied medications and treatment modalities available across multiple levels of healthcare to address mental health challenges. It consists of pharmacological treatment, psychosocial interventions, and telemedicine solutions. However, no official protocol or set of guidelines specifically govern the use of child and adolescent medication and treatment modalities. Therefore, following guidelines can be referred to better inform and regulate treatment practices -

NATIONAL LIST OF ESSENTIAL MEDICINES (NLEM)

NLEM is an evolving list of medications that includes agents essential for managing diseases of significant public health concern in the country (Parmar et al., 2023). The list is approved by the Drugs Controller General of India and is further recommended by the respective national programmes (Parmar et al., 2023). The latest edition of September 2022 is representative of public health conditions, cost-effective solutions, and safety provisions.

The latest observations made with respect to psychotropic drugs listed in NLEM (2022) (Parmar et al., 2023) are -

- 16 medications have been mentioned in the section '*Medicines used in the treatment of Psychiatric Disorders*'
- No drugs have been dropped from the aforementioned section, but three have been added under the new sub-head of '*Medicines used in disorders of Psychoactive Substance Abuse*'
- The list does not include medications for the acute management of alcohol withdrawal or for the long-term maintenance of alcohol dependence.
- Drugs such as varenicline and bupropion, which are part of the WHO Essential Medicines List (EML) (2021) for tobacco dependence, have also been excluded.
- It is essential to acknowledge the role of benzodiazepines in managing alcohol withdrawal, given its significance as a public health issue.
- There is an increasing need for medications like memantine to address the rising burden of neurocognitive disorders.

Table 12: NLEM List 2022

Disorder Category as per NLEM	Drugs	Levels of Healthcare for Various Drugs
Psychotic Disorders	Clozapine (Tablet 25/50/100 mg)	T
	Fluphenazine (Injection 25 mg/ml)	P,S,T
	Haloperidol (Tablet 2/5/10/20 mg, Oral liquid 2 mg/5ml, Injection 5 mg/ml)	S,T
	Risperidone (Tablet 1/2/4 mg, Oral liquid 1 mg/ml, Long-acting injection 25/37.5 mg)	P,S,T
Depressive Disorders	Amitriptyline (Tablet 10/25/50/75 mg)	P,S,T
	Escitalopram (Tablet 5/10/20 mg)	P,S,T
	Fluoxetine (Capsule 10/20/40/60 mg)	P,S,T
Bipolar Disorders	Lithium (Tablet 300 mg)	S,T
	Sodium Valproate (Tablet 100/200/400 mg, Modified release tablet 300/500 mg)	P,S,T
	Carbamazepine (Tablet 100/200/400 mg, Modified release 200/400 mg, Oral liquid 100 mg/5 ml)	P,S,T
Generalised Anxiety and Sleep Disorders	Clonazepam (Tablet 0.25/0.5/1 mg)	P,S,T
	Zolpidem (Tablet 5/10 mg)	P,S,T
Obsessive Compulsive Disorders and Panic attacks	Clomipramine (Capsule 10/25/75 mg)	P,S,T
	Fluoxetine (Capsule 10/20/40/60 mg)	S,T
Disorders due to psychoactive substance use	Buprenorphine (Tablet SL 0.4 mg)	P,S,T
	Buprenorphine+Naloxone (Tablet SL 0.4+0.1 mg and 2+0.5 mg)	P,S,T
	Nicotine (nicotine replacement therapy oral dosage 2/4 mg)	P,S,T

P-Primary, S-Secondary, T-Tertiary

NATIONAL MENTAL HEALTH PROGRAMME

As outlined in notice No. V-15011/03/205-PH-1(ii) dated June 24, 2015, the guidelines for implementing District Level Activities under the National Mental Health Programme (NMHP) during the 12th Five-Year Plan (Government of India, 2015a) include specific instructions regarding the regulation, availability, and provision of psychotropic drugs:

Essential Drug Availability: All essential medications must be accessible at every Primary Health Centre (PHC), Community Health Centre (CHC), and district hospital (Government of India, 2015a).

Procurement Regulations: Procurement should be managed through the drug/logistics society or rate contracts, following discussions with the district health society if these mechanisms are not operational in the state (Government of India, 2015a).

Service Utilisation: Individuals with mental illnesses are encouraged to utilise mental health services within the district, as the District Mental Health Programme (DMHP) adopts a public health approach to mental healthcare (Government of India, 2015a).

To ensure a minimum standard of mental healthcare within the peripheral public healthcare system, the following provisions are mandated:

- Antipsychotic medications for individuals with psychosis
- Antidepressants for those with clinical depression
- Educational support and linkages with NGOs for individuals with intellectual disabilities
- Counselling services for individuals with neuroses
- Outpatient detoxification and education for individual's dependent on alcohol
- Counselling for children experiencing emotional difficulties
- Antiepileptic drugs for individuals with epilepsy (Government of India, 2015a)

Additionally, a revised list of psychotropic drugs that should be available at the district hospital, CHC, and PHC levels was issued in 2018 by the Ministry of Health and Family Welfare (F.No. T.20013/40/2017-NCD/PH-I), listed as follows-

Table 13: District Hospital Level – Mandated Psychotropic drugs

Mental Health Conditions	Psychotropic Drugs/Medicines
Psychotic Disorders	Tab Haloperidol 5 mg Tab Risperidone 2 mg Tab Olanzapine 5 mg Inj Fluphenazine 25 mg Inj Haloperidol Inj Risperidone*
Depressive Disorders	Tab Imipramine 25 mg Tab Escitalopram 10 mg Cap Fluoxetine 20 mg
Bipolar Disorders	Tab Lithium Carbonate 300 mg Tab Carbamazepine 200 mg Tab Sodium Valproate 500 mg Tab Olanzapine 5 mg Inj Risperidone*
Generalised Anxiety and Sleep Disorders	Tab Zolpidem 10 mg Inj Promethazine 50 mg Tab Clonazepam 0.5 mg Tab Lorazepam 1 mg Inj Lorazepam
Obsessive Compulsive Disorders and Panic Attacks	Cap Fluoxetine 20 mg
Epilepsy	Tab Sodium Valproate 500 mg Tab Phenobarbitone 30 mg and 60 mg Tab Diphenylhydantoin 100 mg Tab Carbamazepine 200 mg Inj Lorazepam
Miscellaneous Extra pyramidal symptoms	Tab Trihexyphenidyl 2mg Inj Promethazine 50 mg

*To be administered under the supervision of a psychiatrist

(Government of India, 2018)

Table 14: CHC/PHC Level - Mandated Psychotropic drugs

Mental Health Conditions	Psychotropic Drugs/Medicines
Psychotic Disorders	Tab Haloperidol 5 mg Tab Risperidone 2 mg Tab Olanzapine 5 mg Inj Fluphenazine 25 mg
Depressive Disorders	Tab Imipramine 25 mg Tab Escitalopram 10 mg
Bipolar Disorders	Tab Olanzapine 5 mg
Generalised Anxiety and Sleep Disorders	Inj Promethazine 50 mg Tab Clonazepam 0.5 mg Tab Lorazepam 1 mg Inj Lorazepam
Obsessive Compulsive Disorders and Panic Attacks	Cap Fluoxetine 20 mg
Epilepsy	Tab Phenobarbitone 30 mg and 60 mg Tab Diphenylhydantoin 100 mg Inj Lorazepam
Miscellaneous Extra pyramidal symptoms	Tab Trihexyphenidyl 2mg Inj Promethazine 50 mg

(Government of India, 2018)

Timely Procurement: As per the 2015 regulatory notice, psychotropic drugs should be procured every 6 months in the required quantities. It is the responsibility of the programme officer or psychiatrist to guarantee the continuous availability of these medications at all Primary Health Centres (PHCs), Community Health Centres (CHCs), and district hospitals within the district (Government of India, 2015a).

Delay in Procurement: The District Health Society should be approached for special permission to directly procure the required drugs from the rate contract supplier, to minimise delays in procurement (Government of India, 2015a).

Monitoring and Reporting: The psychiatrist should conduct monthly reviews of drug positioning, submit monthly reports, and perform random checks during field visits. These findings should be reported to the District Programme Officer. Standard Operating Procedures (SOPs) must be in place to ensure regular procurement, storage, and dispensing of medications (Government of India, 2015a).

Supervision and Referral: The availability of drugs at the district hospital should be contingent on the presence or posting of a psychiatrist. If a psychiatrist is not available, patients should be referred to the designated medical college/hospital, mental health facility, or private psychiatrist under the District Mental Health Programme (DMHP) (Government of India, 2015a).

Treatment Prescription: Every patient is required to receive a prescription of the treatment advised to facilitate hassle free dispensing procedures. The outpatient services are mandated to have provisions for both new patients as well as old patients on follow-up (Government of India, 2015a).

Dispensing of Drugs: Patients should have access to essential medications free of cost from the hospital dispensary. Measures should be taken to ensure the availability of other listed medications. A mechanism for auditing the dispensing procedure is necessary. Dispensing of take-home medicines for a period longer than two weeks in a single visit should be avoided (Government of India, 2015a).

Regulation of Long-term Medications: Patients prescribed long-term medications should be able to get their medicines at regular intervals at PHC/CHC for the specified duration. This would help reduce the opportunity cost associated with continuing medication. The State Implementation Team and the District Programme Manager should coordinate the logistics and delivery aspects of this process (Government of India, 2015a).

OTHER MANDATED TREATMENT MODALITIES (No. V-15011/03/205-PH-1(ii))

Psycho-Social Interventions

Patients and their caregivers/attendants (post consent from the patients) are to be assessed by trained doctors and are entitled to receive psychosocial interventions/ psychoeducation as dictated by the clinical needs of the case. For the same, it is imperative to involve a multidisciplinary team of medical social worker, counsellor, and psychiatrist (Government of India, 2015a).

All centres of care at the district level should be equipped with facilities to provide psychosocial interventions to patients seeking outpatient and inpatient care in both group and individual settings. Caregivers should also be involved in these interventions. Though specialised psychotherapies might be out-of-scope for these centres, trained manpower and supporting facilities must be available to provide:

- a. Basic psychoeducation about the nature of illness and medications, including potential side-effects and ways to manage them and the importance of treatment adherence;
- b. Motivation enhancement;
- c. Services that help reduce high-risk behaviour;
- d. Brief interventions;
- e. Relapse prevention; and
- f. Counselling and occupational rehabilitation (Government of India, 2015a).

Guidelines for CAMH Management by Indian Psychiatric Society

Other than the mandated generic guidelines on the management and provision of psychotropic drugs and psychosocial interventions, the Indian Psychiatric Society has established clinical practice guidelines addressing several key areas in mental health for children and adolescents. These guidelines cover psychotherapeutic interventions tailored specifically for young individuals, ensuring that assessments for children and adolescents are thorough and effective. They also provide management strategies for various conditions, including Autism Spectrum Disorder (ASD), Specific Learning Disorder (SLD), Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD), and Intellectual

Disabilities (ID). Furthermore, the guidelines emphasise the application of Cognitive Behavioural Therapy (CBT) in treating anxiety disorders, obsessive-compulsive disorder (OCD), depression, schizophrenia, somatoform disorders, dissociative disorders, and bipolar disorder in children and adolescents. Additionally, they address substance use disorders among young people and highlight the importance of family interventions to support treatment and recovery.

Digital Mental Health Interventions

Based on the functionality of the interventions, digital mental health tools can be categorised into:

Monitoring tools - are used for tracking medication, mood, sleep and other significant markers of mental health. They could either be operated manually or via digital phenotyping, wherein data is automatically retrieved from smartphones and wearable devices to analyse patterns and indicators relevant to mental health (Pillutla, 2024). In 2021, the government introduced the monitoring tool MANAS (Mental Health and normalcy Augmentation System) application which offered features related to mental wellness consisting of guided meditation, mood tracking, sleep guidance, task planning and organisation. But the reviews on the app store indicated that owing to technical issues the support extended by the application was inaccessible for the users (Pillutla, 2024).

Treatment tools - are supportive interventions, such as tele-mental health services, unsupervised alternatives like self-guided CBT applications, self-guided grounding exercises, clinical support tools, and peer support groups (Pillutla, 2024).

The Indian government's initiative Tele MANAS caters to digital mental health services. In addition to the core services, the initiative launched a chatbot in Jammu & Kashmir that encourages users to talk to Tele counsellors on WhatsApp. However, this approach has its limitations, as it frequently prioritises relaxation techniques over the option of speaking with a counsellor. This is not an ideal solution in emergency or crisis situations (Pillutla, 2024).

To facilitate better implementation of the standalone digital mental health service, it has been integrated with eSanjeevani, a government initiative aimed at providing online doctor consultations for remote healthcare access, thereby enabling remote psychiatric prescriptions (Pillutla, 2024). However, in practice eSanjeevani is riddled with overburdened personnel and technical glitches. The 2020 24*7 crisis support hotline KIRAN, launched by the Ministry of Social Justice and Empowerment that additionally provided referrals to mental health professionals is to be merged with Tele MANAS (Ministry of Health and Family Welfare, 2024).

To potentiate the use of digital technology to deliver mental healthcare to lessen the treatment gap in resources deficient low- and middle-income countries, Malhotra et al. (2019) developed a digital model of mental healthcare to enable and empower the non-specialist to deliver high quality care especially in remote areas. In addition to these digital interventions, the government is also promoting the use of artificial intelligence (AI) in mental health (Pillutla, 2024). In 2018, NITI Aayog published the National Strategy for AI for research and implementation of AI technologies within the health sector (NITI Aayog, 2018).

Other than these pilot projects and their fallouts, the government has issued telemedicine guidelines to regulate the online prescriptive guidelines of psychotropic medications.

Telemedicine Guidelines

The psychiatric medications in India are broadly categorised based on their use and regulatory guidelines. The Telepsychiatry Operational Guidelines (2020) is one such resource, published by the National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Indian Psychiatric Society, and the Telemedicine Society of India. The prescriptive mandate takes into consideration the type of consultation (first/follow-up), the mode of consultation, the category of medications and emphasises the use of generic names as a norm. Telepsychiatry Operational Guidelines (2020) categorises medications into different lists based on their use during tele-consultations:

List 'O' Drugs - pertains to over the counter (OTC) drugs that do not require a prescription from a doctor to be sold.

List 'A' Drugs - contains relatively safe medicines with low potential for abuse. These are psychotropic drugs as per sub-section (10) of Section 18 of Mental Healthcare Act 2017 (notified as per letter F. No. V. 15012/04/2019-PH-1 dated 16th August 2019). To prescribe List-A drugs, first consultation has to be a synchronous tele-video consult, the follow-up consultations can follow any mode subsequently.

Table 15: List A Drugs under Telepsychiatry Operational Guidelines (2020)

Anti-depressants	Imipramine Escitalopram Fluoxetine
Oral Antipsychotics	Halperidol Risperidone Olanzapine
Anti-epileptics	Phenobarbitone Diphenylhydantoin
Mood Stabilizers	Lithium carbonate Carbamazepine Sodium Valproate
Anti-Cholinergic drugs	Trihexyphenidyl
Sedative-Hypnotics/ Benzodiazepines	Clonazepam Clobazam

Online prescription for injectables (Inj. Fluphenazine, Inj. Haloperidol, Inj. Promethazine) is permissible via a collaborative tele-video consultation with either a registered medical practitioner or a health worker. Cautions regarding specific medication and in-person supervision are mentioned in the telepsychiatry guidelines.

List 'B' Drugs - Dynamic list of drugs that are prescribed to optimise existing psychiatric conditions, which can only be prescribed under tele follow-up for the same health condition under consideration.

Table 16: List B Drugs under Telepsychiatry Operational Guidelines (2020)

Antipsychotics	Aripiprazole, Quetiapine, Clozapine, Lurasidone, Ziprasidone, Chlorpromazine, Paliperidone, Iloperidone, Amisulpride, Asenapine, Zuclopenthixol, Flupentixol, Thioridazine, Droperidol, Pimozide, Trifluoperazine, Loxapine, and other antipsychotics.
Anti-depressants	Sertraline, Paroxetine, Desvenlafaxine, Mirtazapine, Citalopram, Vortioxetine, Vilazodone, Duloxetine, Venlafaxine, Doxepine, Clomipramine, Nortriptyline, Bupropion, Trazodone, Nefazodone, Amitriptyline, Fluvoxamine, Reboxetine, Milnacipran, Protriptyline, Maprotiline, Amoxapine, Moclobemide and other antidepressants.
Anti-cravings and Aversive drug	Disulfiram, Topiramate, Baclofen, Naltrexone, Acamprosate and other anti-craving agents.
Anti-Dementia drugs	Donepezil, Rivastigmine, Memantine, Galantamine and other drugs used in the treatment of Dementia.
Anti-ADHD drugs	Atomoxetine, Clonidine, Modafinil and other drugs.
Mood Stabilizers	Oxcarbazepine, Lamotrigine, Divalproex sodium and other drugs.
Beta-blocker	Propranolol
Anti-anxiety drugs	Buspirone & Pregabalin
Injectables	Online Prescription shall be given by a Psychiatrist to a RMP or to a Healthcare worker after collaborative telemedicine consultation - Zuclopenthixol, Flupentixol, Paliperidone and Aripiprazole.

List 'C' Drugs - Psychotropic drugs that are not to be prescribed during tele psychiatric consultations. These include schedule X of Drug and Cosmetic Act, 190 and Rules, 1945, and narcotics and psychotropic substances listed in the Narcotic Drugs and Psychotropic substances Act, 1985.

Practice guidelines with respect to Tele-psychotherapy/Tele-counselling are also detailed in the manual.



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HUMAN RESOURCES FOR CAMH SERVICES

The effectiveness of mental health services fundamentally depends on its human resources, as the delivery and quality of care hinge on the competence, training, skill sets, and motivation of the cadre. In India, similar to other sectors, there is no dedicated human resource unit specifically for Child and Adolescent Mental Health (CAMH) services. Despite a reported shortage of mental health professionals in lower-middle-income countries—where the median number of mental health workers is just 6.2 per 100,000 population, and a mere 2.5/100,000 in the Southeast Asian region (World Health Organization, 2017)—the existing mental health workforce in India plays a vital role in providing CAMH services. Therefore, to understand the distribution of the mental health workforce, their formal training, and their roles in service delivery, this section will examine the Indian landscape for human resources in mental health to better understand the gaps in CAMH service capacity.

Since there is no standardised repository that collects, collates and presents data related to mental health human resources in the country, the actual number of the respective professionals varies significantly. The picture is further complicated by the presence of mental health and psychosocial support service providers in non-health sectors such as protection and education. The following facts represent this variation and presents an overview of child and adolescent specific human resources in the country-

- According to the Parliamentary Standing Committee on Health and Family Welfare's report (2023) India has **0.75 psychiatrists, 0.07 psychologists, and 0.07 social workers** for every 100,000 individuals.
- As of July 2023, **3372 clinical psychologists** have been registered with RCI (Government of India, 2023c).
- There are around 0.02/100,000 child and adolescent psychiatrists for a population less than 14 years of age in India (Sourander et al., 2017).
- All India Occupational Therapists' Association (AIOTA), the only body of Occupational Therapists in India has about 5000 members. Till date about 10000 have graduated in India but many of them are expatriates (AIOTA, 2015).
- A data narrative on the *State of Special Educators in India* authored by Nath (2024), indicates that as per the Rehabilitation Council of India (RCI), India has 1,66,802 special educators.
- Data of other CAMH personnel like child and adolescent psychologists, speech and language therapists, school counsellors, paediatricians, developmental paediatrics, paediatric neurologists, genetic specialists etc. are not available.

The capacity building mechanism for child and adolescent mental health (CAMH) can also be understood by evaluating:

- A. CAMH content in undergraduate MBBS curriculum
- B. Postgraduate programmes on Child and Adolescent Psychiatry

CAMH CONTENT IN UNDERGRADUATE MBBS CURRICULUM

The National Medical Council of India (2018) has updated the medical curriculum for undergraduates and postgraduates to align with the evolving health needs of the country.

- **Introduction of Psychiatry:** Psychiatry has been introduced early in the graduate curriculum, aimed at generating interest and providing core knowledge and psychiatric skills.
- **Child and Adolescent Mental Health:** While there is a lack of a separate section on child and adolescent mental health, the updated curriculum includes relevant topics such as:
 - **Mental Health:** Conceptual knowledge, warning signals, causal factors, and National Mental Health Programme (NMHP)
 - **Biopsychosocial Factors:** Discussion on biological, psychological, and social factors and their interactions in the causation of mental disorders
 - **Community Psychiatry:** Principles of preventive psychiatry and mental health promotion (positive mental health) along with community education
 - **Developmental Issues:** Normal growth and development, common developmental problems, and behavioural issues
 - **Mental Retardation in Children:** Aetiology, measurement, and psychosocial interventions
 - **Forensic Psychiatry:** Classification of common mental health disorders including PTSD
 - **Adolescent Health:** Common problems related to adolescent health, including psychological changes, eating disorders, and mental health issues.
- **Additional Components:**
 - Understanding salient features of mental health laws in India.
 - Promotion of existing government schemes and programmes like NMHP and Adolescent Friendly Health Clinics (AFHCs).
- **Ethics Coverage:**
 - Different types of consent and ingredients of informed consent are addressed.
 - Rules of consent related to age, emergency situations, mental illness, and alcohol intoxication are described.

POSTGRADUATE PROGRAMMES ON CHILD AND ADOLESCENT PSYCHIATRY

The following institutes offer courses in Child and Adolescent Psychiatry (CAP) in India-

Table 17: Postgraduate Programmes in CAP

Course	Eligibility	Duration	Seats
Doctor of Medicine (DM) in Child & Adolescent Psychiatry, NIMHANS, Bengaluru	MD/DNB in Psychiatry	3 years	4
DM in Child & Adolescent Psychiatry, PGIMER, Chandigarh	MD Psychiatry	3 years	4
Postdoctoral Fellowship (PDF) in Child and Adolescent Psychiatry, NIMHANS, Bengaluru	MD/DNB in Psychiatry	1 year	-
Post-Doctoral Fellowship (PDF) in Child and Adolescent Psychiatry, LGB Regional Institute of Mental Health, Tezpur, Assam	MD/DNB in Psychiatry	1 year	2
Post-Doctoral Fellowship (PDF) in Child and Adolescent Psychiatry, JIPMER, Puducherry	MD/DNB in Psychiatry	1 year	1
Post-Doctoral Fellowship (PDF) in Child and Adolescent Psychiatry, Asha Hospital, Hyderabad, Telangana	MD/MS/DNB or PG diploma	1 year	-
Post-Doctoral Fellowship (PDF) in Child and Adolescent Psychiatry, CMC, Vellore	MD/DNB in Psychiatry	2 years	-
Post-Doctoral Fellowship (PDF) in Child and Adolescent Psychiatry, Kalinga Institute of Medical Sciences, Bhubaneswar	MD/ DPM/DNB Psychiatry + Experience	1 year	1
Fellowship in Child Psychiatry, King George's Medical University (KGMU), Lucknow	MD/DNB Psychiatry	1 year	2
Fellowship in Child Psychiatry, St. John's National Academy of Health Sciences, Bengaluru	MD/ DPM/DNB Psychiatry	1 year	4

Other than these institutes (Table 24), courses related to childhood and adolescent psychiatry are also offered by VIMHANS and Indian Association for Child and Adolescent Mental Health (IACAM). IGNOU also offers a course in the said domain. Registered organisations like Pathways Koval have a one year paid post graduate certificate course in child and adolescent mental health for psychologists, counsellors, teachers, social workers, doctors, therapists, and medical and para medical and psychology students.

Additionally, post-graduate curricula in Psychiatry mandates mandatory postings in CAP for 2 or 3 months (Kommu & Jacob, 2019). However, a study involving 451 respondents who underwent this training revealed that 26.2% perceived the quality of their CAP training as either poor or very poor. Despite these challenges, India has made significant progress over the years in developing CAMH services across the country.

Emphasizing postgraduate courses in child and adolescent psychiatry is not an attempt to confine mental healthcare within a biomedical framework. Rather, it highlights the scarcity of intersectional training opportunities available to medical students. It also critiques the prevailing hierarchical model of care in India, which despite its dominance over horizontalized care, remains inadequate to address the plethora of complex challenges faced by children and adolescents. In contrast, the allied mental health profession offers a variety of postgraduate programs in social work and psychology and its subfields like Counselling Psychology, Forensic Psychology, Developmental Psychology, Educational and School psychology in various universities. Approximately 70 Rehabilitation Council of India approved medical institutes offering M.Phil. and doctoral level programs (Psy.D.) in Clinical Psychology, and MPhil in Psychiatric Social work focus on advanced clinical training. Diploma courses in Guidance and Counselling, offered by institutions such as NCERT and the National Institute of Public Cooperation and Child Development, are instrumental in strengthening school mental health services.

Alongside these are allied postgraduate training courses in Special Education (D.Ed. Spl. Ed.; M.Ed. Spl. Ed.), Early Intervention (PGDEI), Audiology and Speech-Language Pathology (MASLP), Occupational Therapy & Prosthetics (MPO), Community based rehabilitation (DCBR), Vocational Rehabilitation-Intellectual Disability (DVR-ID), Indian Sign Language Interpretation (DISLI), illustrating a diverse though not exhaustive list of courses available in the country.

However, despite the presence of a regulatory body, there is poor implementation of the standardized code of conduct or uniform training structure across psychology and social work programs. Repeated shifts in educational policy, with inadequate transitional phases disrupt and downplay the quality of education, experience, and training. As it stands now, the impact of the New Education Policy (2024), intended to promote holistic, inclusive, and flexible learning while fostering critical thinking, creativity, and innovation, is yet to be fully realized in this domain. While the importance of training frameworks in allied disciplines is recognized, a detailed critical review lies beyond the current scope of this report.



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CAMH DATA AND HEALTH INFORMATION SYSTEM

Data and Health Information System is a critical area requiring urgent attention in the field of Child and Adolescent mental health in India. Though the earliest report on CAMH in India was published in the 1950s, since then no centre or organisation in the country has taken the responsibility of collating relevant data and evidence in a repository. Institutions like NIMHANS, have robust research infrastructure that disseminates CAMH data. Registered societies like the Indian Association of Child and Adolescent Mental Health (IACAM), hold a biennial annual conference and has a journal dedicated to publication of child mental health research (JIACAM). Similarly Indian Council of Medical Research recognizes child psychiatry as one of the thrust areas for research. Institutions, organisations, and government programmes elaborated in the subsections of the mapping report also contribute to CAMH data collection. However, despite availability of data it is difficult to ascertain not only the trajectory, nature, extent, and quality of the data, but also makes it difficult to analyse data for epidemiological trends, treatment/intervention efficacy, service utilisation, work-force task sharing/training, critical policy review, etc. Recent large-scale population-based studies to understand the prevalence of specific mental health disorders are limited. The government data that is, however, readily accessible, includes -

Table 18: National Surveys and Mental Health Specific Information

Survey	Population Covered	Mental Health Information
National Mental Health Survey (2015-16)	Adults (18+), Adolescents 13-17	<ul style="list-style-type: none"> ● Lifetime prevalence of mental morbidity ● Treatment gap for mental disorders ● Ongoing (2023-25)- aims to estimate prevalence, assess disability & care pathways, examine socio-economic impact, specific focus on vulnerable populations.
National Family Health Survey (2019-21)	All age groups	<ul style="list-style-type: none"> ● Focused on reproductive and child health, nutrition, and domestic violence
National Sample Survey – 75th Round	All age groups	<ul style="list-style-type: none"> ● Focused on health and morbidity, socio-demographics, healthcare utilization. ● Mental health aspects are indirectly addressed through questions on health status and disability
Indian Human Development Survey (2011-12)	All age groups	<ul style="list-style-type: none"> ● Multi-topic survey covering health, education, employment, etc

National Crime Records Bureau (NCRB) – Accidental Deaths & Suicides in India (2022) *	All age groups	<ul style="list-style-type: none"> ● Reports on suicide rates, causes, and demographics; provides data on mental health-related causes of suicide
Economic Survey of India (2023-24)	National	<ul style="list-style-type: none"> ● Highlights the economic impact of mental health issues ● Emphasizes the need for a community-based approach to mental health care
<p>*It is imperative to reflect on why suicide rates are still being covered as a domain by National Crime Records Bureau, despite its decriminalization, raising a pressing concern about whether the legislative recognition of mental health rights truly translated into systemic and societal change?</p>		

The table highlights how these surveys primarily documents the epidemiological data, wherein the population sets are varied, the same demographic is operationally defined using different parameters. Most importantly, it underscores how it often overlooks the underlying psychosocial factors that precede the emergence of 'defined-diagnosable-conditions'. The psychosocial dimensions of epidemiology remain underrepresented, particularly in a nation as culturally, religiously, regionally, and socioeconomically diverse as India. Independent studies and reports by organizations such as Sapiens Lab, CMHLP, and Vandrevala, though commendable for their advocacy and sustained contributions, fall short of bridging the critical information gap due to their crowdsourced methodologies. Similarly, various regional and state-level surveys lack rigor and coherence, hindered by underreporting, vague constructs, inconsistent operational definitions, and a lack of integration with broader national frameworks.

The services, ideally designed on the principles of prevention, accessibility, and care have been excluded from the domain of health and information systems, as they are neither documented nor critically reviewed. The latest report by the National Human Rights Commission (2023) draws attention to the existing gaps in infrastructure, accountability, and care provision within institutional mental health settings. It highlights the systemic inertia in translating legislations into action, particularly when it comes to ensuring rights, rehabilitation, and reintegration of persons recovering from mental ill health. Although the commission had directed the respective officials to submit an Action Taken Report in response to these concerns, no public record of compliance is available till date. This omission speaks volumes about the stark dichotomy within the mental health landscape. On one end, mental health care ideals are meticulously outlined on paper, while on the other, systemic dormancy renders these commitments practically non-existent. Clearly, underlining the transitional fallouts of awareness, training, institutional capacity, community readiness, financial support, and cohesive intersectoral action and coordination.

To truly comprehend the state of CAMH from the available data, it is imperative to indulge into a time intensive systematic review of the field across multiple sources to map, compare, collate, produce and present a cohesive picture of culturally relevant child and adolescent mental health data to ascertain future directions in the field.



CONCLUSION

The analysis presented in this report underscores gaps in the current systemic structure supporting CAMH services in India. The primary and secondary data revealed a disjointed approach – the CAMH Policy and Legislation section traces the country's legislative framework concerning child and adolescent mental health pointing out the presence of multisectoral provisions for mental health and psychosocial support.

The report emphasizes that without a substantial increase in financial utilisation and continued investment, including targeted funding for CAMH initiatives, the existing gaps in service provision and accessibility will persist.

Within the settings, limited availability of necessary medications, lack of trained professionals to oversee their prescription and use, and insufficient guidelines for age-appropriate safe prescribing practices were documented. Strengthening human resources is essential for building a robust mental health workforce capable of addressing the ever-changing needs of the target population. Additionally, limited availability of data and health information systems underscore the absence of comprehensive reviewing and monitoring mechanisms and data collection repositories.

Therefore, addressing the identified gaps in CAMH requires a concerted effort towards comprehensive country-wide mapping and strategic resource allocation. By doing so, India can lay the groundwork for a more effective mental health system that supports its most vulnerable citizens- children and adolescents, ensuring their well-being is prioritized in both policy and practice.

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