Reflecting on the Journey of Development of Mental Health Programmes in India: From Paper to Reality

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ABSTRACT

This review paper traces the impact of structural changes concerned with the increasing rate of mental illnesses in India and its subsequent developmental changes, most notably the National Mental Health Programme (NMHP) launched by the Government of India in 1982. Mental illnesses are considered taboo in Indian society and treated with feelings of shame and embarrassment. WHO reports that there is a deficit of mental health professionals which restricts providing adequate help to those who require it. The Government of India has devised a new bill for mental health - National Tele-Mental Health Programme. This paper seeks to document the chronological development of the mentioned programmes and its limitations while providing guidelines for future policies.

Keywords: *National Mental Health Programmes, Mental Health Policies, Tele-Mental Health Programme, Limitations, Future Recommendations, Awareness, Stigma.*

1. Introduction

The term Mental Health is defined by the World Health Organisation (WHO) as, a "state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Mental Health is thus an important aspect that aids in a healthy and functional living of an individual in society.

Therefore, exceptional efforts are taken by the government to provide its citizens with numerous health care plans and policies which help in the betterment of its individuals and ultimately the betterment of the country. In a country with a humongous population such as India, there is a dire need for mental health programmes.

Furthermore, there is a need for more programmes to be made and implemented adequately and appropriately, beginning with spreading awareness and strengthening skilled manpower regarding the same. Statistical data from various research suggests that India as of 2020, requires 54750 mental health professionals whereas 7048 mental health professionals are available (Constantin, Elena-Teodora & Fonseca, 2020).

There were a lot of efforts implemented in order to enhance the mental health of Indians. It was first documented in 1975 in "Strategies for extending mental health care" study, which was later followed by a number of prominent mental health care programmes and related activities promoting the same, namely: 1982's National Mental Health Programme; NGO's grew in popularity which had later bypassed government's primary care centres, 1996's District mental Health Program; 2001's castigation of institutional care for inhumane treatment of the patients in the psychiatric ward, 2005's launch of Mental Health Policy by WHO; 2007's UNCRPD (United Nations Convention Rights of Persons with Disabilities) to include and give equal rights, treatment, and opportunities to people with mental disability like any other disability; 2007 to 2012's restructuring of the NMHP, 2012-2017's special direction to pay special attention to psychiatric care of marginalised and vulnerable sections of the Indian population; 2013's national mental health plan 365; 2014's National Mental Health Policy; 2017's review of Mental Health Care act in concordance with WHO's UNCRPD, and finally 2022's launch of National Tele-Mental Health Program in order to provide affordable and accessible virtual counselling and therapy in the present COVID-19 scenario.

This paper provides the reader with an insight into the overall development of the programs to give a better understanding of these facilities from both the receiver and provider's ends, with an exclusive focus on the implications of these policies on paper versus reality. In addition, the authors have put forward their views on visions for a better future, recommendations for better mental health care facilities, and suggestions on improving the present policies.

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2. Timeline of Notable Policies

2.1 1975-1981

The World Health Organization's Mental Health Division aimed to create national programmes for mental healthcare. An expert committee meeting was held in Addis Abeba in 1974 during which WHO emphasized the organization of mental healthcare services in developing nations. Following this, the "Strategies for Extending Mental Health Care (1975–1981)" initiative was started in seven countries - Brazil, Colombia, Egypt, India, Philippines, Senegal, and Sudan - to put the recommendations into practice.

Decentralizing mental health treatment received technical backing from the experiences of Bengaluru and Chandigarh psychiatric centres. The research from these two centres showed how many people lack access to necessary mental health care and the effects this has on sick people, their families, and the community. Additionally, the two institutes' work showed that it is possible to combine mental health with general healthcare. The two centres created numerous manuals and training resources. These initiatives served as stepping stones for the development of the NMHP in 1982.

2.2 National Mental Health Programme (1982)

A key turning point in the nation's growth of providing mental health care services was the creation of the NMHP in 1982. In seven countries, the WHO's "Strategies for extending mental health care" study used primary-level health workers to deliver mental health care. Raipur Rani, in northern India, was one of the sites (1975–81). It inspired the formation of a small task force committee that prepared the National Mental Health Programme (NMHP) which was later adopted in 1982. They piloted a district-level project in Karnataka's Bellary district. At the same time, the NMHP requested that each state "operationalise a programme in at least one district in their State." As a result, NGOs grew in popularity in order to fill the void in mental health care. They created a number of novel models, including rehabilitation and advocacy, which relied on a diverse group of experts and bypassed government primary care centres.

2.3 District Mental Health Programme (1996)

The District Mental Health Program (DMHP), which began in 1996, benefited from this. The program emphasised community care as an important component in integrating tertiary, secondary, and primary care. Institutional care was condemned by the human rights movement as violations of human rights at psychiatric and religious institutions have been uncovered by the media and human rights advocates in 2001 and during a review of mental institutions by the Supreme Court.

2.4 National Mental Health Policy (2000-2010)

The primary focus of the ninth and the tenth five-year plan was to increase the gross domestic product of the country. The Ninth five-year plan had primarily focused on improving the GDP of the country as a means of eradicating poverty and facilitating a better quality of life. This plan had included several clauses, clause 1.33 to clause 1.41, under the title, 'Areas of Special Importance of State Intervention' which had directly affected the quality of life for citizens; as it had aimed for the betterment of the physical and eventually the psychological health of an individual. The Xth five-year plan had allocated a budget of Rs 139 crores to NMHP with an aim to extend the District Mental Health Policy (DMHP) to 100 districts (Khurana, 2016). The areas that this plan had focussed on are: "widening the scope and exposure of psychiatry in the curriculum for undergraduate training and internships, spreading awareness pertaining to the DMHP in India, strengthening mental healthcare authorities, streamlining and updating mental hospitals to avoid custodianship, appointing MO state headquarters, research and training in the field of community mental health, substance abuse and child/ adolescent psychiatric clinics" (Khurana, 2016).

2.5 Mid-term Evaluation by National Institute of Mental Health and Neuro Sciences (2003)

The National Institute of Mental Health and Neuro Sciences (NIMHANS) conducted a mid-term evaluation in 23 districts in 2003. The review depicted a positive result in the following areas: early detection of mental diseases, geographical ease for the availability of mental health services and a decrease in the caseload at mental health hospitals. Simultaneously, the Government of India faced a shortage of funds, skilled and appropriately trained manpower and support and monitoring systems. This was later followed by an independent evaluation by the Indian Council of Marketing Research in 2009. It highlighted issues related to funds; "chiefly its underutilisation and delay in accessibility, and training; chiefly inadequate training, the availability of drugs, adequate setup for treatment, lack of community involvement, poor awareness programs, and lack of monitoring and implementation system" (Gupta, 2018).

2.6 Mental Health Policy, Plan and Program, WHO (2005)

WHO as one of the policymakers and planners of the Mental Health policy laid down detailed guidelines on the process of development and execution of this policy through various plans and programs. Additionally, in order to realise the goals of the Mental Health policy of the country, it was further supplemented with a guide on the journey for parallelly developing required legislations and policies.

2.7 UNCRPD - United Nations Convention of Rights for People with Disability (2007)

It aims to include all of the population, including the physically and mentally disabled individuals now known as the 'specially abled'. This was to be attained by promoting and ensuring human rights and freedom for all of the PWD (People With Disability) further by obligating its members to take appropriate, adequate and legislative measures. The NMHP (2014) of India is in accordance with the UNCRPD, providing 'right-based care' for PWMI (People With Mental Illness). 'Right-based care' is concerned with the following areas: equity, justice, quality, and participatory care. Furthermore, it has ensured that mental health care services are provided to PWMI in a de-stigmatising manner to promote the social integration of disabled individuals.

2.8 NMHP in the XIth Five Year Plan (2007-2012)

The National Mental Health Programme was re-structured as proposed in the XIth Five Year Plan to include several more components such as expanding the District Mental Health Programme (DMHP) to 123 districts in 30 distinct states and union territories, Manpower Development Schemes, improving and upgrading psychiatric wings of medical colleges and hospitals under the state government, fund training and research, monitoring and evaluation, and IEC (Information, Education and Communication) activities. (Khurana & Sharma, 2016) The DMHP was revised to accommodate new patterns such as "life skills education, counselling in schools, and colleges, stress management in workplaces, and suicide prevention services" (Khurana & Sharma, 2016). The Manpower Development Scheme aimed to overcome one of the biggest hurdles to providing mental healthcare to the Indian population, that is, a severe lack of manpower (Khurana & Sharma, 2016). This scheme focused on improving the training of mental health professionals through two sub-schemes: Centers of Excellence (Scheme A) and Setting up or Strengthening PG Training Department of Mental Health Specialties (Scheme B).

2.9 NMHP in the XIIth Five Year Plan (2012-2017)

The NMHP was redirected to focus more on psychiatric care and mental health of marginalized and vulnerable sections of Indian society. Certain issues have been recognized as the focal point for this policy such as "senior citizens suffering from severely disabling diseases, victims of child sexual abuse, marital/domestic violence and dowry-related ill-treatment, rape and incest, children and adolescents affected by maladjustment problems. ADHD, suicidal behaviour, victims of poverty, abandonment, natural or man-made disasters, etc." (Khurana & Sharma, 2016). The DMHP was extended to the remaining 161 districts whilst pursuing the implementation and completion of previous objectives stated under the XIth Five Year Plan. Following the prescribed goals and objectives of the NMHP and DMHP under the XIIth Five Year Plan, there have been several efforts to make mental healthcare more accessible to marginalized sections of the Indian population such as "outreach services, stress management in workplaces, awareness campaigns, 24/7 helpline number for emergency mental health services, development of MHIS (Mental Health Monitoring System), standardized training for mental health professionals, and extending IEC activities, etc." (Gupta & Sagar, 2018)

2.10 National Mental Health Plan-365 (2013)

The National Mental Health Plan or MHAP-365 described the duties and responsibilities of major stakeholders ranging from "the union GoI, the governments of states/ union territories, local bodies including municipalities and Panchayati raj institutions, civil society organizations, PWMI, medical and health-care providers, medical colleges, academic and research institutes, schools, and colleges, private corporate sectors, and finally, media." (Gupta & Sagar, 2021)

2.11 National Mental Health Policy (2014)

The National Mental Health Policy (NMHP policy) launched by the Government of India launched in 2014 aimed to promote mental health, enhance recovery from mild and severe mental illnesses, spread awareness about the stigmatization of mental health, provide accessible and affordable mental healthcare to people, and promote preventative care. Some of its objectives are: "To provide universal access to MH care, to increase access to MH services for vulnerable groups, to reduce the prevalence and impact of risk factors associated with MH problems, to reduce the stigma associated with MH problems, to enhance availability and equitable distribution of skilled human resources for MH, etc." (Gupta & Sagar, 2021) At the time, the NMHP policy was criticized because the general public could only avail its benefits if the multiple stakeholders dedicated themselves to the cause and complied with the legislation imposed on them. More importantly, execution of such policies at the ground level is extremely crucial, however, a lack of trained manpower, mental health professionals, culture-specific programs, dearth of financial resources, and stigmatization of mental health prevents the successful implementation of the same.

2.12 Mental Healthcare Act (2017)

The Mental Healthcare Act of 2017 was reviewed in concordance with the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) to include the latest recommendations. This act is largely concerned with upholding equal rights for people afflicted by mental illnesses; ensuring that every individual has the freedom to make decisions for themselves in terms of receiving psychiatric care. Therefore, this act described every Indian

citizen's right to access mental healthcare services and the patient's autonomy to make decisions for themselves regardless of the potential risks involved. Three tools- "Advance directives, Nomination of representatives, and Supported decision-making" (Namboodiri, George & Singh, 2019) - have been utilised to uphold the patient's autonomy and dignity.

2.13 NMHP Under the Union Budget (2021-2022)

The Union Budget (2021-2022) proposed INR 5.97 billion for mental healthcare. Only 7% of the total budget has been set aside for NHMP whereas a majority of the funds have been allocated to major institutes such as NIMHANS, Bengaluru, and Lokpriya Gopinath Bordoloi Regional Institute of Mental Health, Assam. This decision was met with a lot of criticism as a huge chunk of the budget has been allocated to organizations rather than the NMHP which works at the district level. People's access to affordable mental healthcare was further hampered due to a lack of funds reserved for community outreach and wellbeing programmes.

2.14 National Tele-Mental Health Program (2022-2023)

Nirmala Sitharaman, Union Finance Minister, unveiled the "National Tele-mental Health Program" while announcing the Union Budget for 2022-2023. She expressed her concern about the exponential growth of mental health problems and illnesses amongst every age group in India during this pandemic. People have been experiencing heightened anxiety, depression, mood swings, and distress due to Covid. This national tele-mental health program aims to provide a network of mental healthcare centres that offer counselling services. These 23 mental health centres will operate under the National Institute of Mental Health and Neurosciences (NIMHANS) and IIIT Bangalore will provide technological support.

Tele-mental health refers to the usage of tele-communication services to disseminate counselling and care services for mental health issues. It is an effective tool for people who are experiencing distress, PTSD, depression, anxiety, etc. These virtual mental health centres close the gap between therapy and people who cannot gain access to physical counselling services. However, there are certain crucial drawbacks such as lack of network connections, high costs, lack of privacy, and access to technology. India's tele-mental health programs aim to provide free mental health services to people, thus, overcoming one of the many barriers to virtual therapy and counselling. Effective implementation of virtual counselling is the first step towards actually providing free and standardized mental healthcare to the general public.

3. Limitations of Previous Policies

The NMHP hasn't been tailored to the needs of the Indian population. It lacks culture-specific and geography-specific actions and programmes because it is based on universally applicable policies put forward by WHO. Universally applicable policies cannot be implemented as it is without tailoring them to the needs of the Indian population. Instead of creating plans for general mental health awareness, future policies should focus more on concerning issues such as the high student suicide rate in India, lack of awareness about autism, ADHD, schizophrenia, and rising rates of depression and anxiety especially due to the pandemic, harbouring deep prejudices that lead to violence, etc. There is also a considerable lack of community-based or community-driven rehabilitation programmes that harness the spirit of togetherness and unity of the Indian subcontinent. Indian culture is bound by values such as perseverance, discipline, resilience, charitability, respect for oneself and others, and maintaining close ties with each other. Inculcating these virtues in community outreach and well-being programmes can aid in the de-stigmatization of mental health and illnesses.

Additionally, a critical lack of funds allocated for ground-level community rehabilitation centres, well-being programmes, and small institutions hinders the development and effective implementation of mental health policies and related programmes. More importantly, inadequate leadership and lack of motivation hinder the development of affordable and accessible mental healthcare, especially for marginalized and vulnerable sections of the Indian population. The time gap between the launch of an initiative and its proper implementation is considerably large such that effective changes do not take place immediately and people are unable to avail the benefits of mental healthcare schemes.

There is a visible lack of proper infrastructure and necessary medical technology that prevents people with mental illness (PWMI) from receiving effective care in rehabilitation centres, mental institutions and psychiatric wards in hospitals as well as educating aspiring psychology students. Institutions and organizations must take the onus to develop technology to meet the demands of the Indian subcontinent.

Equipping educational institutions with psychological assessment tools, software programs such as SPSS, standardized personality tests, clinical self-diagnosis tools, etc, at cheaper rates will not only facilitate learning but make psychological assessments a lot more accessible to the public who otherwise have to pay exponential prices for such tests. There is a considerable lack of awareness regarding mental health in India. Mental health is treated as a taboo and a subject of embarrassment and shame. People are quite reluctant to seek professional help due to the fear of being labelled as "psychotic", "crazy", or "mad" and being perceived as weak by others. Informative campaigns, educational workshops, community welfare

programmes, etc, can help combat this stigma that prevents people from accessing psychiatric help.

Lastly, there is a lack of appropriately skilled and trained manpower is a major impediment. For every 100,000 people, there are less than 3 psychologists and psychiatrists. WHO reports that there are 0.3 psychiatrists, 0.07 psychologists, and 0.07 social workers per 100,000 people in India (WHO, 2017). This marginal rate results in a deficit of mental health professionals, thus, restricting help to those who require it.

4. Vision For a Better Future: Recommendations For Improved Mental Healthcare

Continuing with the tradition observed in previous NMPHs and related policies, de-stigmatization of mental illness and shame associated with psychotherapy should remain the focal point. De-stigmatizing mental health and dispelling several myths related to counselling and therapy will prove to be a beneficial step in the long journey of achieving standardized and affordable mental health care. Awareness campaigns shall remain the top priority of any mental health bill or policy. Another big hurdle towards the path to achieving affordable and accessible mental healthcare for everyone in India is a lack of mental health professionals. Thus, overcoming this obstacle will not only provide standardized psychotherapy for all but generate employment opportunities at the same time.

Future Union budgets should reserve a significant chunk of financial resources for mental healthcare. Most of these funds should be allocated for community centres and organizations working at the ground level rather than funding more prominent institutions that may not be able to reach people at both the urban and rural levels. The DMHP can prove to be more effective than NMHP as it directly reaches out to the rural population to spread awareness about mental illness, provide affordable and accessible mental healthcare, and enhances the quality of life of mentally ill individuals. It is crucial that every stakeholder involved in the execution and implementation of such policies dedicate themselves to the cause, adhere to their assigned roles and responsibilities, do not misuse the allocated funds, and sincerely work towards effectively executing the policies at the ground level.

The National Tele-Mental Health Program aims to provide a network of mental healthcare centres that offer counselling services. Such virtual mental health centres close the gap between therapy and counselling and people who cannot gain access to physical counselling services. Tele-mental health programs can help counter the shortage of healthcare workers as well. However, there are certain crucial drawbacks such as lack of network connections, high costs, lack of privacy, and access to technology. Effective implementation of virtual counselling is the first step towards actually providing free and standardized mental healthcare to the general public.

It is equally important to highlight the contribution and effectiveness of ground-level interventions, campaigns and programmes that aim to combat stigma and raise awareness about mental health. One such community-based intervention was the “Atmiyata” programme, implemented in 41 villages in Nashik, Maharashtra, that aimed to improve well-being and reduce the incidence of mental illness among its people. Members of the community known as “Atmiyata Champions” were trained to assess and identify mental health issues and provide basic treatment for the same. Another group of members known as “Atmiyata Mitras” were trained to identify people afflicted by mental health issues and report them to the champions.

An app was created to circulate films made specifically to address issues such as alcoholism, domestic violence, distress, etc, prevalent in the villages. This programme emphasized the strengths of the community and successfully dealt with the mental healthcare needs of the rural people.

Another intervention that focused exclusively on training community health workers was implemented in Doddaballapur, Bangalore. Mental health issues are often catered by the physicians, one of the primary reasons for this is that mental health issues are usually comorbid with physiological diseases. Thus, making it evident that there is a lack of awareness among the citizens and community health workers pertaining to the issues related to the mental health and treatment is expensive as a result of which people end up either opting for a cheaper alternative or avoid going to the doctor to seek for treatment by opting for medication. To deal with this, 70 community health workers were recruited and trained to improve their ability to identify psychological disorders, thereby redirecting the community health workers’ focus from pharmacological interventions that may be harmful. The finding from this study shows that the intervention was an effective way to enhance mental health literacy of the people and enabling them to opt for better health care services provided by the government.

Looking at other strategies, the Manas program was a joint initiative by the Public Health Foundation of India (PHFI) and the National Health Systems Resource Centre (NHSRC) aimed at integrating mental health care services into primary health care settings to improve access to care in rural and remote areas. Primary care providers were trained to deliver basic mental health care services and mental health clinics were established at primary health care centres where mental health professionals worked alongside primary care providers to provide comprehensive care. Similar to this is the PRIME program (Programme for Improving Mental health care) that aimed at developing and evaluating interventions to improve mental health care in low- and middle-income countries,

including India. The program included a range of interventions, such as task-sharing, community mobilization, and integrating mental health care into primary care settings. Task-sharing involves training non-specialists to provide basic mental health care services. Community mobilization aims to reduce stigma around mental illness and promote community participation in mental health care. Integrating mental health care into primary care settings increases access to care for those who may not otherwise seek it.

It can be noted that these interventions and programs have some common practices such as training community workers to assess mental health of individuals and provide basic treatment, establishing mental healthcare services and integrating healthcare centres to provide care for those residing in remote, inaccessible regions. This knowledge can be utilized by the concerned authorities to bridge the gap between people and access to mental healthcare services. Moreover, such interventions and other strategies accentuate the importance of building upon the community's resources, power, values and people to bring about positive social change in the field of mental healthcare. Policymakers must pay attention to the success of these programmes and implement them at a larger scale.

5. Conclusion

Mental health is a crucial component that supports a person's healthy and productive existence in society. Indian authorities have made extraordinary efforts to offer its residents a range of health care plans and policies to ultimately improve the quality of living for the nation. With a population as large as that of India there's a dire need for Mental Health programs; starting with raising awareness of them. A clinically diagnosable mental condition is thought to affect one in every seven individuals in India, making the country heavily burdened by mental health issues (Sagar, 2020). There is a considerable lack of qualified mental health professionals and infrastructure despite having a high demand for mental health care services (Sagar, 2022).

A key turning point in the nation's growth of mental healthcare was the creation of the NMHP in 1982. Additionally, the NMHP tried to incorporate the expanding private sector psychiatry. A strategy that takes into account the requirements of the entire population, makes full use of the resources of the local community and involves all facets of society. Also, the National Health Policy, 2015 and the Mental Health Policy, 2014 acknowledge the fundamental tenet of the NMHP, 1982, namely, integration with the primary care approach in order to identify those in need of such services, refer them to the proper site, and follow-up with medication and telemedicine links. The advancements in mental health care in India have kept pace with those made elsewhere in the world.

But even before the COVID-19 epidemic hit, India had a significant treatment gap for mental disorders of about 83 percent, which is a sign of a serious issue. In addition to the traditional moral and public health justifications for increased investment in people's mental health, it is now well-established that poor mental health significantly contributes to loss of productivity and thus influences the nation's economy. In 2010, it was projected that there was a $2 trillion annual financial loss due to poor mental health worldwide (Sagar, 2022). If the current trend holds, it is predicted to increase to $6 trillion by 2030. If adequate treatment for mental illnesses is provided, then the nation would witness a higher and more profitable return on their investment in the long-term (Sagar, 2022).

The Ministry of Social Justice and Empowerment currently operates a national mental health helpline for people to call in order to receive high-quality mental health counselling. India is a very diverse country in terms of socioeconomic status, culture, and languages. Therefore, consideration must be given to adapting tele-mental health services to the socio-cultural contexts of various places when planning their implementation at the national level, for example, providing counselling in regional languages and dealing with cultural differences in a sensitive manner. There is a need to combine highly prevalent psychotherapies and models of mental health with beneficial indigenous therapy modalities like yoga or meditation in a way that is culturally respectful. In addition, a sizeable segment of the population in India lacks access to cell phones or high-speed internet, has inadequate digital literacy, and is frequently more likely to experience poor mental health and mental diseases. To ensure that everyone has access to tele-mental health services, a variety of services must be planned, such as a text messaging line where people can request immediate help or schedule a call-back or an appointment with a tele-mental health centre based on the information provided in the text message.

Due to the widespread stigma associated with mental illness, many people choose not to or are afraid to seek treatment. In order to ensure that tele-mental health services are successfully adopted by the public, it is crucial to guarantee the patient's right to privacy and the protection of health-related data. Programs for training mental health practitioners in the technological and clinical facets of tele-mental health practices are required. Additionally, it is necessary to create quality control systems and assurance processes for monitoring and assessment of the delivery of tele-mental health services as well as evaluation of the results in terms of beneficiaries' mental health. As a result, it will be easier to develop a workforce that offers mental health treatments that are uniform and up to basic quality standards.

Finally, a sizable population of severely mentally ill people (such as those affected by schizophrenia or bipolar

disorder), people with cognitive impairments and/or sensory deficits, or any other issues would not be able to access tele-mental health services in an effective manner and will require in-person care. Moreover, virtual mental health care services can complement the prevalent mental healthcare policies and their systems by combining their treatment plans and providing interventions that are necessary for people who require in-person care.

Lastly, it is important to create and implement standardised, scientific and culturally sound virtual mental health services. The National Tele Mental Health Programme is a positive step toward realising the objective of providing mental health treatment for everyone. For such virtual mental health services, standard operating procedures and quality assurance measures must also be developed. This will be crucial for assuring the success of the program's goal of offering affordable, high-quality mental health treatments to all.

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