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THE NATIONAL MENTAL HEALTH PROGRAMME OF INDIA AND THE MUCH-NEEDED S.W.O.T. ANALYSIS

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ABSTRACT *India was one of first developing countries to launch its National Mental Health Programme in 1982. There have been many changes with key pillars being District Mental Health Programme, Mental Health Policy, Mental Health Care Act and recent integration of mental health services in Ayushmann Bharat. The burden of mental health illnesses continues to grow with significant impacts on the social, economic and basic human rights. Mental Health disorders contribute significantly in morbidity, disability and even mortality among affected. As we near the 40-year anniversary of the programme next year, National Mental Health Programme needs to be critically analysed in terms of its success, failures, experiences and lessons learnt, so as to further strengthen mental health services in our country to cope up with the ever-rising burden of mental health illnesses in our country.*

KEYWORDS : National Mental Health Programme, SWOT analysis, National Mental Health Policy, Mental Health Care Act

INTRODUCTION

The burden of mental health illnesses continues to grow with significant impacts on the social, economic and basic human rights. Mental Health disorders contribute significantly in morbidity, disability and even mortality among affected. As per NMHS 2016, the overall weighted prevalence for any mental morbidity was reported to be 13.7% lifetime and 10.6% current mental morbidity. The age group between 40 and 49 years was predominantly affected (psychotic disorders, bipolar affective disorders [BPADs]), depressive disorders, and neurotic and stress-related disorders.[1] In study published in The Lancet Psychiatry "The Burden of Mental Disorders Across the States of India: The Global Burden of Disease Study 1990–2017", there were 197.3 million people with mental disorders in India which contributed to 14.3 per cent of the total population of India. The contribution of mental disorders in the total DALYs in India increased to 4.7 per cent of in 2017 as compared with 2.5 per cent in 1990. [2] Though mental health services are being provided through National Mental Health Programme, there is need to strengthen the same to cope up with rising burden of mental health illnesses in our country.

HISTORICAL BACKGROUND OF NATIONAL MENTAL HEALTH PROGRAMME

India was one of the first few developing countries to draft and launch its own National Mental Health Programme (NMHP). Before the launch of programme in 1982, Resolution at Addis Abba passed in 1975 urged its member states to integrate mental health services into primary health care, so as to broaden the outreach and destigmatize mental health services.[3] For this, the member states were asked to implement community health units to test the implementation of these activities in the community. As a precursor to NMHP, 'Community Health Unit concept' was materialized in Sakalwara by NIMHANS in 1975 with the aim of developing mental health education materials and modules; training of health care workers and identification, treatment and management of patients with mental health disorders. The project aimed to create mental health unit at primary level to promote mental health and provide easy accessibility to those who needed it.[4] In addition to it, as part of multi-national Project "Strategies for Extending Mental Health Care (1975–1981) ,the department of Psychiatry at PGIMER Chandigarh was selected as the centre in India with main focus on integration of mental health care services with general health care services.[5] The individual, family and community burden of mental illnesses which further highlighted the need of providing mental health services along with general health services and the involvement of community to overcome the social stigma. [6][7][8][9] These global commitments and success of local projects paved path for a mental health programme to be started at the national level.

Launch And Evolution Of National Mental Health Programme

The above-mentioned global commitments and success of local projects paved path for a mental health programme to be started at the national level in 1982.

The objectives of NMHP are:[10]

- To ensure availability & accessibility of minimum mental health care for all (particularly the vulnerable & underprivileged sections)
- To encourage application of mental health knowledge in general health care and in social development
- To promote community participation in the mental health services development and to stimulate self-help efforts in the community

The strategies of NMHP are:[10]

- Integration of the mental health care services with the existing general health services.
- Utilization of the existing health services infrastructure to deliver minimum mental health care services.
- Provision of appropriate task-oriented training to the existing health staff.
- Linking of mental health services with the existing community development programs.

As the programme was being carried out, there were many administrative and financial issues that came up.[11] In order to have proper organization of services, Bellary model was conceived by NIHMANS and a pilot project was carried out in Bellary district in 1985-1990.Through Bellary model, district was selected as administrative unit for launch of mental health care services. There was provision to provide mental health care services comprehensively though primary health care centres. Training of physicians and health care workers was done through trainings and workshops to orient them to mental health, the standard treatment protocols and referral services to district. District levels were provided with psychiatrists and counsellors with outpatient department as well as with provision of in-patient hospitalization if needed. There were monthly meetings between district and primary health care centres. Success of Bellary model led to conception of DMHP in 1996 which was launched in 4 districts under NHMP with following objectives:[12][13][14]

- 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.

There have been timely changes in DMHP over years as shown in table 1:[15]

Table 1: Changes in DMHP over subsequent five-year plans

DMHP in 9th five year plan (1997-2002)	The District Mental Health Programme started in 1996 on success of on 'Bellary Model' with the key pillars being: 1. Early detection & treatment. 2. Training 3. IEC: Public awareness generation. 4. Monitoring: The progarmme was started in 4 districts in 1996 with extending to 27 districts by the end of the IX plan
DMHP in 10th Five-Year Plan (2002–2007)	NMHP: re-vamped in 2003 with the following objectives: 1. Extension of DMHP to 100 districts 2. Up gradation of Psychiatry wings of Government Medical Colleges/ General Hospitals 3. Modernization of State Mental hospitals The DMHP was extended to 110 districts, with up gradation of psychiatric wings of 71 medical colleges/ general hospitals and modernization of 23 mental hospitals
DMHP in 11th Five-Year Plan (2007–2012)	Restrategized with following provisions: 1.Program officer (a psychiatrist) and family welfare officer (to work with the psychiatrist) in each district 2.Ten beds for acute care 3.Essential drugs at PHCs and more advanced drugs 4.Training programs for medical officers 5.The Manpower development scheme (Scheme-A & B)
DMHP in 12th Five-Year Plan (2012–2017)	Mental Health Policy Group (MHPG) appointed by the MOHFW 2012 draft for DMHP (under the 12th Five Year Plan). Mental Health Policy 2014 was aimed "to promote mental health, prevent mental illness, enable recovery from mental illness, promote destigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span within a rights-based frame work." The objectives were:[16][17] 1. To provide universal access to mental health care. 2. To increase access to and utilisation of comprehensive mental health services by persons with mental health problems. 3. To increase access to mental health care especially to vulnerable groups including homeless persons, persons in remote areas, educationally, socially and deprived sections. 4. To reduce prevalence and impact of risk factors associated with mental health problems. 5. To reduce risk and incidence of suicide and attempted suicide. 6. To ensure respect for rights and protection from harm of persons with mental health problems. 7. To reduce stigma associated with mental health problems. 8. To enhance availability and equitable distribution of skilled human resources for mental health. 9. To progressively enhance financial allocation and improve utilisation for mental health promotion and care. 10. To identify and address the social, biological and psychological determinants of mental health problems and to provide appropriate interventions.

CRITICAL ANALYSIS OF NATIONAL MENTAL HEALTH PROGRAMME

India was one of the first developing countries to implement a national programme for mental health.The commitment to launch a national mental health programme was preceded by strong international support and demand by psychiatrists and policy makers at the national level. [8]The local projects carried out in Chandigarh as part of multi-national Project "Strategies for Extending Mental Health Care (1975–1981) project and lessons learnt from Sakalwara project reconfirmed the basis of shift of treatment from hospital-based settings to general settings, where providing care at the primary health centre was the key focus.[4][5] The programme was based on success of pilot projects that were carried out at community level. As the national programme was implemented, there were struggles in terms of its implementation comprehensively at national level with non-clarity over distribution of funds, lack of feasibility of programme in real life as compared to pilot project settings, lukewarm reception by psychiatrists especially in private sectors and poor community participation.[11] Though the programme was aimed at providing comprehensive health care services i.e., preventive, treatment and rehabilitation; there were struggles to implement it at national level.

The main pillar of success in terms of kick starting the programme came in form of Bellary model which was carried out in Bellary district of Karnataka. The model was based on selecting district as the administrative unit for implementation of national programme, which highlighted the importance of training of health care workers and physicians at primary care settings and establishment of referral systems with in-patient facilities at district level. Another key component was monitoring and evaluation system being established with monthly meetings organized between primary and district medical officers. The implementation of Bellary model and it morphing into District Mental Health Programme paved way for an organized structure to provide mental health care services in the country.[6][7][8][9]

The DMHP saw timely interventions in every five-year plan with DMHP extending to four districts in 1996 and currently covering 692 districts all over the country.[20] Though fund allocation was given significant importance in early decades of programme implementation, there has been always confusion over fund distribution between states and centre level. In 12th FYP, community interventions through IEC but on field, IEC coverage has been poor and lacking in motivation. Interventions like targeted interventions in suicide prevention, workplace stress management have been part of 12th FYP which was long term in waiting. [16][17]

Despite the programme has been in existence for around 40 years, only 2 mental health surveys have been conducted i.e., in 2003 and 2015-16. Its already tough to assess the burden of mental health illnesses as it has significant social and economic impacts, with India still struggling with stigma attached to it, there should have been more frequent surveys to estimate the status of the programme. The monitoring and evaluation have been poor with lack of motivation among health care workers in terms of service delivery, poor IEC coverage and lack in provision of providing medicines at primary level. [21]

Integration with Ayushmann Bharat in view to provide universal health coverage provides great opportunity to provide quality mental health care services with newer models and strategies. As Mental Healthcare Act aims to destigmatize the same, involvement of local leaders, celebrities and public figures should be promoted to overcome the social barriers. [19]

Although there is provision for Day Care Centres, NGOs should be roped in to provide support as seen in de-addiction

centres. Home based care and community activities need to be strengthened to allow for community awareness and involvement in mental health care.[16][17] Family support and their coping need to be looked into as family is main unit in providing care, especially in Indian scenario.

Mental health care activities can also be introduced in schools with regular orientation workshops and classes. Targeted interventions at workplace in terms of trainings, workshops and suicide prevention, de-addiction should be strengthened as the burden of mental illnesses in on rise. Table 2 shows the S.W.O.T. analysis of the National Mental Health Programme

Table 2: S.W.O.T. analysis of the National Mental Health Programme

STRENGTHS	WEAKNESSES
• India one of the pioneer countries in launching National Mental Health Programme • Shift from "disease hospital settings" to "general settings • Comprehensive care i.e., preventive, treatment and rehabilitation were key focus • The implementation of Bellary Model and its adoption into DMHP • Paved way for an organized structure to provide mental health care services • Provision from community involvement through IEC • Strengthening of tertiary centres through schemes A and B • Timely interventions in every 5-year plan • Focus on targeted interventions • Mental health care act 2017 much needed	• Only 2 surveys till date • Less clarity on fund allocation between state and centre • After 12th FYP, no provisions or changes introduced • Poor medicine availability • Despite comprehensive mental health services, focus has been o curative • Field coverage of IEC has been poor • Marginalized populations such as rural areas still lagging behind.
OPPORTIUNITIES	**THREATS**
• Family support, home based care and community activities • Public private partnerships • Integration with Ayushmann Bharat: new models and strategies • Involvement of celebrities, local leaders and public figures • Research and surveys • Day care centres • Trainings and workshops • School involvement, helpline numbers, NGOs • Mental health care introduced in schools.	• Stigma attached impairs health seeking behaviour • Disproportionate focus on services in Ayushmann Bharat. • New groups coming up: refugees, Covid 19, • Widening of disease spectrum: increasing burden of substance abuse

CONCLUSION

Though Mental Health Programme has been in place since 1982, the basic problems remain the same. There needs to community awareness and acceptance of mental health services if real change needs to be brought up. The social stigma attached with mental health illnesses is still high in India, though the impact of Mental Health Care Act 2017, is yet to be seen. With integration of mental health care services in Ayushmann Bharat under Health and Wellness Centres, there is hope of broadening the reach of these services in the community. The problem of mental health issue is on rise and India needs to be ready to geared up to face the same.

Conflict Of Interest: None declared

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