Medicine and Society

Why mental health services in low- and middle-income countries are under-resourced, under-performing: An Indian perspective

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ABSTRACT

The inadequacies of mental health services in low- and middle-income countries are often attributed to inadequate allocation of resources. This may not be entirely true. The experience in India suggests that a top–down approach to planning, divorced from the ground realities, poor governance, managerial incompetence and unrealistic expectations from low-paid/ poorly motivated primary healthcare personnel play an important role and may result in the failure of even adequately funded programmes. The ambitious National Mental Health Programme (NMHP), launched in 1983 and aimed at providing basic mental health services through the existing primary healthcare system, using the Bellary model, failed to achieve any of its targets over the subsequent decades. In early 2001, the NMHP was radically revamped. It was re-launched as part of the Tenth Five-Year Plan (2002–07) and the budgetary allocation was increased more than 7-fold. However, the programme faltered due to techno-managerial under-performance and the initial momentum was lost. The reasons for this failure are analysed and possible remedial strategies suggested. While the experience documented in the paper is country-specific and relates to India, it may hold useful lessons for other low- and middle-income countries.

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'The mental health scene in India at the dawn of the twenty-first century is a bewildering mosaic of immense impoverishment, asymmetrical distribution of scarce resources, islands of relative prosperity intermixed with vast areas of deprivation, conflicting interests and the apparent apathy of governments and the governed alike. In the context of the huge and perhaps unsustainable levels of over-population, the problems appear to be insoluble. Yet a solution must be found if we are to survive. This calls for courage, vision and a vibrant spirit of innovation, unburdened with the obsolescent shibboleths of psychiatric mythology. We will have to get off the beaten track, and embark upon this journey without a road map to help us along. We will have to invent solutions. We have the technical skills required to achieve this goal. Do we have the wisdom to choose the right path?'[1]

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HISTORICAL BACKGROUND

Though the history of state-funded public hospitals in India can be traced back to the times of Emperor Ashoka in the third century BC,[2] there was no tradition of institutionalizing the mentally ill, who were invariably treated within the community. The first mental asylum came into existence at Calcutta (now Kolkata) in 1787, during the rule of the British East India Company, and catered mainly to 'insane' soldiers.[3] Initially, English laws such as the Act for Regulating Madhouses, 1774 provided the legal framework for these asylums. Following the first war of independence of 1857, the first British Indian law on the subject, the India Lunacy Act, 1858 was enacted. This was followed by the Indian Lunacy Act, 1912, which was replaced 65 years later by the Mental Health Act, 1987. Despite several attempts at reform, conditions in most of these asylums, rechristened mental hospitals in 1920, remained abysmal.[4]

Forty years later, on the eve of India's Independence, and after a detailed survey of all mental hospitals in the country on behalf of the Bhore Committee, chaired by Sir Joseph Bhore, the then Superintendent of the European Mental Hospital, Ranchi and Honorary Consultant to the Eastern Army Command, Colonel Moore Taylor, said: 'Every mental hospital which I have visited in India is disgracefully understaffed. They have scarcely enough professional workers to give more than cursory attention to the patients, to say nothing of carrying a teaching burden… The policy of increasing bed capacity, which has incidentally led to gross overcrowding in most of the mental hospitals, rather than personnel has been stressed in the past, but the cure of mental patients and the prevention of mental diseases will not be accomplished by the use of bricks and mortar…. Finally, I would stress that the conditions in some of the mental hospitals in the country are disgraceful, and have the makings of a major public scandal…'[5]

Over the next few decades, concerned citizens brought to the attention of the Supreme Court the terrible conditions prevailing in some of the mental hospitals through public interest litigation. The Supreme Court, shocked by the conditions and considering them a gross violation of the fundamental rights guaranteed under Article 21 of the Constitution of India, asked the National Human Rights Commission (NHRC) to survey all 37 government mental hospitals (combined bed strength of 18 918) in the country. The conclusions of the well-documented NHRC Report of 1999[6] are echoed in just one sentence: 'It was as if time had stood still.'

FAST FORWARD

Since mental illness had been traditionally treated within the community, with the major burden of care being borne by the families of the mentally ill, it did not evoke much interest among health planners. Health planners had to contend with numerous other issues, such as high maternal and infant mortality, protein–

calorie malnutrition, unsafe drinking water and a rudimentary/colonial public healthcare system. Thus, mental health took a back seat and did not even merit mention in the national five-year plans till 1997, when a token provision of ₹ 270 million (US$ 5.1 million) was made in the Ninth Five-Year Plan for piloting the District Mental Health Programme (DMHP) in 25 of 593 districts. Even this meagre amount remained unspent due to bureaucratic apathy and tardy implementation. This appears inexplicable, in the context of the ambitious National Mental Health Programme (NMHP), launched nearly 15 years earlier in 1983.[7] The NMHP, based on a model validated in a backward district of Karnataka, widely publicised as the Bellary model, was launched with the aim of extending community-based mental healthcare through the existing primary healthcare system.[8] While the Bellary model seemed to work under resource-intensive experimental conditions over a limited time-frame, it failed to deliver in real-life field conditions, as revealed by the Indian Council of Medical Research–Department of Science and Technology (ICMR–DST) study done in 1987 at 4 geographically widely separated sites: Bangalore (present Bengaluru), Vadodara, Patiala and Kolkata.[9] According to Professor R. L. Kapur, the NMHP, launched with the aim of ensuring the availability and accessibility of minimum mental healthcare for all in the foreseeable future, failed because it set unrealistic targets that were neither matched by commensurate grants (₹ 10 million was sanctioned in the Seventh Plan), nor by a realistic assessment of other (e.g. manpower) resources. The targets included training 5000 multipurpose workers (MPWs) and 20% of primary health centre (PHC) doctors within 5 years. In addition, the approach did not take into account the poor functioning of the PHCs in general, the poor morale of the health workers, the lack of enthusiasm in the profession, and the lack of an administrative structure to monitor the progress of the programme in a decentralized manner.[10]

These conceptual, techno-managerial, and human resource fault-lines bedevilled the NMHP during the Tenth Five-Year Plan (2002–07), when adequate budgetary support became available for the first time in the history of mental health in India. Tragically, the same mistakes have been replicated on an even bigger scale in the Eleventh Plan (2007–12), with a much larger fiscal outlay.

2001: THE HOPE ODYSSEY

In early 2001, a small task force was set up with the agenda of developing the NMHP as a functionally viable conceptual entity. As a first step, a comprehensive survey of all mental health resources, including mental hospitals, general/teaching hospital psychiatry units (GHPUs) and mental health professionals in the country was conducted and a detailed district-wise *Mental Health Resource Map of India* was constructed (Table I).[1,11] Detailed analyses of the available evidence base guided the restructuring of the NMHP 1983, from an exclusively DMHP-oriented entity to a comprehensive multidimensional programme. The NMHP was to incorporate pragmatically re-modelled DMHPs linked to the zonal medical college departments of psychiatry, and conceptually re-oriented mental hospitals, with provision for research and information, education and communication (IEC) initiatives. This integrated, seamless system prescribed clearly defined lines of referral and techno-managerial governance, with dedicated fiscal allocations for each domain.[12] In the first phase, it was proposed to implement the DMHP in 100 of the districts that were the most disadvantaged in terms of mental health, with provision for extending it to another 100 districts in the second phase. To lessen the pressure on mental hospitals, the Supervised Domiciliary Aftercare Programme was formulated. This was targeted at those with enduring mental illness and incorporated a provision for reimbursing economically disadvantaged family caregivers for reduced earning capacity. Crisis intervention units were to be constituted in at least one medical college in each state to provide technical support for psychosocial interventions in disaster relief. Fiscal support was to be provided to 75 government medical colleges for strengthening departments of psychiatry and augmenting training facilities, with the aim of enlarging the human resource base.[1] The development of a cost-effective model for a school mental health programme, which could be subsequently integrated with the DMHP, was envisaged. Modernization of the 37 government mental hospitals in the country was linked to innovative strategies for dealing with the problem of long-stay patients (frequently abandoned by their families). There were also plans to rationalize and eventually downsize the larger/unviable institutions. Further, the re-conceptualization aimed to incorporate the following.

1. *A rights-based approach to mental health:* Based on Article 21 of the Constitution of India (protection of life and personal liberty) and UN General Assembly Resolution 46/119 of 17 December 1991 ('All persons have the right to the best available mental health care which shall be part of the mental health and social care system. …Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights…').
2. *Mental health as a development issue:* Mental disorders affect 20% of adults in the community and are bidirectionally associated with socioeconomic disadvantage, class and gender inequity, unemployment and rapid urbanization. Cost-effective community-based mental health interventions offer a viable means of breaking this vicious cycle.
3. *Mental health as a prudent investment—the economic argument:* Mental health offers a cost-effective public health intervention with the potential to yield tangible macro-level economic benefits and increased productivity (e.g. in the country's knowledge industry).

The re-strategized NMHP for the Tenth Five-Year Plan (2002–07) received the final approval of the Government of India in early 2002, with a budgetary allocation of ₹ 1900 million (US $42.3 million), a 7-fold increase over the outlay of the previous plan,[12] and was formally launched in October 2002. There was an

TABLE I. Data related to mental health in 2000–01

Item	*n*
Major mental disorders	11 million
Common mental disorders	110 million
Public sector mental health beds (including 18 918 mental hospital beds)	20 893
Private sector mental health beds	5096
Districts with some mental health services (public/private sector)	219
Districts without any mental health services (public/private sector) (data of 63 districts in Bihar and Andhra Pradesh not available)	311
Psychiatrists	2219
Clinical psychologists	343
Psychiatric social workers	290
Psychiatric nurses	523
Total number of psychiatrists trained during 2000–01	66 (MD 45, DPM 21)

incredible atmosphere of hope and expectation. Departing from conventional bureaucratic practice, an apex steering committee, chaired by the health secretary, was constituted and proposals received from the states were fast-tracked. However, the dream ended there. The basic malaise of government machinery in India reasserted itself and eventually all but scuttled the programme. Financial procedures delayed the release of funds at the Central level, while petty turf wars and apathy at the state and district level meant that the funds released remained largely unspent. The situation was not uniformly dismal. States such as Kerala exceeded targets, while Bihar did not implement the programme at all.[12]

HISTORY FORGOTTEN

Having forgotten the lessons of the 1980s, we made much the same mistakes at the beginning of the new millennium. We re-realized some basic tenets of pragmatic planning in a diverse nation of 1 billion people, a federal entity in which the states jealously guard their autonomy: that the simplest things usually work the best; that one mould does not fit all; that the inertia of a dysfunctional government with lack of accountability at all levels can scuttle even the best thought-out plans; that poorly paid and unmotivated public health staff regards the NMHP as yet another burden to be grudgingly borne/passively sabotaged; that intensive efforts at capacity-building must precede any such endeavour; and, finally, that 'the major hurdle in the path of providing mental healthcare to the community lies not in the purse but in our minds'.[1] Tragically, little seems to have been learnt from the underachievement of targets, if not outright failure, during the Tenth Five-Year Plan (2002–07). The proposals for the Eleventh Five-Year Plan (2007–12) envisage an even more intricate and ambitious programme, with a 5-fold increase in budgetary support to ₹ 9460 million (US$ 210.6 million).[13] The 'revised and revitalized' NMHP reverts to its one-dimensional, purely DMHP-oriented status, with the DMHP itself being split into 2 tenuously linked components. These are a 10-bed district hospital in-patient unit run by a psychiatrist and the larger community component under a primary care physician with 6 months' training in psychiatry and administrative skills. This is made more intricate by an elaborate training schedule to 'train all medical officers and paramedical workers in the district' with the aim 'to identify all serious mental disorders in the community and to start treatment for all with regular follow-up'.[13] To repeat Professor Kapur's *obiter*, this is 'more a wish list than a serious exercise'.[10]

TAKING STOCK

So where do we stand today? Is the picture as gloomy as it seems to those of us traumatized by the failures, qualitative more than quantitative, of the past 5 years? Probably not. Major gains have been made, even though the high expectations at the turn of the century have not been fulfilled. Successful advocacy has sensitized policy-makers at the highest level of government to mental health issues. Mental health is now recognized as a priority. The NMHP is now accepted as a relatively low-cost, high-yield public health intervention which is doable, as shown in states such as Kerala and Gujarat. Maharashtra, which alone accounts for more than one-fourth of all mental hospital beds in the country, has made major gains in addressing the problem of long-stay patients and the derelict native mental asylum at Ranchi is now unrecognizable in its new *avatar*. Fiscal resources, which used to be doled out grudgingly, are no longer the issue, as evidenced by the increased outlay envisaged for the Eleventh Five-Year Plan. Even the non-performing states have gained hands-on experience and, hopefully, learnt lessons from their failures and the success stories of others. All of us are, or should be, wiser and more circumspect. It is from this cautionary perspective that the rather utopian proposals for the Eleventh Five-Year Plan are a cause for concern, though most of us will be very happy to be proved wrong in our gloomy prognostications. We had erred, but perhaps not in vain!

LOOKING AHEAD

Where do we go from here?

From a personal perspective, I would like to reiterate the agenda of the *National Mental Health Policy: Vision 2020* document written in early 2002 which envisaged:

1. *Accessibility* of at least basic psychiatric facilities within the community to as large a section of the population as possible in all parts of the country.
2. *Affordability* of the services with regard to the initial capital cost as well as recurring expenditure (including that on essential drugs) in accordance with our limited resources and low income levels of the consumer population.
3. *Adaptability* to the widely varying geographical, sociocultural and economic mosaic of our vast country.
4. *Acceptability* of mental healthcare by the target population in the context of low levels of literacy, ignorance, superstition, economic backwardness, and lack of empowerment of women, adolescents and children. Cultural congruity, hitherto largely ignored by most of us, needs to be factored into future programmes.[14–17]
5. *Assessment* of performance at the ground level through continuous monitoring, online audit by an independent agency and periodic review at the national level to identify areas of non-performance/reasons for the same at an early stage and introduce necessary corrective measures, as well as relevant feedback for future planning.[1]

To achieve these ends, it would be important to remember the following.

1. *Mental hospitals are not a viable option for delivering cost-effective mental healthcare.* Of the 20 893 public sector psychiatric beds in India, 18 918 (>90%) are located in 37 mental hospitals. Nearly half of these (about 9000 beds) are occupied by long-stay patients. On an average, ₹ 450 (US$ 10) per day is spent on each of these beds, compared to the country's annual per capita public health expenditure of ₹ 200 (US$ 4.5). Gujarat spends considerably more on its mental hospitals than on its medical college hospital psychiatry units, which cater to a vastly greater number of patients. This asymmetry in the cost-to-benefit ratio becomes more glaring if the qualitative aspect of the outcomes is taken into account.
2. *Alternative models of community-based care need to be developed and tested.* As highlighted earlier, the Bellary model has not worked well for the NMHP, so alternative field-tested models are needed. Perhaps the most promising, though not rigorously tested, among these is the innovative 3-tier community-based rehabilitation model developed and tried out in Barwani, a backward district in Madhya Pradesh, using local community resources in a cost-effective manner.[18]
3. *The feasibility of alternative vehicles of programme delivery needs to be explored*. Till now, the focus has been exclusively on using the existing district public health system, which is dysfunctional in many states, as a vehicle for piggybacking the NMHP. Other more robust alternatives are, however, available

and need to be explored. The District Rural Development Agency (DRDA) and the National Rural Health Mission (NRHM) are well-funded and better managed in most states. A proposal to incorporate the mental health component in these was initiated during early 2005 and merits further advocacy.

CONCLUSION

The dawn of the new millennium heralded a new era in the field of mental health in India. Perhaps for the first time in history, paucity of resources ceased to be the limiting factor in mental health planning at the national level. The Tenth Five-Year Plan (2002–07) saw quantum accretion to the NMHP, fiscally and otherwise. The initial momentum could not, however, be sustained and there were significant areas of under-performance. Many of the past mistakes were repeated and contributed to these failures. Tragically, few lessons appear to have been learnt and many of the same, and more, mistakes are likely to be made in the Eleventh Plan. There is still time to heed a wake-up call.

Conflict of interest: *None declared*

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