

National Mental Health Programme–Optimism and Caution: A Narrative Review

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ABSTRACT

India was one of the major World Health Organization (WHO) member countries to launch its National Mental Health Programme (NMHP) in 1982 in accordance with WHO's recommendations to deliver mental health services to the people under the framework of general health care system in the community. NMHP underwent major strategic revisions over its course, starting from setting a district as the unit for program planning and implementation under the District Mental Health Program (DMHP) to incorporating it with the National Rural Health Mission (NRHM) for effectively scaling up the program. The program also underwent evaluations by government bodies and independent agencies and was reviewed by many researchers. The program has been partly successful in terms of enhancing its reach to community, improving service delivery, and getting increased budgetary allocation, but at the same time, its impact was limited by financial and human resource constraints, lack of community participation, ineffective training, poor NGO/private partnership, and lack of a robust monitoring and evaluation (M and E) system. The latest National Mental Health Policy and the incorporation of its objectives have given a new impetus to the ongoing NMHP, however, its implementation needs to be monitored and the impact is yet to be evaluated. We attempted to review the available literature pertaining to NMHP and DMHP to highlight the determinants of its outcome, with special emphasis on on-going programs and to provide some important future directions.

Key words: 12th Five-Year Plan, community mental health and community mental health programme, District Mental Health Program, National Mental Health Programme

INTRODUCTION


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.^[1] Despite the huge burden of the MNS, a WHO report has

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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).^[2] In terms of financial resources, per capita expenditure on mental health by the lower and middle income (LAMI) countries are also scarce (<US\$ 2) as per WHO's mental health atlas (2014).^[3]

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.^[4] 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.^[5] 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.^[5,6]

We aim to explore the progress of NMHP and the determinants of its outcome, with a special focus on on-going NMHP, and intend to provide relevant future directions for the program. This review follows a narrative style. Literature was searched with the help of search engines such as PubMed and Google scholar, using search terms such as "Mental health programme AND India," "National Mental Health Programme," and "District Mental Health Programme." A total of 49 results were obtained. When the duration was restricted to the last 6 years, especially to obtain literature on the latest development of the NMHP since the launch of the 12th Five Year Plan, only seven articles, including two book chapters, remained. Further, websites of Ministry of Health and Family Welfare (MoHFW), Director General of Health Services (DGHS), and other government agencies were visited to obtain relevant documents on NMHP/DMHP such as the document of regional workshops for NMHP (2011–2012), policy draft document for the 12th Five Year Plan (2012), and parliamentary

committee and NITI Aayog report on the on-going program. All the relevant articles/documents thus obtained pertaining to NMHP/DMHP and their evaluation and available reviews were reviewed and presented in a narrative style, followed by discussion and conclusion.

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 multicountry collaborative study.^[7,8] 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.^[9] 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.^[5]

EVOLUTION OF NMHP

NMHP was launched in 1982, with the initial funding of 100 million Indian national rupees (INR) and with the following aims:^[10]

- 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.^[11]

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.^[12]

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.^[7,11,13]

EVOLUTION OF DMHP^[13]

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^[14]

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 case-load 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.^[6] Agency recommended strengthening the services at CHCs, PHCs, and subcenter to gradually shift the financial burden to state government, to improve the manpower of allied mental health professionals, to integrate DMHP with other health programmes (like NRHM), and active involvement of community-based organizations in organizing awareness programs. From an implementation point of view, formation of a permanent mental health advisory group at all levels, development of standard guidelines for service delivery and training, bringing about some flexibility in terms of drug list, and reconsidering the priority mental health conditions covered under the program, ensuring the periodicity of training, and creating a database to record service delivery have been recommended.

DMHP IN 12TH FIVE YEAR PLAN^[15]

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.^[16]

ISSUES FACING THE NMHP

The current review sheds light upon the inception of NMHP, its progress, achievements, and underperformances, 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.^[17] 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.^[11,13,18,19]

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.^[18] 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.^[18,19] 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.^[16] 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. A recent study from north India reports a very high psychiatric patients attendance at the subdistrict level, and in the absence of a trained psychiatrist at

this level, mental illnesses remain undiagnosed and untreated.^[20,21] We emphasize the need to conduct more research on this issue.

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.^[14] Further, fragmentation of responsibilities at all levels has been another cause for poor implementation and performance of DMHP. For example, at the central level, MOHFW is responsible for health provision, whereas the rehabilitation part is mainly looked after by the Ministry of Social Justice and Empowerment (MOSJE). Similarly, in states, psychiatry departments of government medical colleges come under the Director of Medical Education, whereas primary health services come under the Director General of Health Services, leading to poor intra/interdepartmental coordination.^[22] In a progressive move, under the on-going programme, a designated structure has been created with an adequate fund and staff in the form of central/state/district implementation teams,^[15] however, we feel that its implementation needs to be periodically monitored.

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 center 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.^[23,24] Researchers have emphasized that gradually the financial burden of the program should be shifted to states,^[6,25] 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.^[26] 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. Further, to

allow an assessment of the actual progress being made under the pool, the parliamentary committee had also recommended to track the record of the expenditure made under the individual programme.^[27,28] We expect that such a system would regularize and optimize the funding of NMHP, but we also urge for regular monitoring for its proper implementation. Lack of human resource has been another major area of concern throughout the course of the program. Lack of leadership at the district level; poorly skilled and trained, poorly remunerated, overburdened community health professionals; and lack of supervisory support by the trained psychiatrist to community health professionals led to the underperformance of the program. To address the issue of limited human resource in the program, policy group had recommended to increase the number of specialists mental health professionals, relaxing educational requirements for specialists, provision of more number of courses to strengthen the supporting team (psychiatric nurses and social worker), and creating a new cadre of community mental health workers (CMHW) at the PHC level for identifying mental illness and facilitating access to treatment and social benefits.^[15] The on-going NMHP has taken steps in this context, but it would require periodic evaluations to monitor its implementation and take any mid-course corrections. Though, as of now, a total of 517 districts have been covered under the DMHP and 20 centres of excellence have been established, a recent national mental health survey (2016) reported that still the availability of psychiatrists (per lakh population) is low, which varies from 0.05 in Madhya Pradesh to 1.2 in Kerala. Further, except for Kerala, all other states fell short of the requirement of at least one psychiatrist per lakh population.^[21,26] We emphasize that effective implementation and strengthening of NMHP can be ensured by incorporating it under the umbrella of NCDs as a “horizontal programme.”^[28] Further, creating the post of chronic disease worker (a social worker or a lay health worker) at the PHC level could be a viable option in view of rising number of NCDs, including mental illnesses, to ensure psychosocial support for all chronic diseases and to ensure sustainable manpower, as highlighted in a previous study from LAMI country.^[29]

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.^[18,19,25] 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.^[15]

Further, an inefficient monitoring and database system had left the program with no scope for mid-term evaluation and course correction. The cited reasons for the same are lack of central support and nonmaintenance of the database by many states. Hence, policy group for the on-going program has recommended that states should appoint a state health authority for monitoring of DMHP services, and that there should be regular sharing of data with the centre for evaluation.^[9,15] To address this issue, in the on-going NMHP, a central mental health information system has been commissioned with a budgetary allocation of 40 million INR. The system has clearly defined indicators, data sources, and reporting protocol, and would be linked to a national surveillance system.^[16] Though this has been undertaken in the on-going programme, its implementations are yet to be seen.

Public-private partnership, community participation, and IEC activities related issues

Since the inception of the DMHP, over the last more than 20 years, the program has primarily relied on government-run treatment centres for service delivery, without involving NGOs and private sectors, despite the fact that the latter has played an important role in success of program like family planning. Moreover, governmental bodies, with the available resources, could only cater to 20–30% of needy population, and as a result, scaling up and implementation of the programme has been inefficient.^[18] On a positive note, lately, the government has taken some initiatives such as inviting/financially supporting NGOs and private sectors for IEC activities, providing continuous community care through day care facilities and halfway homes, training/sensitization of health workers, and hiring private mental health professionals for service delivery.^[16] Community participation and IEC activity, which played an important role in the success of national programs like National TB control programme, were lacking throughout the course of the DMHP, and as a result, the program lagged in areas of creating awareness, reducing stigma, and continued community care for PWMI.^[9] The same has been envisaged under the ongoing program with the establishment of CIT and SITs, which would ensure effective community participation and supervision of DMHP

with the help of state and district Mental Health Care Committees (MHCCs), user groups, caregiver groups, and *Jan-Sansad*. Technical Support and Advisory Group (TSAG) community action would be providing technical support to CIT to suggest processes for initial facilitation and capacity development, implementation of the community participation components, and involving civil society organizations in this process. The government has recently allotted 450 million INR for IEC activities in the form of launching websites and TV/radio programs to promote mental health.^[15]

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.^[15] 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.^[19,25] 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.^[6] Though the National Mental Health Policy, 2014 covers these issues explicitly, how it would be implemented need to be monitored to intervene if required.^[15]

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.^[15]

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.

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Conflicts of interest

There are no conflicts of interest.

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