

District Mental Health Programme in India: A Case Study

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Understanding the Problem

Mental health is undeniably one of our most precious possessions, which needs to be nurtured, promoted, and preserved as best as we can. It is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully, and facing up adversities without losing the capacity to function physically, psychologically and socially. It is undoubtedly a vital resource for a nation's development, and its absence represents a great burden to the economic, political, and social functioning of the nation.

The World Health Organisation (WHO) defines mental health as a positive sense of well being encompassing the physical, mental, social, basic economic, and spiritual aspects of life; not just the absence of disease. Mental health is a barometer of the social life of a population and the rising level of morbidity and mortality is a sign of social as well as individual malaise. The scope of mental health is not only confined to the treatment of some seriously ill persons admitted to mental health centres, rather it is related to the whole range of health activities.

In the past, besides the various steps taken by the government, non-governmental organisations (NGOs) and other agencies to improve mental health services, mental health did not find its appropriate place in the national and State health planning. Since independence, the government recognised the need to be proactive in its approach to promote good mental health of its citizens and to provide good quality care to those suffering from mental disorders. But, unfortunately, these efforts are only reflective and confined to various recommendations and meetings, perhaps due to various reasons and the common misconception that prevalence of mental illness is low in India, particularly as compared to the West. It is unfortunate that after fifty years of independence, besides having a National

Mental Health Programme (NMHP), we do not have any country-wide epidemiological data of mental illnesses and there are only estimates, and those estimates are based on the prevalence and incidence in other countries (Kumar 2002).

Although we do not have any epidemiological data, research studies from different parts of the country have shown that mental illness is as common in India as it is elsewhere and it is equally common in the rural and the urban areas. Mental disorders cause an enormous burden on affected individuals, their families and society, although this suffering may not be visible to others. Over the years, mental illnesses have increased manifold. Although there has not been any epidemiological study, psychiatrists estimate that about 2 per cent of Indians suffers from mental illnesses, i.e., a staggering 20 million people out of a population of one billion.

Rationale and Objective of the Study

With this background, a study was undertaken to examine the state of mental health services in India from a public health perspective, considering preventive and promotive aspects of mental health and recognising the socio-cultural factors in mental health services.

The objective of the study was to review the development of mental health services in India and to analyse the implementation of the District Mental Health Programme (DMHP) under the National Mental Health Programme (NMHP).

Methodology

The study largely relied upon the various secondary sources (viz., government reports, policy papers related to mental health published by the Ministry of Health and Family Welfare, Directorate General of Health Services, Planning Commission, and books and articles published in various Journals) for literature review and conceptual clarity on the subject of mental health. Both primary and secondary sources were used to gather information about the services rendered. Initially, information was gathered through the ministry about the programme and its objective. Further information was collected from different studies and research papers from various sources. Information was collected from the field by administering case studies on selected nine patients and informal interviews with local people, patients and their family members, and service providers (the doctor and social worker).

For the in-depth qualitative insights, the study was undertaken using observation technique [at the Psychiatric OPD at Babu Jagjivan Ram Memorial Hospital (BJRMH)] and in-depth case studies were conducted with nine patients visiting the DMHP clinic at Jahangirpuri in Delhi during September-

December 2000. In observation the emphasis was on service delivery, doctor-patient relationship, infrastructure availability, and problems in service delivery in the background of DMHP guidelines and objectives of DMHP and NMHP. Informal interviews were also done with 25 patients and 25 family members (care-givers) about the services available at Psychiatric Unit (DMHP, Jahangirpuri) and their understanding and perception of mental health and illness. Apart from these, secondary data was collected from various sources and in some cases informal unstructured interviews were also carried out.

Tools of Data Collection

Structured and unstructured interview schedule and observation technique were mainly used to collect information for the study. Apart from these, secondary data from various sources and in some cases informal unstructured interview was also carried out.

Observation Technique: This technique was followed throughout the study from the services point of view to see the services rendered by the OPD keeping in background the DMHP guidelines, local needs, and infrastructure availability. For the case studies, details regarding living conditions, demographic and socio cultural factors of the patients were collected.

Case study method: This study is mainly based on the qualitative data and case studies on patients. Within the case studies, quantitative information was also gathered, such as monthly income etc. In the case studies, the key areas of emphasis were personal information and demographic information of the families, substance abuse, and the patients' perception of the problem. Emphasis was also given on the perception of the problem/ illness among the patients' family members/caregivers, the place of living, migration, major stresses, information about the community outreach programme/DMHP, details of any previous medical interventions (in the context of type of practitioners/cost/satisfaction), need for mental health services, suggestions to improve the existing facilities, problem with present facilities, and the patients and family members perception of services and mental health and illnesses.

Interviews: Informal interviews were done with the patients and their family members while they waited for their turn at the psychiatric OPD about the services, facilities available and their perception of mental health and the need for services.

For interviewing service providers (the doctor and social worker) same method was followed.

Both, the case studies and the informal interviews with the patients and their family members gave valuable insights about their perception of mental health conditions and the services available. The informal interviews helped in

exploring processes, relationships and its consequences in greater detail. Some key results of the study are presented here.

National Mental Health Programme (NMHP)—The Beginning

The National Mental Health Programme (DGHS 1990), started in 1982 by the government, was the outcome of the various initiatives taken to provide mental health care through different methods as well as overall goals of health care in general. It aims at providing mental health care to the population utilising the available resources.

The Government of India initiated the National Mental Health Programme in 1982 with the objective of improving mental health services at all levels of health care (primary, secondary, and tertiary) for early recognition, adequate treatment and rehabilitation of the patients with mental health problems within the community and in the hospitals. However, the programme did not make much headway either in the Seventh or the Eighth Plan. Mental hospitals are in poor shape. The States have not provided sufficient funds for the mentally ill requiring inpatient treatment despite the Supreme Court having directed the Centre and the States to make necessary provision for these hospitals so that the inmates do get humane and appropriate care (Ninth Five-Year Plan, Government of India).

The Central Council of Health and Family Welfare recommended that mental health must form an integral part of the total health programme and should be included in all national policies and programmes in the field of education and social welfare and the importance of mental health must be raised in the courses/curricula for various levels of health professionals. A committee under the chairmanship of G.N. Narayana Reddy, Director, NIMHANS, Bangalore submitted a plan for the implementation of the NMHP. The salient features of the plan were:

1. Programme of community mental health at primary health care level in States/union territories;
2. Setting up of regional centres for community mental health;
3. Formation of a national advisory group on mental health;
4. Setting up of a task force on mental health;
5. Prevention of mental illness and promotion of mental health;
6. Integration of multipurpose training schools in NMHP;
7. Involvement of voluntary agencies in mental health;
8. Mental health education for the undergraduates;
9. Evaluation of community mental health programmes;
10. Preparation of manuals and records; and
11. Training programmes for mental hospital staffs;

An outcome of these recommendations was the order of 22 September 1987 issued by the government, which outlined the pattern of assistance for NMHP during the Seventh Five Year Plan to the States.

NMHP: The Objectives and Approaches

The key objectives of NMHP (Government of India 1982) are:

- a) To ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly the most vulnerable and unprivileged sections of the population;
- b) To encourage the application of mental health knowledge in general health care and social development; and
- c) To promote community participation in developing mental health services, and to stimulate efforts towards self help in the community.

The specific approaches suggested for the implementation of NMHP are:

- a) Diffusion of mental health skills to the periphery of the health service system;
- b) Appropriate appointment of tasks in mental health care;
- c) Equitable and balanced territorial distribution of resources;
- d) Integration of basic mental health care within general health services; and
- e) Linkages to community development.

The Central Council of Health and Family Welfare has recommended that mental health should form an integral part of the total health programme and should be included in all national policies and programmes on health, education, and social welfare. The Central Council of Health and Family Welfare reviewed the progress and resolved that the National Mental Health Programme should be accorded due priority and full-scale operational support, (including social, political, professional, administrative, and financial back up) are provided.

During the Eighth Plan, National Institute of Mental Health and Neurosciences (NIMHANS) developed a district mental health care model in Bellary district of Karnataka (Isaac 1988). It is proposed that during the Ninth Plan period the experience gained in implementing mental health care, both in the central and State sectors, will be utilised to provide sustainable mental health services at primary and secondary care levels and to build up community support for domiciliary care. Information, education, and communication (IEC) on mental health, especially prevention of stress-related disorders through promotion of healthy lifestyle and operational research studies for effective implementation of preventive, promotive, and curative programmes in mental health through existing health infrastructure will receive due attention.

As decided in the meeting of the Central Council of Health in 1995 and as recommended by the workshop of all the health administrators of the country held in February, 1996, the District Mental Health Programme was launched in 1996–97 in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu with a grant assistance of Rs. 22.5 lakhs each. A budgetary allocation of Rs. 28 crore has been made during the Ninth Plan for the National Mental health programme.

The programme envisages a community based approach to the problem, which includes:

- (i) training of the mental health team at the identified nodal institute within a State;
 - (ii) increasing awareness about mental health problems;
 - (iii) providing services for early detection and treatment of mental illness in the community itself with both OPD and indoor treatment and follow-up of discharge cases; and
 - (iv) provide valuable data and experience at the level of community in the State and Centre for future planning, improvement in services, and research.
- NIMHANS, Bangalore is providing the training to the trainers at the State level regularly under the National Mental health Programme.

The District Mental Health Programme (DMHP) was extended to seven districts in 1997–98, five more districts in 1998, and six more districts in 1999–2000. Thus this programme is being implemented in 22 districts covering 20 States.

DMHP—The Beginning

District Mental health Programme (Under the National Mental Health Programme 1996–97) was successfully developed by National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore in the Bellary district of Karnataka, and it is conceived as a model and adopted by all States for implementation.

DMHP—The Objectives

The objectives of the programme are:

- a) To provide sustainable basic mental health services to the community and to integrate these services with other health services;
- b) Early detection and treatment of patients within the community itself;
- c) To ensure that patients and their relatives do not have to travel long distances to go to hospitals or nursing home in cities;
- d) To take the pressure off from mental hospitals;
- e) To reduce the stigma attached towards mental illness through change of attitude and public education; and

- f) To treat and rehabilitate mental patients discharged from the mental hospital within the community.

DMHP—Key Features

1. The States will set in motion the process of finding suitable personnel for manning the DMHP teams. They can take in service candidates who are willing to serve in this pilot project and provide them the necessary training in the identified institution.
2. The patients will be from the district itself and the adjoining areas.
3. District Mental Health Team will be expected to provide service to the needy mentally ill patients and their families, such as—daily out-patient service, ten bedded in-service facilities, referral service and liaison with the primary health centres, follow up service, awareness programmes, and also community survey if feasible.

DMHP—The Jahangirpuri Experience

The District Mental Health Programme is being implemented as a pilot project, in Chhatarpur district of Delhi. The allocation grant by the central government for the programme is Rs. 1.5 crore for five years. This covers training, recruitment of staff, provision of medicines and IEC activities. The nodal agency is the Institute of Human Behaviour and Allied Sciences, Shahadara, New Delhi. In place of Chhatarpur District the programme was implemented in Jahangirpuri, at Babu Jagjiwan Ram Memorial Hospital, because the Pradhan of Chhatarpur district was not ready for such programmes. Although from December 2001, DMHP also began its operations at Chhatarpur, the present study covers only Jahangirpuri area.

Profile of Jahangirpuri Resettlement Colony

Jahangirpuri presents a mix of Slum characteristics and refugee resettlement pattern. The colony was earlier meant for resettlement of the refugees from Pakistan and Punjab. There are 11 blocks in the colony with plotted housing scheme, which are interspersed with *jhuggi-jhopri* clusters. With the passage of time, many of these plots have been sold to migrant workers, mostly daily wagers or petty traders.

The colony is overcrowded and the population density is quite high where five to six people are living in one room of 10x12 ft size. The basic amenities are inadequate. There are common toilets for both males and females. This creates problem of availability and become unsafe for human habitation. In addition, overcrowded public utilities often face the problem of maintenance and sustenance of public utility.

In Jahangirpuri, the squatter (*Jhuggis*) settlement over-crowded. Dwellings are small—on an average about 2.5m wide and about 3m long. A few people have

a second floor, usually reached by a ladder. The streets are irregular in width. Most are just wide enough for a rickshaw to pass through. There are some small open spaces on the streets—usually at the end of culs-de-sac—but there are a few more formal community spaces, such as temple courtyards. Drainage is a problem. The site is relatively flat and is at the edge of a swamp. Many of the open drains are blocked. They are cleaned twice a week, but mostly remain full with household wastes. In some places streets have been paved with bricks, which have raised their level above the floor level of the houses, with obvious consequences during heavy rain.

Occupational Structure

The occupational structure is quite diverse. There are people working in government service, private service, sales, production, labour, self-employment, and petty business. Basically the population is involved in the informal sector for bare survival. A large number of them belong to categories such as driver, mechanic, safai, brush maker, factory worker, rickshaw puller, construction worker, or house maid etc.

Income

The qualitative data based on the case studies shows that due to a large number of informal sectors, there is a great variation in the level of income. Level of income as economic stratification has been playing pivotal role in determining the issue of access to basic amenities and health services.

Status of DMHP in Jahangirpuri: A Preliminary Report

The study in Jahangirpuri was undertaken with an objective to understand the development of mental health services in India and to see the implementation of District Mental Health Programme under the National Mental Health Programme (1982) as a decentralised model of mental health care in India.

In this study, a modest attempt is made to examine the implementation of DMHP, its shortcomings and other associated factors. The findings of the study, which are based on interviews, give preliminary insights into the functioning of DMHP.

The psychiatric OPD is situated at Babu Jagjiwan Ram Memorial Hospital in a single room in the general ward of the hospital. There is no signboard where the service is presently given. This leads to a lot of running around for the illiterate population in trying to locate the doctor or the room where the service is given. The room allotted for the purpose is very small. However, the room is used for the treatment of patients as well as for distribution of medicine by the social worker. The resident doctor coming from IHBAS to assist the main

doctor also uses the same room. With so many officials operating from the same room and the presence of waiting patients in the room, the patients find it difficult to share their problems with the doctor.

Presently the service is available once a week on Wednesdays, between 10 a.m. and 2 p.m. whereas the programme specifies daily OPD service. Consequently, there is a lot of overcrowding on Wednesdays. This affects the quality of treatment, as the doctor is not able to allocate adequate time to each and every patient. Even the doctor corroborated the facts and felt constrained and suggested the extension of the OPD service on a daily basis. Due to the non-availability of daily OPD services, the programme is not accessible to majority of the working population. As has been mentioned earlier, most of the inhabitants of the area are engaged in petty activities like vending, rickshaw pulling, masonry, daily wage labour, or government servants. It is difficult for most of them to miss out their daily labour. People expressed the need to make the service available either in the evening or on Sundays. The present emphasis of service is only curative, whereas the patients also need guidance and counselling to adjust with families and other rehabilitative measures. This is presently not possible due to crowding and it is practically impossible for the doctor to give enough time to each patient.

Although from the beginning there is emphasis on comprehensive approach and teamwork in the field of mental health including professionals like clinical psychologist, physician and other professionals, whereas the services available are run only by a psychiatrist and a social worker. Even at the programme level, the psychiatrist and social worker give only curative services against the broader objective of the DMHP. The social worker is supposed to take care of the social aspects of mental health problems, which include preparation of case history, giving insight into the sociological causes of a patient's problem to the psychiatrist, visiting patients at home, rehabilitative measures, and follow up at the community level. It is his duty to arrange and organise the community mental health awareness programmes along with other measures, which will enhance the coping mechanism of the community. But unfortunately, the social worker is doing the work of distributing medicines, thereby not utilising the creative space, which is given to him.

The sole objective of providing a social worker is to develop a community based approach towards the problem. The social worker is supposed to look into the social aspects of the problems through counselling and regular interaction. He is also supposed to look into the social problems which can either create conditions leading to mental problems or help in accentuating them. A proper study of these could also be beneficial to the doctor in diagnosing the patient better and such valuable data and experience can also

help the government and policy makers in the future planning and improvement in services and reach. The social worker is supposed to be the formal as well as informal link with the community. Contrary to the role expected of him, the social worker here (Jahangirpuri) was mostly engaged in the distribution of medicines. There was no effort to build a community based approach to the problem, nor was there any effort to educate the community about the various aspects of prevention from mental health problems.

It is evident from the case studies that at present there is no emphasis on awareness programmes, which is not difficult keeping in mind the area covered by the programme. In the case studies and interviews, it was repeatedly stressed that most of the patients came to know about the services through neighbours, fellow patients, or family members of the patients. Most of the patients are not aware of the DMHP but a large number of them have an idea that this psychiatric unit is a part of Babu Jagjiwan Ram Memorial Hospital.

Other forms of Coping Mechanisms

It was found in the case studies that there is a substantial section of the population, which visits various spiritual healers, priests, and mystics for solutions to their problems. It is quite evident from case studies that patients are taking treatment at psychiatric OPD and simultaneously they are under the treatment of spiritual healers. Even in the case studies, one patient reported that her epilepsy is under control due to the medicine that she is taking prescribed by psychiatrist and other problems like of Devi Aana are under control due to spiritual healing of Usha Mata. On the basis of this study, it can be reasonably established that since its inception, the DMHP has not been sensitive to these cultural needs and intricacies.

Another significant finding that came out in the case studies is the doctor's refusal to take into cognisance these coping mechanisms such as visiting the shamans, priests and other indigenous practitioners. Preference for these practitioners has its roots in diverse social factors which affect the general being of the patient and his family. Whereas the case history taken by the doctor does not record this fact and, as a consequence, the whole focus is narrowed down to a techno-centric (read curative) approach to the problem of mental health. Thus, the much rhetorical emphasis on the issues of awareness, prevention and other supportive mechanisms professed in the programme is structurally excluded while implementing the programme. This may not be entirely intentional; rather it may be an outcome of the scant resource allocation, which derails the whole programme. The policymakers and planners should take these shortcomings into account and an appropriate methodology can be evolved.

Some Problems in the Implementation of Programme

Some of the salient observations based on the case studies, and in-depth interviews are as follows:

1. There is no provision for guidance and counselling. It is found that at times patients and family members need guidance and counselling to cope with illness.
2. The service available is run by a psychiatrist and a social worker. There is no comprehensive approach and teamwork with the inclusion of professionals like clinical psychologist and physician.
3. Due to crowding, the doctor is not able to give adequate time to each patient.
4. There is no coordination between the facilities and various agencies, especially the NGOs working in the area.
5. There is no integration of mental health care with primary health care.
6. No attempt is made to include the community leaders, workers at the grass root level such as ANM's, anganwadi workers, and the local NGOs in training programmes organised by the nodal institute.
7. There is no provision for early detection and treatment of patients within the community. Presently services are available to those visiting psychiatric OPD themselves.
8. There is no awareness programme to reduce the stigma attached to mental illness through change of attitude and public education.
9. There is no provision to treat and rehabilitate mentally ill patients discharged from the mental hospitals within the community.
10. There is no effort to undertake community surveys on mental illnesses and other associated factors, although it is feasible.
11. At times some medicines are not available and patients have to buy them from market and there is no provision for reimbursement.

Concluding Observations

The development of mental health programmes in India is still at an embryonic stage. Perhaps this is an advantage for the development of mental health programme as it is occurring at a time when the emphasis is on community care and utilisation of community resources. This could help us avoid the problems of too much institutionalisation in the field.

The above discussion clearly signifies that mental health is an important component of health and development of the human society. Despite various recommendations and policies, the development of mental health services has been uneven. Since Independence various committees have recommended policies to conduct epidemiological survey to generate base-line epidemiological data and information system for the development of mental health services. But till date we are dependent on estimates that vary regionally and are mostly generated on the basis of hospital admissions and discharge. A

similar lag has been noticed in the implementation of the Mental Health Act, which in spite of having been accepted by the parliament in 1987 become operational only in April 1993.

It is necessary on the part of public health personnel to conduct research in bringing out the epidemiological basis of such programmes. Responsibilities also lie with the social scientists to influence the government and public health workers in order to have a broader view and better understanding for the problems related to mental health. In the Indian context, no proper research has been done to see the ways in which culture and religion influence mental illnesses and health. It is also clear that mental illness is a significant cause of disability in India, which has been largely ignored in health related development activities. The impact of economic structural adjustment in impoverishing people, the breakdown of traditional community and family relationships caused by urban migration, and the myriad adverse effects of newer diseases like AIDS are likely to cause a greater impact on people's psycho-social health. In addition, these programmes do not incorporate proper preventive measures and even curative and rehabilitative services provided are inadequate in terms of the estimated needs.

The case studies of the DMHP at Jahangirpuri in Delhi show that the development of support materials and models at the district level facility for initiating and coordinating the large-scale expansion of the mental health problem is a serious problem. These programmes lack in-built evaluation mechanisms and have no space for continuous research and community participation at the functional level.

There are a number of new issues that have come up in the country with implications for mental health. The most notable are alcohol policies, violence in society, the growing population of elderly persons, urbanisation, mental health of women, disaster care, migrants and refugees, street children, and stress at the work place. These new problems pose serious challenges to existing mental health services and infrastructure. It is also doubtful, given the status of DMHP, whether the existing programme can take care of such a complex mental health scenario.

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