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Editorial

Mental Health Programme in the 11th Five Year Plan

The National Mental Health Programme (NMHP) of India was initiated in 1982[1] and this year it will be completing 25 years. The programme is at a crucial stage of expansion to cover a larger population of the country. The approach paper for the 11th Five Year Plan[2] outlines the scope of mental health as follows: "The 11th Five Year Plan will recognize the importance of mental health care and will concentrate on providing counselling, medical services, and establishing helplines for all , especially people affected by calamities, riots and violence"(p.72).

It is also significant that the National Farmers Commission also identified the need for mental health interventions to address the growing problem of farmers suicides[3]. Similarly some of the welfare programmes, like the Integrated Child Development Scheme (ICDS) are reaching a national coverage[4]. This is an opportune time to review the progress of NMHP and place the future activities based on the lessons learnt in the last quarter century of the programme.

There are three aspects relevant to the 11th Five Year Plan that call for attention, *(i)* what is currently known about mental disorders and mental health interventions *(ii)* what are the salient aspects of the first 25 years of the NMHP and *(iii)* what should be the focus of the 11th Five Year Plan.

Mental health/Mental disorders

Mental disorders form an important public health priority, both in terms of the numbers of people suffering from mental disorders and due to the burden of these disorders in the community[5,6]. These conditions include the severe forms of mental disorders like psychoses, substance abuse and mental retardation. Of the health conditions contributing to the disability adjusted life years (DALYs), of the top 10 conditions, four are mental disorders. Women form a specially vulnerable group for depressive disorders. In addition, populations living under rapid social change, disasters, conflict situations, migrant populations, and poor, have higher rates of prevalence of mental disorders and psychosocial needs. The growing problem of suicides in farmers, associated with the financial problems is an indication of the way mental health gets affected by social situations.

There are effective interventions to address the wide range of mental disorders that include medicines, psychological interventions, social interventions and rehabilitation. There are demonstrable projects of such cost-effective interventions from India[7]. The currently accepted approach is to provide care in the community and not to isolate them in mental hospitals. Specifically, the integration of mental health care with primary health care is an accepted approach to care. There is also sufficient evidence to show that specific and focused care can be provided by a wide variety of community resources like the family members, school teachers, volunteers, and the ill persons themselves[8,9]. There is a need to use an optimal mix of services ranging from self-care to institutional care (Fig.)[10,11]. In addition to the limited resources available for care, there is an important role played by stigma about mentally ill persons and their families.

In addition to providing services to the ill persons, a number of measures can be taken to prevent some of the mental disorders and to promote mental health. Life skills education of adolescents is known to enhance self-esteem and also to prevent a number of mental health problems. Interventions at the preschool level can prepare the children for better development and fuller utilization of the education in the schools.

In the national media, issues of farmers suicide, growing problem of substance abuse, inappropriate places of care for the mentally ill (*e.g.*, the Erwady tragedy in 2001), increasing popularity of measures to address stress of day to day life through meditation are indications that mental health is a

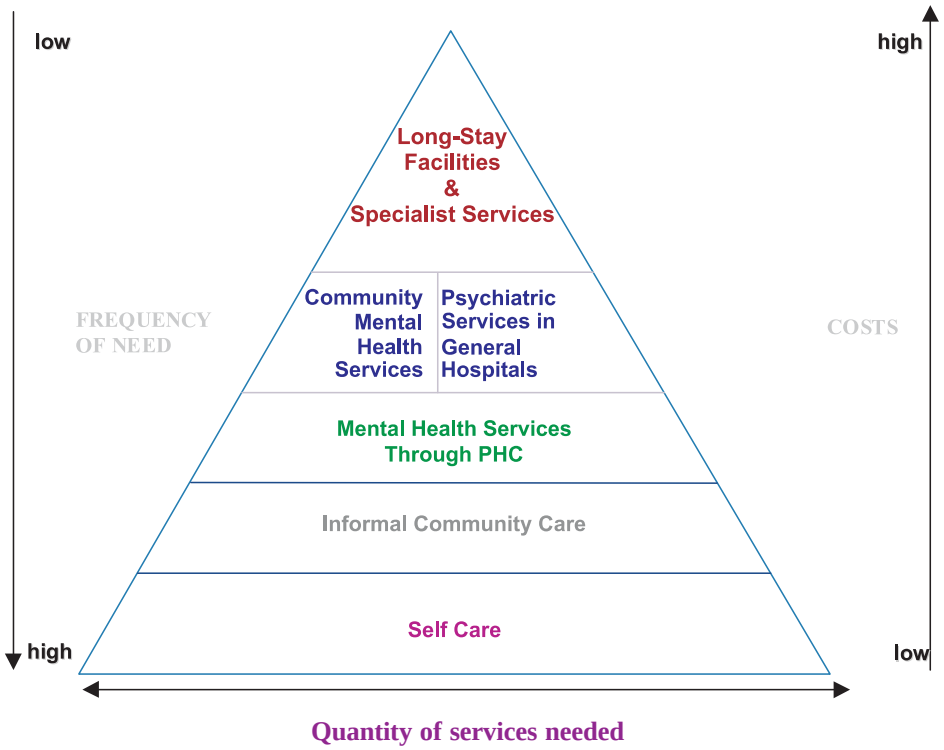

Fig. Optimal mix of different mental health services (*Source* : Ref. 10,11).

recognized priority in the minds of the general population.The recent recognition for universal coverage of ICDS by the Supreme Court[4] offers opportunities for integrating child mental health care at an early age.

NMHP (1982-2007)

Prior to the formulation of the NMHP in 1982, there was growing recognition of the need to develop Indian models for mental health care. Two experiments at Chandigarh and Bangalore (1975-1982) demonstrated the feasibility of providing a certain level of mental health care through the existing health care system[12,13]. The NMHP (1982) had the objectives of making available basic mental health care to all of the population; application of mental health in social development and to promote community participation[1].

During the first 10 years of the NMHP, the initial small scale models of care were systematically evaluated and a district level model was developed in the Bellary district of Karnataka. During the next 15 years, the district mental health programme (DMHP) was initially extended to 27 districts and later on to 100 districts. Thus, within a relatively short time the basic approach to integrate mental health with general health care was taken to a larger coverage of the population.

During the same period, a number of other initiatives, specially by the voluntary organizations[8], have enlarged both the scope of mental health care as well as the care providers. These initiatives have included setting up of day care centres, half-way homes, long-stay homes, suicide prevention centres, school mental health programmes, disaster mental health care, community based programmes for the care of the mentally retarded, elderly persons, persons with dementia, and substance abuse. One India specific development of significance is the increasing role played by the family members both for self-help, mutual support and towards advocacy[9]. This development, to a large extent, has occurred with the partnership with the professionals, unlike in some of the western countries where there is this lack of co-operation between patients, families and professionals.The developments between 1946-2003 has been critically and comprehensively covered by different professionals[12-14].

There are some limitations of these developments. The extension of the district model has brought to the forefront a number of managerial and care issues. As of now, the DMHP, still requires a lot of fine tuning (the amount of training for the programme managers, finalization of training material, public mental health

education, lack of measures to monitor the effectiveness and the impact of the programme, lack of a supportive team at the central, regional and state levels, *etc.*). Finding professionals to work as part of the basic mental health team at the districts has been a problem in a number of States, especially the non-medical mental health professionals. Though professionals have accepted the NMHP, the effort to give a solid foundation to the DMHP is still insufficient. There is a need to know about what proportion of persons with mental disorders seek care, what can be achieved in the best case scenario and what it will take to achieve this in a phased manner. In other words, the 11th Plan could systematically ask for some missing pieces of the evidence, set some targets and put in place a monitoring mechanism.

The voluntary agency initiatives have been isolated to pockets of the country, limited in reach, and have not been adequately supported with funds, by the government, both at the State and the Centre[8]. In spite of the many positive developments, the State level planning has occurred to a limited extent (only two States, namely Karnataka and Gujarat have developed State level plans).

There are areas, of mental health programme that have not been given adequate attention. Of these, the following are important. The nationwide, ICDS programme has not received the effort to make pre-school education an effective mental health development force. The life skills education for adolescents and youth is still in its initial phase in few centres. In spite of the attention to suicide by farmers, the number of centres providing suicide prevention is limited to a few dozen centres when it should be available in a few hundreds. The excellent models of disaster mental health care have not been a part of the past NMHP efforts.

The undergraduate training of basic doctors is extremely limited. The human resource development to meet the needs has not been addressed. The issues of rapid social change and the ways to help populations experiencing the ill effects of these changes are still not a subject of attention. The current models are largely rural population oriented and viable models for urban populations are far away in development.

The Indian Council of Medical Research (ICMR), New Delhi, provided valuable support to a large number of research projects directly and indirectly related to the emerging mental health programme during the 1970s and 1990s. However, this linkage has lessened during the 1990s and 2000s[15]. A reflection of this is the limited ad hoc projects funded during the period of 2002-2005, and only a few research publications about mental health services, in spite of two editorials focusing on public mental health in the country[16,17].

The last 25 years of NMHP can be summarized as follows: it is possible to develop a national mental health programme but it has been a gradual process; government support for the programme is essential for large scale activities; NGO initiatives can stimulate change but cannot address the larger needs of the population; mental health professionals have an important role in bringing about changes and creating the models of care that can give results; mass media needs to be fully utilized to fight stigma of mental disorders; there is a greater need for the stakeholders (families, community groups, human rights activists, *etc*.) to join hands in view of the multi-sectoral nature of mental health and lastly, general development of society is important for mental health to receive importance in the development process. The scope of mental health programme should be broad based and include wider range of issues related to mental health (*e.g.,* suicide, life skills development, disaster care, *etc.*)

Looking to the 11th Five Year Plan

India was one of the first developing countries to develop and implement a national mental health programme. It would be tempting to extend the current programme to cover the whole country hoping that solutions to the unsolved problems will be found in the extension of the programme. Such an extension, carries the danger of failure and discredit to the approaches utilized during the last 25 years.

The following aspects of the NMHP require attention during the 11th Five Year Plan:

The overall effort should be to create structures that will meet the long-term mental health programme development in the country, as against the focus on only rapid expansion of the current models of care. There is a need to recognize that no amount of progress in private psychiatry in India will take us to the goal of providing essential mental health care for the majority.

Firstly, there is a need for greater emphasis on development of mental health technology of community mental health care, in addition to the current emphasis on ideology. Such an emphasis on detailed service delivery has been an important component of other national programmes (*e.g.*, leprosy

control programme). A system of support and supervision, along with evaluation should be the foundation of the programme. This should be achieved by creating teams of professionals at the central level, at the regions and the State levels to continuously develop the interventions, evaluate the quality of care and make mid-course corrections. In this effort research, as in the past, should be an integral part.

Secondly, there is a need for a national level initiative for human resource development for mental health care. This should include improving the psychiatric training in the undergraduate medical education, increasing the training for non-medical mental health professionals, utilizing to a larger extent and bringing clear guidelines for the different paraprofessionals like counselors, volunteers, family level carers, *etc.*, to be part of the mental health care programmes.

Thirdly, there is a need for consolidating the different models of care by systematic evaluation, specifically the DMHP, the school-based interventions, the suicide prevention programme, substance abuse programmes, family support initiatives, rehabilitation needs of the chronic patients to enable the viable programmes to be implemented to cover a large population. A big challenge in India is that 70 per cent of health care contacts occur with the private sector. In an environment where the private sector is largely unregulated, there is a need to engage these stakeholders within the context of a national mental health programme.

Fourthly, there is a need for integrating the mental health components in national level programmes like the ICDS, education system, and use of traditional systems like yoga, meditation, so that the mental health promotive activities become part of the programme.

Fifthly, the areas not included in the earlier plan periods like support for families of the mentally ill persons, prevention of suicide, life skills education, disaster mental health care, care of the elderly, should be taken up to develop models during the 11th Plan, so that suitable expansion in the next Plan period can occur.

Sixthly, there is a greater need to use the mass media and information technology to spread the mental health information to the total population. This effort of mass mental health literacy should be a continuous process and to be included in both the public and private sector initiatives.

Seventhly, similar to the recent focus of HIV/AIDS programme targeting the migrant labour as a high risk group for interventions, there is a need for greater attention to the mental health impact of rapid social change, urbanization and changes in the family life and to develop corrective interventions to address these effects.

Conclusion

The last 25 years of developments in the area of mental health has brought mental health care from the closed confines of mental hospitals to the larger community. The progress is impressive. India has the opportunity to develop a viable and effective mental health care programme by giving attention to certain areas that need attention. The goal should be to create public mental health programme for the country and to create structures and processes to address the needs. It is by adopting such an approach of openness, continuous evaluation, learning from the experiences, making mental health an agenda of the patients, families, professionals, different sectors of society, planners and politicians that required results can be achieved.

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