

Primary (Mental) Health Care and the National Mental Health Program

'Doctors are like chandeliers — beautiful and exquisite, but expensive and inaccessible... I'm like a lamp — inexpensive and simple. And I can transfer light from one lamp to another, lighting the lamp of better health, easily, unlike the chandeliers. Workers like me can light another and another and thus encircle the whole earth. This is Health for All.'

- A village health worker from Jamkhed, India^[1]

INTRODUCTION: THE MENTAL HEALTH POLICY GROUP

The National Mental Health Program (NMHP) of India is rapidly changing. With the setting up of the Mental Health Policy Group (MHPG) and their observations and recommendations, the District Mental Health Program (DMHP), in the 12th Five-Year Plan (FYP),^[2,3] has been considerably revamped, compared with the 11th FYP.^[4] Other than the usual outpatient (OP) and inpatient (10 bed) mental health (MH) services, it has spelled out a day care centre for rehabilitation and a residential/long-term continuing care centre (site unspecified, though the MHPG suggests two each per district with a capacity of 25 beds at each facility), with explicit statement for financial support and MH helpline. It has also specified a Central MH Team to supervise/implement the programme and support the Central Mental Health Authority (CMHA). Financial support for the state and CMHA for implementation of the Mental Health Care Act (MHCA), 2017 has also been indicated. Moreover, unlike in the 11th FYP, Information, Education and Communication (IEC) activities are now relatively more concrete, harnessing the potential of different public media. In addition, the 12th FYP has a definitive plan for the Public-Private Partnership (PPP) activities, and delineates areas of participation. The plan for human resource development scheme nearly remains the same but with quantitatively increased financial allocation. In this context, the review article^[5] published in this issue analyses the achievements and shortcomings of the NMHP to chart a future course for the program.

However, certain contentious issues still remain, particularly from a health service perspective. This guest editorial discusses key issues in an attempt to refine

the conceptual understanding that has implications for practice.

HUMAN RESOURCE CRUNCH

Human resources crunch for MH in India are rather ever-present as in many other Low and Middle Income Countries (LMICs). Most models today for the LMICs have suggested the use of lay health workers to close this gap, referred to as task sharing/shifting.^[6-9] But, due to multidisciplinary team involvement for the treatment of MH disorders, the question arises how to substitute the team (social worker, clinical psychologist, psychiatric nurse and psychiatrist) at the Primary Health Centre (PHC) level? Easy answer will be a registered nurse and a medical officer to replace psychiatric nurse and psychiatrist. But the role of the social worker and the clinical psychologist would be borne by whom? The 12th FYP suggests that two community health workers (CHWs) would do pro-active case finding and a clinical psychologist/psychiatric social worker would be posted at the community health centre (CHC). At some places, this model may work, but in most other parts of India, we have scarcity of clinical psychologists/psychiatric social workers. Then how to plug this gap? Ideas circulated that the nurses can double up as counsellors and CHWs as social workers, to help access social care benefits and tackle other family psychosocial issues. But what would be the (dis)incentives for increased responsibility? Moreover, in situations such as in India, a mix of locally specific models may be more appropriate. At places where appropriate health worker resources are unavailable, peer counsellors and local self-help groups may come into play. Then the DMHP team, with whatever composition they might have, has to take the responsibility of training such volunteers. Or, as suggested by the Lancet group on Alma-Ata: rebirth and revision,^[10] creating an extra cadre of lay health workers to meet psychosocial issues in all chronic disorders including MH would be an option. This may have some logic, considering the fact that the already existing PHC workers are overburdened with maternal and child health programme, immunisation and communicable disease programmes. Moreover, the management of chronic non-communicable diseases involves common principles of psychosocial

care. And this can easily address comorbidity. Though concerns may arise in creating an extra cadre of workers considering the magnitude of the task in a vast country such as India, yet in recent times we have seen huge number of Accredited Social Health Activists (ASHAs) who have been trained and inducted in the Indian primary health care system.^[11] Thus it can be considered a feasible strategy.

THE SITE OF MH SERVICE DELIVERY

The 12th FYP suggests district hospital as the primary site of delivery of OP and inpatient services, CHC for OP and emergency services, and PHCs for OP and counselling services. Considering the DMHP team to be situated at the district hospital, they have to organise satellite clinics at CHC and PHC. This is applicable when ideally the team is fully staffed with psychiatrist, clinical psychologist, psychiatric nurse, psychiatric social worker, community nurse, monitoring and evaluation officer, case registry assistant and ward assistant/orderly. Of them, it is expected that the psychiatrist, clinical psychologist, psychiatric social worker, community nurse (the four most important participants), monitoring and evaluation officer and case registry assistant would go for satellite clinics. Of the most important participants, often missing will be the clinical psychologist/social worker component, considering the human resource crunch, and this would have to be managed by task sharing as discussed above. Moreover, for initial emergency management at CHC, presumably general medicine specialist will have to bear the responsibility. Thus a component of training will have to be put in place by the DMHP team.

Moreover, as shown in a recent research done in Tamil Nadu^[12] on the Universal Health Coverage (UHC), when drugs for non-communicable disease are available at health sub-centre along with improved services, patients prefer to collect their drugs and have follow-up locally, going to PHC only on referral or routine quarterly check-up and renewal of treatment plan. This not only improves OP attendance at health sub-centre but decreases out of pocket health expenses and share of private OP care. As the DMHP consolidates enrolment of patients, for the realisation of UHC, availability of psychotropics and appropriate training at the health sub-centre has to be planned, though currently the DMHP has no plan for this.

PUBLIC-PRIVATE PARTNERSHIP (PPP) IN DMHP

The 12th FYP has suggested the involvement of the Non-Government Organizations (NGOs) in the DMHP,

specifying areas of participation that includes IEC activities and hiring and training of human resources aspects of service provision. This is a welcome move, considering the enthusiasm to engage the not-for-profit agencies who have the motivation to innovate and experiment. But this PPP model has limited potential considering the magnitude of the requirement in India. On the other hand, hurdles also exist for the involvement of private for-profit organisations (which likely has a greater reach) because psychiatry is less technology-intensive and hence the business incentive is less robust and the associated stigma is also there.^[13] Moreover, the increased legal regulation consequent to the new MHCA 2017, private players would be reluctant to engage in service provision that may be profitable. Therefore, extensively engaging a PPP model is unlikely in DMHP.

HUMAN RESOURCES DEVELOPMENT AND TRAINING

The focus on human resource development through upgradation and support of specialised psychiatric institutions and departments at medical colleges has been the focus of DMHP since the 10th FYP, with extensive financial outlays. But this proposal inadvertently concentrated on training specialised MH professionals: psychiatrists, clinical psychologists and psychiatric social workers. But when specialised professionals are trained at high public cost, consequent brain drain either offshore or to the private health care industry is often difficult to prevent, such as in India particularly in a globalising world. In this context, the MHPG pointed out the importance of training at the primary and secondary care level and developing mental health orientation for PHC physicians, CHWs, untrained psychologists, social workers and the local community members. Thus, to revitalise MH program, a shift of focus and financial commitment to the latter seems more important. On this account (and for general health care too) transforming district hospitals as knowledge centres to train primary and secondary level health care human resource seems apt.^[14] Moreover, the content of such training has always focussed on identification, referral and management of priority MH conditions. Training in MH education so as to develop locally relevant IEC materials and preventive care orientation has never been attempted. Without consideration of these issues, the 12th FYP^[15] still has harped on specialist training and now for support of technology-intensive neurology and neurosurgical services in two central MH institutes.

On the other hand, new methods of teletraining are being tried in Karnataka and other places by the

NIMHANS.^[16,17] Of interest, here is the continuing telepsychiatric ‘On-Consultation Training’ which attempts to train PHC physicians through video conferencing while they are consulting psychiatric patients at their PHC clinic. This can be a useful tool for continuing follow-up training, support and supervision.

On the other hand, focus on revamping graduate medical training towards MH would orient future doctors to manage not only psychiatric problems but also the psychosocial bearings of chronic diseases in the long term. This is especially when the Medical Council of India, responsible of medical graduate training, has been recently dissolved letting its way to a new body, the National Medical Commission, which has the chance to seize the opportunity to reorient medical training to models of chronic disease care. This is applicable for nursing and paramedical training as well.

COMMUNITY PARTICIPATION

One of the primary objectives of NMHP, as conceived in the beginning, was to promote community participation in MH service development. This has been described as partly contributed by the influence of the Primary Health Care movement and ensuing Alma-Ata declaration.^[18] But, later with the re-strategised DMHP, this important issue took a backseat. Now, as the MHPG has cast a renewed focus, the 12th FYP strategy has operationalised community participation by linking DMHP to self-help and family/caregiver groups, the Village Health and Sanitation Committees and NGOs. Other methods include engaging CHWs from within the communities for MH services. This can be a good start, but in the long run, to realise the true potential of community participation, MH services (and in general all health services) may require reorientation on the part of health service providers to step down from a position of power and devolve control in terms of planning, monitoring and finally managing MH programme to the community. Research suggests this is more than a health intervention with set indicators; it is rather a process.^[19] Thus, in due course, the proposed Technical Support and Advisory Group – Community Action needs to evolve and take the role of capacity building at the local level. Moreover, as community participation remains a politically entwined concept, it is to be seen how this unfolds in practice in the transforming landscape of India’s health care services.

CONCLUSION

The MHPG has allowed a renewed focus on the aims of the NMHP as conceived and imagined in the beginning. For various reasons, the achievement was

less than satisfactory, though the re-strategised DMHP, with more modest objectives, could find some success. Viewing from a health service perspective, a shift of focus from the tertiary care to primary care and from specialist to lay health workers is the need of the hour, in terms of finances as well as training needs. Relying on the non-government/private sector is expected to have very limited output. Moreover, an overarching goal that understands community participation, not as an intervention but a process of ‘putting people’s health in people’s hand,’ a problem founded on power and control will continue to perplex health service experts.

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