Review Article

Mental Health Promotion in India: A Critical Analysis

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ABSTRACT

Mental health service delivery system has not been found to be uniformly developed in India or even all regions of a particular country. It is found from the reviews on the health service patterns of different countries that very few countries have an optimal mix of services. Even within countries there are usually significant geographical disparities between regions. A key goal of mental health promotion is to ensure that the social, cultural, economic and environmental conditions conducive to good health are accessible to all members of a given community.

Key Words: Mental Health, promotion, environmental, cultural

INTRODUCTION

Promotion of mental health is as important as the promotion of physical health. In fact to have healthy body and mind there must be equity in promotion of both physical and mental health. A key goal of mental health promotion is to ensure that the social, cultural, economic and environmental conditions conducive to good health are accessible to all members of a given community.

The role of health promotion in mental health is embedded in the WHO definition of health (1948): "Health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity." The Ottawa Charter of World Health Organization defines health promotion as "a process of enabling people to increase control over, and to improve their health." [1-2]

In the year 2001 the World Health Organization enumerated that about 450 million people had any kind of mental disorders, be it psychosis or neurosis. According to the World Health Organization, neuropsychiatric disorders account for 12.3 % of the Disability-Adjusted Life Years (DALYs) out of the total DALYs for all other disorders. [3]

Historical Evolution of Mental Health promotion:

In literary sense mental health promotion programmes were started in the last part of 18th Century and first decade of 19th Century under the guidance of few noble clinicians as well as reformers, like, Phillipe Pinel, John Tuke, and Benjamin Rush so on. Previously mental illnesses had

been deemed as the mandatory sufferings of those persons who did something very wrong like 'evil act', 'blasphemy', 'deviations', etc. So society's attitude and understandings related to mental illness was those people had been penalized by the Almighty or Devine forces for their evil acts.

The concept of "mental hygiene", firstly appeared in 1843 in a book entitled "Mental hygiene or an examination of the intellect and passions" designed to illustrate their influence on health and duration of life. [4] Later in 1849, the slogan of "healthy mental and physical development of the citizen" had been by the Berlin Society of Physicians and Surgeons to promote mental health of common people. [5]

During the last decade of 19th century and first decade of 20th century a group of people started a reformatory movement in western countries like USA and UK to change the existing condition of mental health institutions and make it more humane in nature. The famous 'mental hygiene movement' came into the picture during that time and this movement was ably led by few enlightened persons like 'Clifford Beers', 'Adolf Meyer', so on.

The origin of the mental hygiene movement was initially a result of the work "A mind that found itself" by Clifford Beers in the USA in 1908, which had resulted in the formation of Mental Hygiene Society in the same year. In USA the National Committee for Mental Hygiene (NCMH) was founded in 1909 through the efforts of Clifford W. Beers and Adolf Meyer. The mental hygiene movement was primarily concerned with the improvement of the care of people with mental disorders. Clifford Beers once said: "When the National Committee was organized, in 1909, its chief concern was to humanize the care of the insane: to eradicate the abuses, brutalities and neglect from which the mentally sick

have traditionally suffered". [6] Finally efforts of Beers and others got the international support and recognition and the "International Committee on Mental Hygiene" was created and later superseded by the "World Federation of Mental Health".

In the middle of 1930s "the US National Committee for Mental Hygiene" stated its final objectives to promote mental health scenario of the country and mentioned their objectives as: a) promoting early diagnosis and treatment; b) developing adequate hospitalization; c) stimulating research; d) securing public understanding and support of psychiatric and mental hygiene activities; e) instructing individuals and groups in the personal application of mental hygiene principles; and f) cooperating with governmental and private agencies whose work touches at any point the field of mental hygiene . [7]

The NCMH of United States of America did some significant works to professionalize the American psychiatry in the first two decades of 20th century. Its leaders and activities played a central role in the shift of psychiatry's focus from institutional care within mental hospitals to psychotherapy and preventive activities based in community mental health centres. The attention of mental hygiene psychiatrists became increasingly directed towards well-adjusted individuals and away from the mentally ill. [8]

Additionally, emergence of several important theories and deliberation of some scholarly works by some eminent thinkers related to mental health and psychology had also fostered the demand of humanization of mental health service.

In the 1950s the concept of 'positive mental health' came into the field of psychiatry and psychology. During that time there was a massive hue and cry among the mental health professionals to promote as

well as protect the positive mental health of the both mentally ill and normal people. [9]

Indian Scenario:-

The picture of mental healthcare system is not so glittering. In this large country the ratio of mental health professionals like psychiatrists and psychologists and population are just 0.4 and 0.02 per 100,000 people, and 0.25 mental health beds per 10,000 population. Before independence the availability of mental health service was almost negligible and very few institutes and professionals were available to cater the needs of common people. But in the year 1946 a Committee, namely 'Bhore Committee' had been investigated the mental health situation of the country and put up some suggestions to develop the mental health infrastructure of the country. After that the Government of India and state governments have been trying to purport some positive changes in mental health care. India was perhaps the first country in the world, and certainly the first among developing countries to recognise the need to integrate mental health services with general health services at the primary care level. [10]

In India, the concept of mental health institutes like 'asylums' had been propagated by Europeans, like Britishers, Portugueses, Dutches etc. The early institutions for the mentally ill in the Indian subcontinent were greatly influenced by the ideas and concepts as prevalent in England and Europe in early 17th and 18th centuries. Primarily, mental asylums were built to protect the community from the insane and not to treat them as normal individuals. Accordingly, these asylums were constructed away from towns with high enclosures, in dilapidated buildings like the barracks left by the military. Their function was more custodial and less curative. [11]

But in the 20th century the condition of mental health care in India had been changed to some extent to positive direction. Development of modern mental hospitals in India started in the early part of the twentieth century. The British Government was forced to do some reformatory work for the existing mental asylums and welfare for the mentally ill people because of few reasons: e.g., 'increased activities undertook by the presses, both in Britain and in India, about the conditions of the mental health institutes and the influence of some enlightened people who were also influenced by 'mental hygiene movement in west' to incorporate more 'humanistic approach to take care of the mentally ill people'. This period is also significant, for another reason: in 1906, a central supervision system of these hospitals was contemplated. The concern of the Government of India ultimately resulted in a few more changes. In 1905, at the initiative of Lord Morley, the control of mental hospitals was transferred from the Inspector General of Prisons to the Directorate of Health Services and, at the local level, to the Civil Surgeons. [11] In the early part of the first decade of 20th Century the British Government felt there must be a legislation to cover all aspects related to mental health and illness. This way in the year 1912 the Indian Lunacy Act came into being. Before enactment of Mental Health Act this was the major legislation which looked after the areas of mental health. Under the Indian Lunacy Act 1912, a central lunatic asylum was established in Berhampur (Murshidabad) for European patients, which later closed down after the establishment of the Central European Hospital at Ranchi in 1918.

In pre-independence era Col (Dr.) Owen Berkeley Hill contributed a lot to reform the mental health service delivery system in India. He became the 'Medical

Superintendent' of the European Mental Hospital (now Central Institute of Psychiatry) later and under his able guidance the institution became the foremost and most modern mental health institute not only in India but Asia too. Dr Berkeley Hill was deeply concerned about the improvement of mental hospitals in those days. [11] During the period of 1920-47 many positive steps had been undertaken by Col (Dr.) Owen Berkeley Hill to reshape the deplorable condition of mental health service in India, some of those steps were: "change of the term 'asylum' to 'hospital' in 1920", "inclusion of occupational therapy as a part of psychiatric treatment", "recognition and inclusion of social scientists like 'psychologists' in the diagnosis and management of psychiatric patients", "introduction of family units at the then European Mental Hospital at Ranchi", "establishment of the Association of the Medical Superintendents of Mental Hospitals in 1930", "using of improvised treatment and diagnostic measures like Electro-Convulsive Therapy (ECT), insulin-coma treatment, psychosurgery and electroencephalography (EEG) for treating mental illness" and above all "shifting of emphasis from custodial care to a curative approach in mental hospitals".

Other significant feats had been achieved during this span of time were: Opening up of the first psychiatric outpatient service, precursor to the present-day general hospital psychiatric units at the R.G. Kar Medical College, Calcutta in 1933 by Dr G.S. Bose. The second such unit was organised by Dr K.R. Masani at the J. J. Hospital, Bombay in 1938. [11]

After independence the pace development of mental health service has been continued for few more years and many steps and targets had been achieved successfully. Major achievements were: introduction of family wards at the Amritsar Mental Hospital and at the Mental Health Centre, Christian Medical College, Vellore respectively to use the comprehensive involvement of families in the care, recovery and aftercare of psychotic patients and to facilitate their acceptance and return to their own homes in the community. Dr Vidya Sagar, the superintendent of the Amritsar Mental Hospital was instrumental in opening up of the family units in India and using of the family's resources and active therapeutic participation in the long-term care of the psychotic patients. [12]

Lots of achievements so far have been observed in the field of mental health in India, but somehow those achievements are not adequate and long-lasting for the people of India. Mental health care in India over the last 25 yr has experienced an intense period of growth and innovation. Prior to the formulation of the NMHP in 1982, the major initiatives included setting up of mental hospitals during 1950s and early 1960s and general hospital psychiatric units in the 1960s and 1970s. After the independence few major steps in mental health have been commissioned so far in the form of "introduction of National Mental Health Programme" (NMHP) in 1982, "introduction of the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985", "enactment of the Mental Health Act (1987)", "establishment of National Trust and finally "enactment of the Persons with Disability Act 1995".

In the decade of 1970 due to burgeoning demands of mental health service in the community, the Government of India felt the necessity to formulate a long-standing plan to improvement the mental health sector as well as the components of mental health in order to make it better able to provide the necessary services to the people. This way an 'expert group' was formed to develop an enduring National Health Programme. In February

1981, a small drafting committee prepared and presented the first draft of NMHP at a workshop of experts (over 60 professionals) on mental health, drawn from all over India at New Delhi on 20–21 July 1981. In the workshop the draft was substantially revised by the attendees and resource persons of the workshop and a revised version of the 'draft' was presented at the second workshop on 2 August 1982 to a group of experts from not only the psychiatry and medical stream but also education, administration, law and social welfare. The final draft was submitted to the Central Council of Health, India's highest health policy making body at its meeting held on 18–20 August 1982, for its adoption as the NMHP for India. [13] After the implementation the NMHP reviewed the mental health situation in terms of needs, facilities and services. Researchers and scholars of the field of mental health found that about 10 to 20 per 1,000 of the population are affected by a serious mental disorder at any point in time (point prevalence). The main burden of psychiatric morbidity in the adult population in India consists of acute mental disorders; chronic or frequently recurring mental illnesses; emotional illnesses such as anxiety, hysteria, neurotic depression; alcohol abuse, and alcohol and drug dependence and psychiatric disturbances among children. [13]

The NMHP in the year 1982 came up with the following objectives:

i. Within one year, each state will have to adopt definite plan of action in the field of mental health.

ii. Within one year, the Government of India will have appointed a focal point within the Ministry of Health, specifically for mental health action.

iii. Within one year, a National Coordinating Group will be formed comprising representatives of all states, senior health administrators and professionals from psychiatry, education, social welfare and other related professionals.

iv. Within one year, a task force will have worked out the outlines of a curriculum of mental health workers identified in the different states as the most suitable to apply basic mental health skills, and for medical officers working at Primary Health Centres (PHCs) level.

v. Within five years, at least 5,000 of the target non-medical professionals will have undergone a two-week training programme on mental healthcare.

vi. Within five years, at least 20% of all physicians working in PHC will have undergone a two-week training programme in mental health.

vii. The creation of the post of a psychiatrist in at least 50% of the districts within five years.

viii. A psychiatrist at the district level will visit all PHC settings regularly and at least once every month, for supervision of the mental health programme for continuing education. This programme will be fully operational in at least one district in every state and UT, and in at least half of all districts in some states within five years.

ix. Each state will appoint a programme officer responsible for the organisation and supervision of the mental health programme within five years.

x. Each state will provide additional support for incorporating community mental health components in the curricula of teaching institutions (within five years).

xi. On the recommendation of a task force, appropriate psychotropic drugs to be used at the PHC level will be

included in the list of essential drugs in India.

xii. Psychiatric units with in-patient beds will be provided at all medical college hospitals in the country within five years.

Evaluation of the works done in NMHP-

Though there are some overt and covert limitations and pitfalls could be seen in NMHP but to some extent it did some good works too. There is no doubt that it has been the guiding principle for the development of the mental health programme in India. This programme has been very much influential in the development of models for the integration of mental health with primary healthcare; the model of integrating mental health with primary health care started its journey with the establishment of two model projects in two places, namely Raipur Rani in the North and Sakalawara in South India. [13] The Indian Council of Medical Research (ICMR) developed a project as: "Severe Mental Morbidity Demonstration Project" where it has applied the model of integrating primary health care and mental health in four different centres of the country, namely, Kolkata, Patiala, Baroda and Bangalore. This experiment showed that about 20% of people with mental disorders could be given psychiatric treatment and care through the existing primary care. However, the population covered in this experiment was very small in comparison to the national need. In 1984 the NIMHANS, Bangalore had initiated the district model for mental healthcare was initiated by NIMHANS, Bangalore, in collaboration with the district administration and the director of health services, Karnataka. This approach of giving of community based mental health care to the people of rural and remote areas showed some promise and under this model about 2 million people were taken as the targeted people. Under this model those people were given mental health services through some primary health centres equipped with adequate and necessary mental health resources like 'professionals' and 'medications'. The existing staffs of those primary health centres had also given active services to the people. This model of mental health service delivery identified the practicability of a district mental health team initiating mental healthcare and became the precursor of the District Mental Health Programme (DMHP) which has been propagated later to serve the people of 25 selected districts in 20 states between 1995 and 2000. It is anticipated that in the Tenth Five Year Plan, it would be extended to 100 districts. In a way, India has both identified this as an approach as well as demonstrated its feasibility across many states and differing health systems.

However the goals of NMHP could not be fulfilled in an uniform manner in all states of the country because of few reasons:

- ### *Inadequacy of Fund-*

The goals of NMHP were too ambitious to begin with and not enough administrative and ministerial attention had been paid to all aspects of its implementation. The first and foremost barrier of NMHP is 'inadequate funding' or 'inadequate budgetary allocation'. Though the NMHP came into being in 1982, the subsequent three Five Year Plans did not keep adequate funding allocation for it. Further, even the funds allotted were not fully utilised. It was only in the Ninth Five Year Plan that a substantial amount of Rs 280 million was made available for and Rs. 1,900 million in the Tenth Five Year Plan. The availability of funds in 1995 for the district mental health programme has shown that once funds are available, states are ready to take up intervention programmes and professionals are keen to take up a wide variety of initiatives for integrating mental health with primary healthcare. But

whenever funds are not available every activity tends to become non-functional or under-functional.

- **Lack of Human Resources to cater the services to people-**

Indian mental health sector has been having some covert and overt challenges to implement some really beneficial, enduring and effective mental health programmes for the people. The main challenges to the health sector, especially the mental health sector are the extremely limited number of mental health professionals (about 10,000 professionals of all categories for one billion populations) and the very limited mental health service infrastructure (about 30,000 psychiatric beds for over a billion populations)

Undergraduate training in psychiatry has not been satisfactory in India despite application of some efforts in this direction, and this continues to be a major barrier to have adequately trained medical doctors in psychiatry after their basic training. The inadequacy of other mental health professionals like 'clinical psychologists', 'psychiatric social workers' and 'psychiatric nurses' is another barrier to successful implementation of NMHP. Most districts of the country do not have public sector psychiatrists. Some of the medical colleges do not have full departments of psychiatry, especially the government medical colleges. The lacuna of not having enough training facilities for training in clinical psychology, psychiatric social work and psychiatric nursing is also a major limitation of NMHP.

- **Not having contemporary and duly evaluated model of DMHP-**

The community care models developed in NMHP and subsequently DMHP have not been adequately evaluated, especially the DMHP. Its implementation between 1995 and 2000 continues to be one of extension services by professionals rather than true integration of mental health with primary healthcare.

- **Uneven distribution of the resources-**

Another major barrier is the uneven distribution of the resource across states and Union Territories. This uneven distribution spoils the goals of national level plan to be implemented in all the states and UTs uniformly.

- **Other barriers-**

Non-implementation of some suggestions and directives related to mental health given by different potential sources and showing reluctance to pay attention to the welfare of mentally ill people from the government and public sector agencies of some states and UTs is another barrier to successful implementation of NMHP. Though the Mental Health Act 1987 was very progressive, its non-implementation has been a major drawback. Specifically, the state mental health authorities have not functioned as they should have and the norms for licensing and maintaining standards of care have been insufficient.

Another major barrier is privatisation of healthcare in the 1990s. It is a well-known fact that globally the amount of money available for healthcare has decreased. In addition, India has the least amount of public funding for healthcare—more than 5% of its GDP is spent on health, out of which 83% comes from private, mostly out-of-pocket expenditure rather than from the public exchequer.

Other major challenges to the mental health sectors are: availability of very limited mental health service infrastructure (about 30,000 psychiatric beds for over a billion population); and problems of poverty (about 30% of population live below poverty line) and low literacy with associated stigma and discrimination for persons with mental disorders. [14]

The National Institute of Mental Health and Neurosciences (NIMHANS) have identified few potential barriers of District Mental Health Programme (DMHP) thus: [15]

i. Lack of motivation of the mental health professionals to deliver appropriate care and clinical services to the people.

ii. Having interpersonal problems among the professionals and persons engaged in mental health service.

iii. Lack of intersectoral and interdepartmental coordination.

iv. Lack of proper understanding about local culture, values, communication tune and poor skills to develop 'Information-Education-Communication' (IEC) materials for making the people aware about the mental illness and treatment.

v. Lack of leadership and man management skills.

vi. Inadequate monitoring and supervision skills to run a long term health project by various professionals.

Revised goals of NMHP in 2001

Thanks to some active participations made by some different groups and agencies of the country the level of common peoples' awareness related to mental disorders has been escalated remarkably. This process has also been fuelled by a tragic incident of 'burning alive of few chained mental patients at a rural mental asylum occurred at Erwady village of the state of Tamil Nadu. The responses from the various corners like public, press, planners, professionals and judiciary related to the Erwady tragedy were very positive and that surpassed the level of expectation. After this incident the Hon'ble Supreme Court India gave some verdicts to preserve the rights of mentally ill people and make the mental health service more efficient and far-reaching. In NMHP, nine plans of actions have been thought of to make the existing mental health service delivery system of the country friendlier to the people and more efficient in providing clinical and therapeutic services to the people. Those are:

1. Organising services
2. Community mental healthcare facilities
3. Support to families
4. Human resource development
5. Public mental health education
6. Private sector mental healthcare
7. Support to voluntary organisations
8 Promotion and preventive interventions
9. Administrative support.

Community Based Mental Health Service in India

The inspiration for the community mental health movement in India comes from three sources. The first source is the 'deinstitutionalization movement' which mentioned long-term treatment of severely ill mental patients in mental hospitals might be counterproductive and emergence of the concept of 'Social Breakdown Syndrome', of the patients who had been treated at mental hospitals for long-time. Due to this negative result of prolong hospitalization of severely ill mental patients alternative mode of care, i.e., community based treatment came into existence in western countries and later percolated in developing world including India.

The second source is the realisation that institution-based psychiatry through trained professionals can be very expensive and that countries like India will not have the sufficient manpower and facilities to deliver services through conventional methods, for many years.

The third source was the discovery of the fact that in poor countries para-professionals and non-professionals could, after undergoing simple and short training of mental health, deliver reasonably adequate mental healthcare. [16]

Community based mental health service in literary sense started for first time under the able leadership of Dr. Vidyasagar in late 1950s in Amritsar Mental Hospital. He involved family members in the treatment of mentally ill patients who were admitted to the Amritsar Mental Hospital. In 1975 NIMHANS opened up a community psychiatry unit with the following objectives:

- To start Primary Health Centre (PHC)-based rural mental health programme for the people who live in remote rural areas
- To start General Practitioner (GP)-based urban mental health programme
- Organizing school mental health programmes for improving mental health of the children and adolescents
- Arranging the provisions of home-based follow-up system of psychiatric patients
- Organizing psychiatric camps for people living in interior villages

Other notable community based mental health programmes taken up in India are "Bellary district mental health programme", "Raipur Rani prograame", etc.

The Indian Council of Medical Research (ICMR) did a prospective study to examine the ability of doctors and health workers to recognise and manage psychotics and epileptics at the PHC level. The study was carried out at four centres- Bangalore, Vadodara, Patiala and Kolkata. At each study centre, training was provided to the Multipurpose Workers (MPWs) to detect cases in the community and follow them up on the instruction of the doctors. Doctors were trained to diagnose as well as treat the cases with appropriate medication. The results showed that the knowledge about mental illness and treatment gained after training by the both doctors and MPWs was extremely good but their actual performance over the year was not so good. Only 20% of the actual cases were picked up by a few MPWs who were motivated; there were many who did not refer even a single case to the PHC doctors. Hardly any patient detected was followed up by the MPWs in the community. Most of those who went to the PHC doctor for follow-up treatment came on their own. Many patients preferred to consult the specialist staff in the research teams.

From this study the pitfalls of Indian community mental health service could be seen. There are many factors which are responsible for inadequate implementation of community mental health in India, those are:

 i. not considering the local cultural factors and belief systems
 ii. not including community people in the programme
iii. not making the community empowered to take some measures to promote their mental health status or solve the simple mental health related problem by their own
 iv. massive illiteracy and prejudices related to mental illness
  v. inadequate and irregular supply of psychotropic drug at community level
 vi. lack of an administrative structure to monitor the functioning and progress of the community mental health programmes

Role of Non – Governmental Organizations (NGOs) in Mental Health Promotion:
Non-Governmental Organizations (NGOs) which were identified as non-profit or welfare-oriented organizations have significant role to play in the field of mental health and mental health promotion. They can accomplish this task through advocating, providing services, and by doing a wide

range of researchers in different areas related to mental health. Most often they facilitate the mental health services in collaborations and partnerships with other agencies, either of government background or private background or both. The NGOs have been found to have higher accessibility of the professionals like academicians, technicians, clinicians, social workers, rehabilitation workers, remedial teachers and clinical and educational psychologists, so NGOs could make the best use of those professionals in mental health promotion. [17] The services provided by the NGOs can be broadly categorized as:

- Clinical care and rehabilitation services
- Community outreach programmes
- Developing support groups
- Professional and non professional training
- Advocacy and building awareness for public
- Research
- Networking between different agencies, government and community people.

CONCLUSION

Mental health service delivery system has not been found to be uniformly developed in India or even all regions of a particular country.

In India do not have specific mental health agendas or programmes to cater the mental health needs of the people. Keeping in view of the aforesaid issues following steps can be taken by the countries especially the developing countries like India to improve their mental health service infrastructure, thus

- Appropriate integration of mental health services into primary care is a viable strategy for increasing access

to mental health care in many developing countries.
- Appropriate training of primary care staff in the identification and treatment of mental disorders.
- The integration of mental health services into existing general health and social care programmes for providing care to vulnerable populations would be a useful strategy for overcoming resource constraints and increasing the reach of mental health services in developing world.
- Infrastructures of the regional referral general and super-speciality hospital could be used to provide the training and supervising skills to mental health workers and primary care worker in their respective regions.
- Professional organizations might be given the charge and responsibility of producing educational or training materials for mental health workers.
- Governments might provide subsidies to voluntary bodies for the purpose of providing mental health services to communities.
- It is also conventional for governments to establish contracts with institutions or individuals in universities for the monitoring and evaluation of activities in the field of mental health. In many instances this approach is more cost-effective than setting up research organizations in health ministries.

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