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Assessment of Mental Health Policy and Programmes in India

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ABSTRACT

An explicit mental health policy is an essential and powerful tool for the mental health section in any ministry of health. When properly formulated and implemented through plans and programmes, a policy can have a significant impact on the mental health of the population concerned. The outcomes described in the literature include improvements in the organization and quality of service delivery, accessibility, community care, the engagement of people with mental disorders and their careers, and in several indicators of mental health. Despite wide recognition of the importance of national mental health policies, data collected by WHO reveal that 40.5% of countries have no mental health policy and that 30.3% have no programme. This paper presents evidence-based guidance for the development and implementation of mental health policies, plans and programmes. The experiences of several countries are used as practical sources for drawing up mental health policies and implementing them through plans and programmes.

KEYWORDS: *Mental Health, Policy, Programmes and Legislation*

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INTRODUCTION

Mental health policy is commonly established within a complex body of health, welfare, and general social policies. The mental health field is affected by many policies, standards Mental health policy is commonly established within a complex body of health, welfare, and general social policies. The mental health field is affected by many policies, standards and ideologies that are not necessarily directly related to mental health. In order to maximize the positive effects when mental health policy is being formulated it is necessary to consider the social and physical environment in which people live. It is also necessary to ensure intersectoral collaboration so that benefit is obtained from education programmes, health, welfare and employment policies, the maintenance of law and order, policies specifically addressing the young and the old, and housing, city planning and municipal services.

The information provided in this module is considered relevant for various health systems, including those that are decentralized. It is generally accepted that national policy, plans and programmes are necessary in order to give mental health the appropriate priority in a country and to organize resources efficiently. Plans and programmes can be developed at the state, province, district, municipal and other local levels within countries in order to respond to specific local circumstances, while following national plans. If no overall national plan exists there is a risk of fragmentation or duplication of plans developed more locally.

The concepts and recommendations presented in this paper is intended for countries and regions with a wide range of circumstances and resource levels. The paper provides examples of how policy, plans and programmes can be developed for countries with low and medium resource levels.

Objectives:

1. To study the inception and evolution of both NMHP and DMHP in India.
2. To assess the Mental Health Policy and Programmes of India.

Methodology:

This is a descriptive research paper, where secondary information produced by different authors and researchers has been used. For obtaining necessary information, various books, journals as well as websites have been explored by the researcher which has been mentioned in the reference section.

Mental Health Policy in India

This paper is focusing on the current statutory provisions for mental health care in India. The National Health Policy-2002 includes mental health. However, there is no separate policy on mental health. The National Mental Health Programme for India (NMHP) was adopted in 1982 by the Central Council of Health which is the country's highest health policy making body.

Mental Health Act (1987)

The country also has a Mental Health Act (1987), which simplified admission and discharge procedures, provided for separate facilities for children and drug abusers and promoted human rights of the mentally ill. Other acts relevant to the mental health field are the following: the Juvenile Justice Act, the Persons with Disabilities Act and the Narcotic Drugs and Psychotropic Substances Act.

The Mental Health Act was drafted in 1987 but was implemented in all states and union territories in India only in 1993. Undoubtedly, considerable changes have taken place in mental health legislation and policies over the last two decades with the introduction of the NMHP which encouraged the development of a community-based model of care. This programme was further modified as the District Mental Health Programme and aimed to improve mental health care by training government health professionals in diagnosis, treatment and health promotion activities. It also sought to upgrade government psychiatric wards and hospitals and introduced psychiatry in the medical curriculum.

In a review of this Act, Doshi has pointed out that there is much to commend in the new Act, though some of the changes are merely cosmetic and may not lead to tangible changes in the services provided to people with mental disorders. According to Rastogi, most of the act is similar to the Mental Health Act 1959, the Mental Health (amendment) Act 1982, both of England and Mental Health Act 1960 of Scotland with minor changes. Further, the Act fails to address the removal of social stigma attached to mental disorders and educating society. Failure to mandate medical opinion to licensing authorities of service organizations, emphasis on institutionalization, lack of after care and rehabilitation measures, lack of measures to restrict unnecessary detention by families or law agencies and adopting a different view of government and private hospitals are some of the serious limitations of the Act. As pointed out by Dhanda, the Act is only concerned with regulating admissions to institutions.

The Mental Health Care Act (Draft, 2010)

The Mental Health Care Act has been recently proposed. The Act aims to provide access to mental health care for persons with mental illness while ensuring that their rights and dignity are protected during the delivery of mental health care. The new Act is based on the premise that persons with mental illness are both vulnerable and face discrimination, the burden of their care often falls on their families and efforts should be made to facilitate recovery and rehabilitation. The new Act also acknowledges that the Mental Health Act of 1987 has failed to ensure the rights of persons with mental illness.

Prevalence of Mental Disorders in India: The Magnitude of the Problem

It is essential that policy and planning be based on reliable information about available mental health resources and an epidemiological profile of the mental health problems in the country. The information base to guide planning, however, is lacking in many countries, and often expert synthesis and interpretation is required of the best available data from local, national, regional and international levels. Currently, around a third of countries have no system for the annual reporting of mental health data, and often data, when available, are not sufficient to guide planning.

It is important to understand the prevalence of mental disorders as this would be essential in policy planning. Epidemiological studies have provided stark evidence of how large segments of the population have been totally deprived of mental health services. Further, mental health concerns also get low priority in the overall national health policy in India. This section will first focus on the enormity of the problem and then attempt to examine how psychology both as an academic discipline and in its practitioner, avatar has interrogated these issues

Mental disorders constitute a wide spectrum. They can attain the disorder/disease/syndrome levels which are usually considered easy to recognize, define, diagnose and treat. These are referred to as "visible mental health problems" in a community and can be classified further as "major and minor mental disorders." Another group of mental health problems remains at the subclinical/non-clinical/ sub-syndromal level and are usually related to the behaviour of the individual. They are difficult to recognize and are referred to as "invisible mental health problems". They have often been ignored in epidemiological studies because of the difficulty in denning and identifying the "case".

Epidemiological Studies

Epidemiological studies have provided data about the prevalence of mental disorders in the community. Varying prevalence rates have been reported even in international studies. Above all, psychiatric disorders are known to vary across time within the same population and also vary across populations at the same time. This dynamic nature of the psychiatric illnesses will impact planning, funding and health care delivery.

Review of Implementation of both NMHP and DMHP in India

The global burden of mental, neurological, and substance use disorders (MNS) in terms of morbidity and premature mortality has been very significant. According to World Health Organization's (WHO) community-based epidemiological studies, the lifetime prevalence rates of mental disorders in adults range from 12.2 to 48.6% and 12-month prevalence rates range from 8.4 to 29.1%. Further, 14% of the global burden of disease, as measured by disability-adjusted life years (DALYs), can be attributed to MNS disorders. Despite the huge burden of the MNS, a WHO report has highlighted that, globally, there is a huge gap between the burden of mental illnesses and the provision of services, with the global median number of mental health workers being just nine per 100,000 population. Moreover, there is extreme variation in their distribution among countries (from below one per 100,000 population in low-income countries to over 50 in high-income countries).

To address mental health burden and treatment gap, way back in 1974, at Addis Ababa, in its expert committee meeting, WHO expressed serious concern over the huge burden of mental health problems and significant lack of treatment facilities and asserted mental health care of the developing countries as its priority. In continuation with this, WHO's Mental Health Advisory Group, in 1979, urged all its member states to develop their own National Mental Health Programme (NMHP) to provide compulsory mental health care by utilizing the existing general healthcare model. In compliance with WHO's recommendations, India launched NMHP in 1982, and became a major developing country to do so. Since then, NMHP has undergone many strategic revisions such as developing/strengthening primary and community health centre (PHCs, CHCs) for mental health service delivery under NMHP, setting district as the unit for program implementation under District Mental Health Programme (DMHP), and incorporating DMHP with National Rural Health Mission (NRHM) for better program implementation, regular budgetary increment, and periodic evaluation.

Inception of NMHP

In India, the feasibility of providing decentralized and deprofessionalized community mental health services under the existing general healthcare system was established by the pivotal community health projects conducted at Sakalwara, a Bengaluru rural district; and Raipur Rani block, Chandigarh, as a part of WHO multicounty collaborative study. These pilot works were further substantiated by an Indian Council of Medical Research (ICMR) and Department of Science and Technology (DST) project, which revealed that as much as 20% of mental illness could be detected by PHC staff under the supervision of a psychiatrist. This research created a ground for the development of NMHP. The relentless work of the then leaders of Indian psychiatry led to the drafting of NMHP in 1981, which finally came into existence in 1982.

Evolution of NMHP

NMHP was launched in 1982, with the initial funding of 100 million Indian national rupees (INR) and with the following aims:

- To ensure the availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population.
- To encourage mental health knowledge and skills in general healthcare and social development.
- To promote community participation in mental health service development and to stimulate self-help in the community.

Under NMHP, the unit of service delivery was PHCs and CHCs. However, this model had many hurdles in terms of management and implementation. Hence, the extent of service delivery was limited. The program had some inherent conceptual flaws in the form of no budgetary estimation or provision for the programme, lack of clarity regarding who should fund the programme – the central government of India or the state governments, which perpetually had inadequate funds for healthcare. Further, the responses toward the program from psychiatrists were unwelcoming, even to the extent of its virtual rejection.

Inception of DMHP

To overcome the limitations of NMHP and to scale it up, it was perceived that the district should be the administrative and implementation unit of the program. The National Institute of Mental Health and Neurosciences (NIMHANS) undertook a pilot project (1985–1990) at the Bellary District of Karnataka to assess the feasibility of DMHP and demonstrated that it was feasible to deliver basic mental healthcare services at the district, taluk, and at PHCs by trained

PHC staffs under the supervision/support of a district mental health team. The success of the Bellary project paved the way for DMHP, which was subsequently launched in 27 districts in 1996 with the initial budget of 280 million INR.

The aim of DMHP was to extend mental health services to persons with mental illness (PWMI) in the district through the existing healthcare personnel and institutions.

Specific Objectives of DMHP

To develop and implement a decentralized training program in mental health for all categories of health personnel in a way that would be the least disruptive to on-going general healthcare activities

- To provide a range of essential drugs such as antipsychotics, antidepressants, anticonvulsants, and minor tranquilizers for the management of PWMI
- To develop a system of simple recording and reporting of care by mental health personnel
- To monitor the effect of service of the mental health program in terms of treatment utilization and outcomes
- To reduce the stigma by bringing about a change of attitude through public health education
- Treatment and rehabilitation of patients within the community by adequate provision of medicines and strengthening the family support system. DMHP was conceptualized to expand the mental health services of NMHP by specific service provisions, training programs, public education on mental health issues, human resource building, and facility improvement.

Evolution of DMHP

Since its inception in 1996, DMHP has evolved greatly over the last 15–20 years under the 10th, 11th, and 12th Five Year Plans. It has also been periodically evaluated by various government agencies and independent bodies. Some of the key features of DMHP's evolution can be enumerated as follows:

DMHP in the 10th Five-Year Plan (2002–2007)

Under the 10th Five-Year Plan, the budgetary allocation of the program was increased to 1390 million INR, five times more than the 9th Five-Year Plan, and by the end of the 10th Five-Year Plan, DMHP was extended to 110 districts, with upgradation of psychiatric wings of 71 medical colleges/general hospitals and modernization of 23 mental hospitals.

DMHP in 11th Five-Year Plan (2007–2012)

DMHP was revitalized as part of the 11th Five-Year Plan with the provision of the following:

- Program officer (a psychiatrist) and family welfare officer (to work with the psychiatrist) in each district
- Ten beds for acute care
- Essential drugs at PHCs and more advanced drugs such as lithium, valproate, carbamazepine, benzodiazepines, and inj. haloperidol at district hospitals
- Training programs for medical officers
- Strengthening of infrastructure with the establishment of 11 centers of excellence by upgradation of mental institutions/hospitals (Scheme-A) and setting up/ strengthening of 30 units each of psychiatry, clinical psychology, social working, and psychiatric nursing (Scheme-B).

Mid-Term Evaluation by NIMHANS, 2003

Mid-term evaluation was carried out in 23 districts. The evaluation reported that the program had positive impacts in terms of enhancement of early detection of mental disorders, reduction in distance travelled by patients to seek treatment, and a decrease in caseload at the mental hospital. However, there were hurdles for effective implementation of the program, such as problems in fund accessibility, unavailability of trained and motivated mental health professionals, and lack of effective central support and monitoring. The agency recommended a need for effective central support and monitoring; development of an operational manual for effective implementation of DMHP; revamping of the training of the PHC personnel in terms of its content, curriculum, and method with continuous support (on-the-job training after initial training); a review of the priority mental health conditions covered under DMHP; and incorporation of preventive and promotive mental health services.

The above evaluation was followed by an independent evaluation by the Indian Council of Marketing Research in 2009. The agency also highlighted the issues pertaining to funds (underutilization and delay in its accessibility) and training (inadequate, less simplistic, and lacking refreshing training) adversely affecting the implementation of the program. Other areas of concerns were related to the availability of the drugs, community clinic still not being the most common setting for treatment seeking, lack of community involvement, poor awareness programs, and lack of monitoring and implementation system.

DMHP in 12th Five Year Plan

A Mental Health Policy Group (MHPG) was appointed by the MOHFW in 2012 to prepare a draft of DMHP for 12th Five Year Plan (2012–2017). The group also emphasized many of the findings of previous evaluations performed on the program and came up with a draft for DMHP (under the 12th Five Year Plan) with the following principles, goals, and objectives:

- Principles Life course perspective: Giving attention to the unique needs of children, adolescents, and adults.
- Recovery perspective: Provision of services across the continuum of care and empowerment of PWMI and their caregivers.
- Equity perspective: Accessibility of services to vulnerable groups and geographies.
- Evidence-based perspective: Service provision through established guidelines and experiences.
- Health system perspective: Clearly defined roles and responsibilities for each sector.
- Right-based perspective: Ensuring that rights of PWMI are protected and respected

Goal

To improve health and social outcomes related to mental illness.

Objectives

The primary objective is to reduce distress, disability, and premature mortality related to mental illness and to enhance recovery from mental illness by ensuring the availability of and accessibility to mental health care for all in the 12th plan period, particularly the most vulnerable and underprivileged sections of the population.

Other objectives include reducing stigma, promoting community participation, increasing access to preventive services to at-risk population, ensuring rights of PWMI, broad basing mental health with other programs like rural and child health (RCH), motivating and empowering workplace for staff, improving infrastructure for mental health service delivery, generating knowledge and evidence for service delivery, and establishing governance, administrative, and accountability mechanisms.

As of now, efforts have been made to achieve these objectives by extending services to the community by strengthening outreach services (satellite clinics, school counselling, workplace stress management, and suicide prevention), organizing awareness camps in the community through local bodies, etc., improving community participation (by linkage with self-help and caregiver groups) and public–private partnership (PPP) with designated financial assistance for establishing daycare and long-term residential care facilities. Further, strengthening of community mental health services (outpatient and inpatient services, counselling, and proactive mental health promotion) with improved manpower, setting of 24-h dedicated helpline number (to provide information to the public about emergency mental health services, etc.), supporting central and state mental health authorities (SMHA and CMHA) for developing infrastructure, encouraging research in the field of mental health such as understanding regional needs and framing plans, etc., standardized format of recording and reporting for the continuous evaluation of program activities, and information, education and communication (IEC) activities (through a central-level website and extensive local-level mass-media activities in native vernacular) have been taken up. Moreover, a central mental health team has been constituted to supervise and implement the programme. Mental Health Monitoring System (MHIS) is being developed (with a proposed online data monitoring system). Standardized training with the help of standardized training manual has been proposed, and a fund has been earmarked for the same.

Issues Facing the NMHP

The current review sheds light upon the inception of NMHP, its progress, achievements, and under performances, as well as the reasons behind them, with special emphasis on on-going NMHP. This review focuses chiefly on on-going NMHP (by reviewing all the available literature since the launch of the 12th Five Year Plan). We have discussed the pertinent issues and its implication under the following headings:

Problem with the initial model of NMHP

The very launch of the program and its subsequent progress is not beyond scrutiny and criticism. The initial model for service delivery through PHC/CHC was affected by the lack of skilled human resource, ambiguity about the role of health professionals in service delivery, and lack of managerial skill at the community level. Further, right from its inception, there was a lack of clarity regarding who would fund the program in the long run for its sustenance – central or state government. Moreover, there was a lukewarm response from the psychiatry community. The program was further affected significantly in the absence of any inherent M and E system, which would ensure the accountability of the service providers. Though the DMHP was launched on the premise of the positive outcome of the Bellary project

which showed that district could be a robust model for service delivery, implementation, and scale-up of the program; however, Bellary district chosen for this purpose was not found to be representative of districts of the whole country as it had more numbers of outreach mental health service facilities compared to the rest of the country. Moreover, the model was predominantly pharmacologically driven and completely overlooked psychosocial interventions. Further, the program followed a top-down approach, not involving the local voice in the planning and implementation of the programme, which led to the poor show of the program. The latest NMHP of the country does emphasize community/stakeholder's participation in the designing and implementation of the program and some of these aspects have been incorporated in the on-going program, but their impact is yet to be evaluated. Further, though the district has been the main administering unit of DMHP, as envisaged under the DMHP, setting psychiatric units only at the level of a district may not be sufficient in addressing the mental health needs of the population at the subdistrict level or those lower in the hierarchy.

Administrative Issues

The coverage and functioning of DMHP remained nonuniform across the country. Various evaluations and reviews of the programme have highlighted that the success of the programme was predominantly determined by the commitment of the nodal officer but there has been a lack of leadership at all levels (central, state, and districts). Further, lack of fund utilization by the states, administrative bottleneck at the centre level, and lack of enthusiasm of the PHC professionals (medical officer and the supporting staff) led to the poor implementation of the program. Further, fragmentation of responsibilities at all levels has been another cause for poor implementation and performance of DMHP.

Issues Related to Human and Financial Resources

The program has always been hit by shortage of two major resources – financial and human. The regular flow of funds from the centre to state and from state to districts was not ensured in the program. Underutilization of funds, delay in applying for funds by states, and poor accessibility of funds because of administrative delay both at the state and central levels have been important hurdles in utilizing financial resources. Researchers have emphasized that gradually the financial burden of the program should be shifted to states, but because many states still face financial constraints, its implementation has not been uniform. To ensure adequate and regular fund flow, the latest national survey also proposes a ring-fenced financing for the programme. As a progressive move under the on-going NMHP, financial management mechanism of the National Health Mission has been utilized to ensure regular release of funds and its optimum utilization. Under this new system, funds have been allocated to NMHP from the flexible funds earmarked for the noncommunicable diseases (NCDs) in order to ensure its adequate availability.

Training and Monitoring Related Issues

Training of primary health care service provider has been another major area of concern. Under DMHP, duration of training for community health professionals was reduced and so was the specialists' support to already overburdened primary health service providers. Moreover, when training was provided, it was found to be less comprehensive and too biomedically driven without incorporation of psychosocial aspects. Further, there has been no provision of regular refresher training or on-the-job support by specialists to primary health care service providers. Consequently, the extension of DMHP was limited, and service delivery remained inefficient. These issues would be addressed under the on-going NMHP with the provision of decentralized and on-the-job standardized training programme, which would be ensured by Central Implementation Team (CIT) and State Implementation Team (SIT), with a budget allocation of 150 million INR.

Issues related to coverage of mental illnesses and provision of treatment

The program has also been criticized for noncoverage of a full range of mental disorders such as substance use disorders (SUDs) and child and geriatric psychiatric disorders. The program has also been criticized for being too much treatment-centric whereas preventive and promotive aspects such as school mental health services, college counselling, workplace stress management, and suicide prevention have largely been ignored. Further, issues such as mental illness and homelessness; participation of PWMI and caregivers in programme designing, implementation, and monitoring; patchy coverage of disability certification; and urban mental health are other areas of concern which require their integration in the programme. Though the National Mental Health Policy, 2014 covers these issues explicitly, how it would be implemented need to be monitored to intervene if required.

Issues related to incorporation of NMHP with National Rural/ Urban Health Mission

Incorporation of DMHP into the existing National Rural/ Urban Health Mission (NRHM/NUHM) was expected to bring about significant change in the functioning of NMHP/DMHP in diverse ways. Their

outcome still needs to be evaluated, though there have been some initial reports which highlighted lack of coordination between NMHP and NRHM, and at many places, NRHM has not included mental health in their agenda. As a result, basic mental health services such as measurement of serum lithium was not available.

Conclusion

As the NMHP, now under the NITI Aayog, has completed more than three decades, the lessons learned from the past can bring about a lot of insights about the future course of action. Leadership at all the levels of governance/administration and financial and human resources have been important determinants for the outcome of the program, so are community and stakeholders' participation standardization of training for community mental health professionals, IEC activities, the involvement of NGOs and private sectors, and a robust M and E mechanism. Though NMHP has given due consideration to these issues and many of these aspects have been incorporated in the on-going programme, its progress needs regular monitoring and mid-term correction, if required, for effective implementation. Overall, the current review shows that the NMHP has been a blend of achievements and failures

References:

[1] Epidemiological Studies Depression 10

[2] Epidemiologic concepts 18

[3] Issues Facing the NMHP 201

[4] Issues Related to Human and Financial Resources 203

[5] Mental Health Act (1987) 187

[6] Mental Health as a Part of General Health 138

[7] The Mental Health Care Act 189