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Review

The context of formulation of India's mental health program: Implications for Global Mental Health

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ABSTRACT

India, among the low- and middle-income countries, in the 1980s, made an early attempt at formulating a mental health program. India's National Mental Health Program (NMHP) intended to attend to the mental health needs of all her citizens. Some aspects of this program bear significant resemblance to what recent experts in global mental health (GMH) have been proposing. The paper uses India as a country-level example to review and critically analyze the contextual background culminating in the formulation of the NMHP. Literature searches from two bibliographic databases (PubMed and Google Scholar) with supplementary searches and manual search from Indian Journal of Psychiatry were made relating to the context of formulation of India's NMHP. The search helped isolate 12 peer reviewed journal articles, three chapters from books, and one policy group approach paper. This literature has been synthesized to enumerate the various contextual factors. The present analysis identifies two vital factors relevant for international health, viz. the primary health care movement and the changing concepts of institutional care/de-institutionalization in mental health. This then puts in perspective the opportunities allowed and challenges produced, for NMHP, by subsequent changes in public health services in India. The lessons for GMH movement are then pointed out.

Contents

1. Introduction

India was among the first few in the league of low and middle-income countries (LMIC) to have formulated a national program for mental health. The National Mental Health Program (NMHP) was launched in 1982 with a pilot program in *Bellary* district of Karnataka, India. Since then this district model (often referred to as the 'Bellary model') has been attempted to be expanded to various districts (the basic territorial unit of administration) throughout the country but with limited success (Mental Health Policy Group, 2012). Some of the strategies for mental health services under NMHP have been described to have similarities with that of the Global Mental Health (GMH) movement (Jacob, 2011). Such as, the use of primary health care infrastructure for the delivery of mental health care, use of para-professionals/non-specialist health workforce for task-sharing/shifting and most importantly both cite the vital role of community participation. Considering the particular focus of GMH movement for the LMIC and India's special position due to the national government's early attempt at planning mental health care for its vast population, it becomes pertinent to learn from this country-level example.

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2. Methods

The concern of this paper is the contextual background culminating in the formulation of the NMHP. An understanding of the context in such public health tasks helps to exemplify relevant political and economic processes in a society. This helps in identifying opportunities and barriers for policy reform (Haider and Rao, 2010). Using this conceptual background the present attempt is to explicate such factors in the formulation of India's NMHP that will also help to refine strategies for mental health care not only in India but also provide directions for GMH.

For this task a literature search was conducted on internet databases (PubMed and Google Scholar) using the following keywords; '*mental health program*', '*National Mental Health Program*', '*NMHP*', '*District Mental Health Program*', '*DMHP*', '*community psychiatry*', '*community mental health program*', '*mental health services*'. The search was restricted to literature on 'India'. All English-language literature till April, 2013 was considered for the search. Supplementary searches (reference checking, Internet searches and relevant policy documents) were also made. In addition, an extensive manual search of issues of the Indian Journal of Psychiatry (the official publication of Indian Psychiatric Society) was also conducted.

A detailed assessment of each abstract and (or) article, policy document and chapters from books were done to include only those that dealt with the context of formulation of the NMHP. Those describing only mental health services or only its evaluation were excluded. This resulted in inclusion of 12 peer reviewed journal articles, three chapters from books, one policy group approach paper (Duplicate publications, e.g. chapters from books that were previously published as journal articles, were excluded).

3. Results

On the contextual factors contributing to the formulation of NMHP, seminal analyses (Isaac, 2011; Jain and Jadhav, 2008) have pointed towards a few important influences. Others (Srinivasa Murthy, 2011) have avoided such analysis and projected that the Government of India (GoI) by some mysterious way felt the need to evolve a national plan for mental health care.

Most of all papers were important analysis and commentaries authored by influential practitioners of NMHP (e.g., R. Srinivasa Murthy, Mohan Isaac, R.L. Kapur, S.C. Malik). Another set of study (Jain and Jadhav, 2008, 2009) traced the 'cultural' history of NMHP through interviews with Indian mental health professionals, and analysis of policy document and published literature.

The following sections of this paper first enumerates the different factors reviewed from literature, then points out among these factors some crucial issues which have global relevance, and finally discuss with it the opportunities and challenges provided by the context for the formulation of NMHP. This then is proposed to be used as a case to understand pertinent aspects of mental health practice for the GMH movement.

3.1. The context of NMHP

As a concern for the task that is charted out above, the contextual factors on NMHP have been arbitrarily categorized as international and national issues. The following factors have been relevantly enumerated in two seminal papers (Isaac, 2011; Jain and Jadhav, 2008) with further elaboration from pertinent literature.

A major international influence was a set of recommendations titled '*The organization of mental health services in developing countries*' by an expert committee of the World Health Organization (WHO, 1975). This report indicated the integration of mental health in primary health care (PHC) services and delegation of this task to trained local health workers. The report provided impetus for organization of such services for India and some other developing countries of Southeast Asia, Africa and Latin America (Srinivasa Murthy, 1998). It also influenced the decision-making in developed countries (Sartorius, 2011).

Another factor (and a more important one for this analysis) was the Alma Ata declaration in 1978 on PHC (Nizamie and Goyal, 2010). This also contextualized the former 1975 WHO report (Jain and Jadhav, 2008). The influence of Alma Ata declaration on NMHP was also evident in a 1981 editorial by the then editor of the Indian Journal of Psychiatry (Sethi, 1981). While general concepts relating to health care services in this era were radically rethought (elaborated shortly), elementary understanding projected it as essentially an approach to the provision of *basic* health services in developing countries (Isaac, 2011).

At the national level an important development was the setting up of Community Psychiatry Unit at the National Institute of Mental Health and Neurosciences, Bangalore, India in 1976 with a field site at *Sakalwara* village to develop a model of rural mental health services. This was supported by the GoI. The unit had also launched other experimental programs, viz. an urban program of training general practitioners on common mental disorders, school program of training teachers to identify emotional problems in children and counsel them, program for home-based monthly follow-up of psychiatric patients by trained nurses and finally psychiatric camps (Kapur, 2004).

Shortly after the *Sakalwara* project, in 1975 WHO launched a multi-country project for extending mental health services into the community (Sartorius and Harding, 1983), as a response to the 1975 WHO expert committee report. A part of this was the *Raipur Rani* project in (a block of Haryana district of) India, set up at the Post-Graduate Institute of Medicine, Chandigarh, India (Wig et al., 1981). Six other countries – Philippines, Brazil, Colombia, Egypt, Senegal and Sudan – were involved in this study, from 1975 to 1981. The project involved research on the efficacy of available general health service workers in the identification and treatment of 'priority' psychiatric conditions.

The final and the most debated of influences was the Indian Council of Medical Research–Department of Science and Technology (ICMR–DST, 1987) collaborative project on 'Severe Mental Morbidity' funded by the GoI. This was a four center collaborative study [one each from the South (Bangalore), North (Patiala), East (Calcutta) and West (Baroda) of the country] to evaluate the feasibility of training Multipurpose Health Worker (MPWs) to provide mental health care as part of their routine work, backed by appropriately trained doctor at the primary health center. This study has been described to be one of the most exhaustive studies that prospectively evaluated the performance of the PHC team (Kapur, 2004). Though experts differ on whether this study had actually influenced the operationalization of the NMHP (Isaac, 2011; Kapur, 2004), the findings of the study show that the MPWs could identify only 20% of the actual cases of which, next to none were followed up in the community (Isaac, 1988). In addition, no mental health education programs could be organized by the primary health center staff despite it being one of the objectives of the project. The influence of PHC personnel on the community was poor, so was the record keeping and the MPWs lacked motivation for the task (Kapur, 2004).

4. Discussion

4.1. Reworking the context

In the consideration of the author two vital sets of conceptual changes at the global level converged at the specific period when the NMHP was formulated exemplified by the aims conceived in