

Community-based mental health services in India: Current status and roadmap for the future

Внебольничные службы психиатрической помощи в Индии: текущее состояние и перспективы на будущее

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Short Communication

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ABSTRACT

An estimated 197.3 million people have mental disorders in India, and majority of the population have either no or limited access to mental health services. Thus, the country has a huge burden of mental disorders, and there is a significant treatment gap. Public mental health measures have become a developmental priority so that sustainable gains may be made in this regard. The National Mental Health Programme (NMHP) was launched in 1982 as a major step forward for mental health services in India, but it has only been able to partially achieve the desired mental health outcomes. Despite efforts to energize and scale up the programme from time to time, progress with development of community-based mental health services and achievement of the desired outcomes in India has been slow. Public health measures, along with integration of mental health services in primary healthcare systems, offer the most sustainable and effective model given the limited mental health resources. The main barriers to this integration include already overburdened primary health centres (PHCs), which face the following challenges: limited staff; multiple tasks; a high patient load; multiple, concurrent programmes; lack of training, supervision, and referral services; and non-availability of psychotropic medications in the primary healthcare system. Thus, there is an urgent need for a fresh look at implementation of the NMHP, with a focus on achieving sustainable improvements in a timely manner.

АННОТАЦИЯ

По оценкам, в Индии 197,3 миллиона человек страдают психическими расстройствами, при этом большинство населения страны или вовсе не имеет возможности обратиться к службам психиатрической помощи, либо его доступ к ним ограничен. Таким образом, в стране прослеживается колоссальное бремя психических заболеваний при наличии существенной разницы между общим числом случаев возникновения рассматриваемых расстройств и количеством людей, получающих необходимое лечение. Меры профилактики психических заболеваний среди широких масс населения стали приоритетным направлением развития, ввиду чего в данной области можно ожидать долгосрочных успехов. В 1982 году была запущена Национальная программа психического здоровья (НППЗ) – важный шаг вперед в области развития служб психиатрической помощи Индии, который, однако, лишь отчасти смог достичь желаемых результатов в соответствующей области. Несмотря на все усилия по ускорению и оперативному расширению программы, прогресс в развитии внебольничных служб психиатрической помощи в Индии оказался недостаточным, а желаемые результаты не были достигнуты. Меры общественного здравоохранения, наряду с внедрением служб психиатрической помощи в систему

первичной медико-санитарной помощи, предлагают наиболее устойчивую и эффективную модель с учетом ограниченных ресурсов специализированной психиатрической службы. Основным препятствием на пути такого внедрения является перегруженность центров первичной медико-санитарной помощи (ПМСП) и следующие проблемы, с которыми сталкиваются данные центры: ограниченное число персонала, чрезмерно широкий спектр задач, большое количество пациентов, одновременное проведение ряда различных программ, отсутствие профессионально подготовленных медицинских специалистов, надзорных и справочных служб и нехватка психотропных препаратов в системе первичной медико-санитарной помощи. Таким образом, существует острая необходимость в новом подходе к реализации НППЗ с фокусировкой на как можно более быстрое улучшение ситуации.

Keywords: *community psychiatry; India; low- and middle-income countries (LMICs); public health; mental health services*

Ключевые слова: *внебольничная психиатрия; Индия; страны с низким и средним уровнем дохода (СНСД); здравоохранение; службы психиатрической помощи*

INTRODUCTION

Estimates made by the World Health Organization (WHO) suggest that mental and behavioural disorders account for around 12% of the global burden of disorders.¹ It has been suggested that this may be an underestimation, considering the interconnectedness between mental illness and other socioeconomic conditions, especially in low- and middle-income countries (LMICs), which account for almost three quarters of the global burden of mental and behavioural disorders.^{2,3} An estimated 197.3 million people have mental disorders in India.⁴ Additionally, there is a significant treatment gap present in both developed and developing countries, with the vast majority of patients in LMICs lacking any access to treatment facilities for mental and behavioural disorders.² Thus, public mental health measures have become increasingly important and should be a development priority, especially in LMICs, including India.⁵ Progress in this regard can be assessed according to the following criteria: presence of an official mental health policy; programmes or plans for mental health; budgetary allocations; a dedicated mental health workforce; availability of essential psychotropic medications in primary care; increased treatment coverage; reduced suicide rates; and protection of the human rights of those who are mentally ill.³

HISTORICAL PERSPECTIVES OF COMMUNITY MENTAL HEALTH IN INDIA

Historically, in India, psychiatric patients have been cared for by family members in the community, in the absence of formal community psychiatric services. Community psychiatry barely existed in British India. The first psychiatric outpatient service, the precursor to present-

day general hospital psychiatric units (GHPUs), was set up at the R.G. Kar Medical College, Calcutta, in 1933, by Ghirindra Sekhar Bose. This was followed by similar set-ups in Bombay (1938) and Patna (1939). However, for both mental health and general healthcare, many people did not have access to Western medical institutions and relied either on the traditional sector or Western-trained private practitioners.⁶

The spread of community services can be traced back to the early 1950s in India. While there was a drive for deinstitutionalization in the Western world (based on the principle that humans have the right to be cared for in the community), institutionalization was not a major issue in India as there were few psychiatric beds available in hospitals.⁷ Thus, an important difference between the West and India, regarding development of community services, was that in India, this approach was supported primarily to make up for inadequate hospital-based services, rather than out of concern for human rights per se.

One of the earliest experimentations in community care (in 1952, before the advent of formal services) involved making provision for family members to stay with patients in tents on hospital premises during treatment, due to a shortage of available beds for admission to mental hospitals (an initiative instigated by Dr Vidya Sagar in Amritsar).⁷ In later decades, many new initiatives were introduced, which laid the foundations for community psychiatry in India. In 1964, a weekly community mental health service was started as part of the Comprehensive Rural Health Services Project (CRHSP), in Ballabgarh, by the All-India Institute of Medical Sciences (AIIMS), New Delhi. This was followed by establishment of two important

community mental health services in the late seventies. WHO funded the project at Raipur Rani in Haryana under the aegis of the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh. Further community mental health services were introduced in Sakalwada, Karnataka, under the aegis of the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore.⁷ These programmes were the forerunners of the National Mental Health Programme (NMHP) in India, which now includes community clinics in primary health centres (PHCs), supported by mental health professionals at district level, training of medical and multipurpose health workers, school mental health initiatives, home-based follow-up services by nurses and organization of psychiatric 'camps'.

NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

The National Mental Health Programme (NMHP) was launched in 1982 as a major step forward for mental health services in India. It had three key objectives, including ensuring the availability and accessibility of a minimum level of mental health care for all, encouraging the application of mental health knowledge in general healthcare and promotion of community participation in the development of mental health services. Despite this being a ground-breaking initiative, the initial phases of implementation of the programme were marred with difficulties. Various factors contributed to initial shortcomings like unrealistic targets; inadequate staff resources; inefficient administration; failure to develop indicators for addressing objectives; an inadequate emphasis on creating awareness among users; uncoordinated, fragmented efforts by various stakeholders; and inadequate budgetary support.⁷ Notwithstanding these flaws, one of the important achievements of the programme during its first decade was recognition of a district-based model for provision of mental health services, with satellite primary health centres (PHCs) providing mental health services (based in the Bellary district in Karnataka state).⁸ This district model was subsequently expanded to cover four districts. The programme was re-strategized in 2003 to include two schemes, namely 'Modernization of State Mental Hospitals' and 'Up-gradation of Psychiatric Wings of Medical Colleges/General Hospitals', to act as hubs, supporting mental health services in the community. The manpower development scheme (aimed at achieving

mental health human-resource sufficiency) became part of the programme in 2009. Under the first scheme, 15 existing mental hospitals/institutes/medical colleges were upgraded to start/strengthen courses in psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing. Under the second scheme, 39 departments in 15 government medical colleges/government mental hospitals were given support to start/increase their intake of students for postgraduate (PG) courses in mental health.⁹

DISTRICT MENTAL HEALTH PROGRAMME (DMHP)

The District Mental Health Programme (DMHP) forms the core of the mental health services available at community level. The DMHP was launched as an extension of the NMHP in 1996, building on the success of the Bellary model in Karnataka, based on the realization that mental health services should primarily be dispensed through existing primary health facilities as creation of a parallel infrastructure for mental health was not immediately feasible, considering the prevailing (severe) limitations of mental health infrastructure and manpower. Thus, existing staff in these primary health centres (PHCs), like doctors and paramedical workers, were trained to provide mental health services. The National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, provides medical officers with three months' training to equip them with the skills and knowledge necessary to treat psychiatric disorders at the primary level.¹⁰ There is also provision for referral services so that patients suffering from severe mental disorders can be directed to district hospitals.⁷ Table 1 lists the components of the DMHP.⁹

In the period up to 2002, the DMHP was gradually extended to 25 districts across 20 Indian states.¹¹ As of now, 241 districts (out of 718 districts in India)⁹ are covered under the scheme, and it is proposed that the DMHP be expanded to all districts in a phased manner. The population of various districts in India is highly variable, with a range from 0.008 million (in the least populated) to 11 million (in the most populated).¹² The average population of districts in India in 2019 was 1.86 million (as per the Indian census).¹³ The National Mental Health Survey (NMHS) 2015–16 found the overall weighted prevalence for any mental morbidity in India to be 13.7% over a lifetime (then averaging 10.6%) and that (at the time of the survey) there was a large treatment gap.¹⁴ This

Table 1. Components of the DMHP

District Mental Health Programme:	
Service provision: provision of mental health outpatient and inpatient mental health services, with a 10-bed inpatient facility	
Outreach component	<ol style="list-style-type: none"> 1. Satellite clinics: four satellite clinics per month at community health centres (CHCs)/ primary health centres (PHCs) by the DMHP team 2. Targeted interventions 3. Life-skills education and counselling in schools 4. College counselling services 5. Workplace stress management 6. Suicide prevention services
Sensitization and training of health personnel (at district and sub-district level)	
Awareness camps to promote awareness of mental illnesses and related stigma, through involvement of local Panchayati Raj Institutions (PRIs), faith healers, teachers, leaders, etc.	
Community participation	<ol style="list-style-type: none"> 1. Links with self-help groups, family and caregiver groups, and non-governmental organizations (NGOs) working in the field of mental health 2. Sensitization of enforcement officials regarding legal provisions for effective implementation of the Mental Health Act

translates into very high numbers of individuals requiring psychiatric services in these districts, which might be difficult to achieve even with universal coverage under the NMHP across all districts in India. Additionally, most of the population may have to bear the cost of out-of-pocket payments for mental health services as DMHP services with limited manpower may struggle to meet the mental health requirements of these populations, especially in overpopulated districts. Table 2 lists the manpower allocation for the DMHP.⁹

NATIONAL MENTAL HEALTH POLICY

A robust and comprehensive mental health policy is important to drive the growth of mental health services and systems.¹⁵ The National Mental Health Programme (1982) and the Mental Health Act (1987) provided the implicit policy directions for community and institutional mental health care in India until recently. India’s Mental Health Policy group was formed in May 2011. The National Mental Health Policy of India, entitled ‘New Pathways, New Hope’, was published by the Ministry of Health and Family Welfare, Government of India, in October 2014.¹⁶ The policy is inclusive in nature and incorporates an integrated, participatory, rights- and evidence-based approach, encompassing both medical and non-medical aspects of mental health. The strategic

Table 2. Manpower for the DMHP

S.No.	Manpower (on a contractual basis)	Number of positions
1	Psychiatrist	1
2	Clinical Psychologist	1
3	Psychiatric Nurse	1
4	Psychiatric Social Worker	1
5	Community Nurse	1
6	Monitoring and Evaluation Officer	1
7	Case Registry Assistant	1
8	Ward Assistant/Orderly	1

areas identified for action are as follows: effective governance and accountability; promotion of mental health; prevention of mental disorders and suicide; universal access to mental health services; enhanced availability of human resources for mental health; community participation; and research, monitoring and evaluation. It stresses delivery of mental health services within the existing healthcare system, using the primary healthcare approach, based on principles of universal access, equitable distribution, community participation,

intersectoral coordination and use of appropriate technology. It also recognizes that these services should be comprehensive and should address the needs of persons with mental illness, their care providers and healthcare professionals.

LEGISLATION

Dedicated mental health legislation legally reinforces the goals of mental health policies and plans.¹⁷ Legislation is also important to prevent abuse and violation of the rights of patients with mental illness. As early mental health legislation was primarily drafted to safeguard the public from dangerous patients (by isolating such patients), the welfare of the patients themselves was always a secondary consideration. As a paradigm shift has occurred globally, towards a more rights-based approach for persons with a disability, including a mental disability (e.g., UNCRPD, 2006),¹⁸ the same principle is reflected in mental health legislation (i.e., the Mental Healthcare Act) (MHCA 2017), which superseded the Mental Health Act (MHA 1987). The new act is progressive and rights-based, but it mainly focuses on the rights of persons with mental illness during treatment in hospital, with limited discussion of the continuity of treatment in the community and the role of the family and community in management of individuals with mental illnesses.¹⁹

The MHCA 2017 has been criticized for failing to address Indian cultural sensitivities related to the involvement of families in treatment decisions.¹⁹ Families are a key resource for management in Indian society due to the cultural tradition of interdependence, and treatment teams also depend heavily on the active involvement of family members.

Mental health legislation must engage and work in tandem with legislation for people with disabilities, e.g., the Rights of Persons with Disabilities Act, 2016²⁰ and the National Mental Health Policy of India (2014).¹⁶ The Rights of Persons with Disabilities Act, 2016 includes mental illnesses, and it stresses full and effective participation and inclusion in society, non-discrimination, accessibility, equality of opportunity and protection of the rights of individuals with disabilities.²⁰ In LMICs (including India) where most people live in poor socioeconomic conditions, greater benefits and welfare measures like job preservation and housing schemes for patients with mental illness are needed.

OTHER APPROACHES TO COMMUNITY MENTAL HEALTH IN INDIA

Other significant approaches to community mental health in India include the camp approach, school mental health, NGO initiatives, media-based interventions, and telephone helplines.

There has been a long tradition of the camp approach for people living in remote areas with limited access to health services. The duration of these camps can vary, but most usually remain for a day in areas accessible by car or several days in places with limited access by road. The camp approach has been used to treat a range of mental health conditions (including addictions) and has also been utilized in times of natural disasters.⁷

Initiatives in school mental health have included a life-skills education programme for children and adolescents, with sensitization training for schoolteachers, focused on mental health problems prevalent in children and adolescents.

Non-governmental organizations (NGOs) have been engaged in delivering mental health services with innovative models, to address the needs of local populations. There is also provision within the National Mental Health Programme (NMHP) for state governments to execute activities relating to mental health in partnership with non-government organizations/agencies.⁹

IMPACT OF COMMUNITY MENTAL HEALTH SERVICES

The availability of studies considering long-term trends in prevalence rates of various psychiatric disorders in the Indian population is limited. These studies provide indirect and limited information about the performance of various mental health initiatives which have been implemented in the Indian population over previous decades. Early epidemiological studies in India reported variable prevalence rates for psychiatric conditions, thus impacting on planning, funding, and delivery of mental health care facilities.²¹

The National Mental Health Survey (NMHS) 2015–16 suggested that the overall weighted prevalence for any mental morbidity in India was 13.7% over a lifetime and 10.6% at the time of the survey.¹⁴ It also found a very high treatment gap of between 70% and 92% for different disorders, including 85% for common mental disorders, 73.6% for severe mental disorders and 75.5% for psychosis, among others.¹⁴ There have been suggestions

about an increase in the crude prevalence and disability-adjusted life-years (DALY) rate for depressive disorders, anxiety disorders, bipolar disorders and schizophrenia in India between 1990 and 2017, and a doubling of the proportional contribution of mental disorders to the total disease burden in India in the same period.⁴

Thus, despite the initiatives implemented to improve mental health services in India, minimal improvements have been seen at ground level. The factors contributing to this are the high treatment gap, poor implementation of mental health services, gender differentials in treatment and poor evidence-based treatments.²²⁻²⁶

ROADMAP FOR THE FUTURE

Budgetary Considerations

One of the primary reasons for the initial shortcomings following launch of the National Mental Health Programme in 1982 was the shortage of allocated funds. Lack of a designated budget for mental health within a nation's health budget is a major impediment to service development.²⁷ Another major difficulty which has been seen in India is under-utilization of allocated funds²⁸ because of multiple factors, ranging from difficulty in employing mental health manpower to an inability to execute infrastructure projects in a time-limited manner. 'Redtapism' and lack of a coordinating nodal agency can also be a major hurdle in the timely execution of projects.

Funds allocated to the NMHP have decreased significantly in recent years, and this is a matter of concern. The Union Budget of India 2021-22 set a corpus sum of 712.69 billion Indian Rupees (INR) for the health budget, including 5.97 billion INR for mental health. Only 7 percent of the allocated amount for mental health has been earmarked for the NMHP.²⁹ By way of comparison, the budget allocation for the NMHP in 2010 was 0.44% of the total budget allocated to the Ministry of Health and Family Welfare, but this was reduced to 0.06% in 2020. Moreover, another major cause for concern is that major cuts have been made in the revised NMHP budget estimates in recent years. For example, in 2018-19, the allocated amount of 500 million INR was slashed to 55 million INR, and in 2019-20, the allocated amount of 400 million INR was slashed to 50 million INR.³⁰ Thus, underfunding continues to be a major barrier, contributing to slow gains under the NMHP.

Hence, ring-fencing allocated funds to be used exclusively for mental health services, along with a nodal agency to ensure this, may go a long way towards ensuring proper utilization of funds allocated for mental health.³¹

Mental Health Service Delivery

The recommendation to deinstitutionalize mental health and to adopt a primary health model for service delivery has been longstanding.³² While institutionalization has been seen as a major challenge in the West since adoption of a rights-based approach to mental health, this has not been the case in India, along with other LMICs.⁷ Direct adoption of the same approach in LMICs (including India) may not necessarily have similar desirable effects on overall service provision in these countries as they already have a dearth of mental health resources. However, existing mental hospitals and institutions can serve as referral centres in the management of patients with severe mental illnesses, especially where there is insufficient social support and for medicolegal cases,³³ while the transition to predominantly community-based services is being planned and implemented. The current policy of strengthening and upgrading existing mental hospitals to 'Centres of Excellence', along with provisions for strengthening of the mental health training being incorporated into the National Mental Health Programme, will provide the essential building blocks for successful community-based services as envisioned.⁹ However, periodic reappraisal of the goals set, achievement thus far and course corrections is essential, and the mechanisms ensuring this must be built into the programme to prevent skewed development. In recent years, the overall scope of mental health services and a significant reduction in stigma have been achieved, but this comes with the caveat that these services are essentially concentrated around urban and semi-urban areas.

Mental Health Workforce

Factors contributing to the shortage of mental health professionals in LMICs (including India) are urban concentration, a preference for private practice and the brain drain.^{1,5} There is an acute shortage of mental health professionals in India, with two mental health workers and 0.3 psychiatrists per 100,000 population, which is a major limiting factor when it comes to planning mental health services for communities.³⁴ Retaining

mental health professionals is an even greater challenge, along with ensuring their equitable distribution. Minimizing the brain drain and retaining professionals in the public sector must be afforded a high priority by means of financial incentives, favourable working conditions, and provisions for career advancement.³⁵ At the same time, efforts should be made to ensure that enhanced training capacities are adequately utilized by ensuring equal professional opportunities for trained personnel. It is envisaged that, in the District Mental Health Programme, existing manpower will be trained in PHCs (like doctors and paramedical staff) and equipped with the skills and knowledge necessary to provide mental health services. Non-specialist health workers contribute to service delivery and play an important role in detection, diagnosis, treatment, and prevention of common and severe mental disorders as part of a complex stepped-care approach. There should be better provision for their in-service training to enable them to deliver effective services to the general population.³⁵

Another important approach to improving service provision for the general population is to improve psychiatry education and training at the level of undergraduate medical courses.³¹ The ability to independently diagnose and treat mental disorders and make appropriate referral decisions will improve service provision on a much wider scale, with visible improvements.

Mobilization of Community Resource

In many LMICs, including India, faith healers, religious leaders and practitioners of alternative systems of medicine are often the first point of contact for patients with psychiatric disorders, rather than mental health services.³⁶ Efforts must be made to educate and sensitize this subgroup of the population about the importance of seeking a professional diagnosis and undergoing appropriate treatment (with regular follow-up), supported by better delivery of mental health services in the community. Some services can be sought as time-limited interventions (like camp services), which can mobilize large numbers of people in a limited time, in remote areas. Community campaigns to increase awareness about psychiatric illnesses and decrease the associated stigma should also be prioritized as stigma and discrimination against people with mental health problems are important barriers to identification

and treatment of mental disorders.³⁷ Family members are essentially the primary caregivers in most LMICs, including India, and can contribute to detection, treatment-seeking, and management of family members with mental disorders.³⁵

Integration with Primary Care

Currently, integration of community mental health services with primary healthcare is the most viable method to provide mental health services in most LMICs, including India, but significant shortcomings still exist in terms of achieving this goal.³⁸ The main barriers to integration include the following: already overburdened PHCs with limited staff; multiple tasks; patient load; multiple concurrent programmes; lack of training, supervision and referral services; and non-availability of psychotropic drugs in the primary healthcare system.³² In this context, alternative mechanisms for programme delivery, like the National Health Mission (which subsumed the National Rural Health Mission and National Urban Health Mission in India), should be considered. It has also been suggested that mental health care should be integrated with better performing services for other chronic conditions or, alternatively, with other systems like social care or education.³⁹

Mental Health Research

The WHO's Mental Health: Global Action Programme envisages multidimensional research efforts in LMICs to improve the mental health situation.⁴⁰ There is a wide gap between research efforts focused on developed countries and those focused on LMICs (in terms of mental health), and this divide has not decreased over time.⁴¹ Furthermore, research does not seem to have had an impact on the policy and practice of mental health due to a disconnect between researchers and communities.⁴² Attention needs to be focused on a systemic approach in order to debate the relevance of research questions, with the involvement of all stakeholders at appropriate levels (including policymakers, practitioners, advocacy groups and the community at large), and to generate resources and funds for this.⁴²⁻⁴⁴

CONCLUSIONS

Although progress has been slow in development of community-based mental health services and achievement of the desired outcomes in India, the

importance of these cannot be understated. India has a huge burden of mental disorders and a significant treatment gap.^{2,4} Public health measures, along with integration of mental health services in primary health systems, offer the most sustainable and effective model for LMICs with few resources, including India. Despite the National Mental Health Programme having been in effect since 1982, it has only been able to partially achieve the desired mental health outcomes.⁸ It is important to continuously assess performance with independent audits and periodic reviews in order to identify problems at the earliest and initiate corrective measures.⁴⁵ Thus, there is an urgent need to take a fresh look at implementation of the programme, with a focus on achieving sustainable improvements in a timely manner.

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