Health as a fundamental right: the national mental health programme initiative

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Introduction

Health is one of the important indicators of economic development of any society. Health is defined in the preamble of the World Health Organisation (WHO) and in Article 25 of the Universal Declaration of Human Rights. This states that everyone has the right to medical care. Medical science, the humanities and international conventions all recognise mental health as an integral part of health care. This chapter elaborates on the evolution of health as a fundamental right and role of human rights in improving mental health care in India. It also attempts to highlight the important innovations in improving mental health care through the National Mental Health Programme, which seeks to provide easily accessible and acceptable mental health care in the community.

International development

The right to health has evolved rapidly under international law, and its normative clarification has significant conceptual and practical implications for health policy. The preamble of the WHO Constitution, adopted in 1946, proclaims that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (1). Since then, right to health has been recognised in a wide range of international and regional human rights legislation.

The concept of health has moved from a narrow medical model to a broader and holistic social view. The constitution of WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1). Mental health thus is an integral part of health care. This evolution of defining health from a social context and the emergence of health as a public issue has changed the perspective and dimensions of health. This paradigm shift was further confirmed in the

Declaration of Alma-Ata on Primary Health Care 1978, in which states pledged to progressively develop comprehensive health care systems to ensure effective and equitable distribution of resources for maintaining health.

National Development

The Constitution of India guarantees Fundamental Rights under Chapter III. One of these rights provided under Article 21 reads as follows 'Protection of Life and Personal Liberty': No person shall be deprived of his life or personal liberty except according to the procedure established by law (2). The Constitution of India also has provisions regarding the right to health. They are outlined in the Directive Principles of State Policy- Articles 42 and 47, in Chapter IV (2). Article 42 states that; "Provision for just and humane conditions of work and maternity relief" and Article 47 states, "Duty of the State to raise the level of nutrition and the standard of living and to improve public health" Further there are sufficient case laws on the issue of right to health. Our judiciary has interpreted the right to health in many ways and also in a number of instances, through public interest litigation as well as litigation arising out of claims that individuals have made on the State, with respect to health services.

Although it is not listed as a fundamental right in the constitution, the Supreme Court has almost accepted the right to health as a fundamental right in *Vincent Vs Union of India* (3) reflected in the statement "A healthy body is the very foundation for all human activities". Hence the adage 'Sariramadyam Khalu Dharam Sadhanam'. In a welfare state, therefore, it is the obligation of the state to ensure the creation and sustenance of conditions congenial to good health". Similarly, Article 21 imposes an obligation on the State to safeguard the right to life of every person.

The role of courts nowadays is no more only as the protector and custodian of the indefeasible rights of the citizen. They have also been empowered to go a step further and give compensatory relief under public law jurisdiction. The first landmark in the Indian human rights jurisprudence was articulated by the Supreme Court in *Rudul Shah Vs State of Bihar* (4) in which it was held that the compensatory jurisprudence for the infraction of article 21 occurred. In *Bandhua Mukti Morcha Vs Union of India* (5), the Supreme Court has held that the Right to life includes the right to live with dignity. The recognition that the right to health is essential for human existence and is, therefore, an integral part of the right to life, is

laid out clearly in *Consumer Education and Resource Centre Vs Union of India* (6).

In *Francis Coralie Vs Union of Delhi* (7), it was held that the right to life does not mean a mere animal like existence but a more meaningful life, a life of physical and mental integrity. Further, in *State of Punjab and Others vs. Mohinder Singh* (8) it was also stated that right to health is integral to right to life. The state government has a constitutional obligation to provide health facilities and denial of medical aid due to non-availability of beds in government hospital amounts to violation of Article 21. This issue of adequacy of medical health services was articulated in *Paschim Banga Khet Mazdoor Samiti vs State of West Bengal* (9). Preservation of human life is thus of paramount importance. The government hospitals run by the State and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his/her right to life guaranteed under Article 21. Further, the Court ordered that primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgement that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation. Similarly, in *Mahendra Pratap Singh vs State of Orissa* (10), a case pertaining to the failure of the government in opening a primary health care centre in a village, the court held, "In a country like ours, it may not be possible to have sophisticated hospitals, but definitely villagers within their limitations can aspire to have a Primary Health Centre". The necessity for timely intervention by medical professionals has been clearly stated in *Parmanand Katara vs Union of India* (11). It states that every doctor whether at a government hospital or otherwise has the professional obligation to render medical services when it is required during an emergency situation, with due expertise for protecting life. Now the doctor's ethical duty to treat the patient (professional and ethical obligation) has become a legal obligation.

From the above discussion it is clear that the Constitution of India incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Right to Life means the right to lead a meaningful, complete and dignified life. It is something more than just surviving or leading an animal existence. As far as Personal Liberty is concerned, it means freedom from physical restraint of the person by personal incarceration or otherwise and it includes all the varieties of rights other than those provided under Article 19 of the Constitution. The Right

to Health includes availability, accessibility, acceptability and equality (2). Non-discrimination and equal treatment are among the most critical components of the right to health. The concept of right to health translates in practice to the right to health services.

Mental health as a fundamental right

A human rights approach to health is critical to address growing global health inequalities, poverty, violence and establishing accountability for protection of rights (12). Human rights refer to the freedom and entitlements concerned with the protection of the inherent dignity and equality of every human being. They include civil, political, economic, social and cultural rights. Human rights are inspired by moral values, such as dignity, equality and access to justice. However, they are more than moral entitlements: they are legally guaranteed (13). The international community has accepted the position that human rights are universal, indivisible, inter-dependent and interrelated (Vienna Declaration and Programme of Action, 1993) (14). Human rights and health are connected in a number of ways (15). The mentally ill person deserves the same privileges as enjoyed by any other human being. This includes a right to better and more accessible care, to good recovery and increased hopes of reintegration into society (16). The National Human Rights Commission (NHRC) is mandated under section 12 of the Protection of Human Rights Act 1993 to visit government run mental hospitals to study the living conditions of the admitted persons and make recommendations thereon.

Health professionals' practice, typically governed by ethical codes, may benefit from human rights guidelines. Human rights approaches include holding States and other parties accountable, developing policies and programmes consistent with human rights, and facilitating redress for victims of violations of the right to health and human rights. A human rights approach to health is critical and has been advocated wherever there is inequity in health and poor access to health care (2).

Mental health care has always received the least or almost no priority among health needs. Lack of insight, lack of recognition of the seriousness of mental illness, lack of understanding about the benefits of treating mental disorders and stigma **have all led to the** discrimination of mental health and mentally ill persons. This attitude not only exists among health professionals but also among policy makers, the judiciary, insurance companies, various other organisations and the public at large.

People afflicted by mental disorders are vulnerable to violations of their human rights, including the right to health, life, non-discrimination, privacy, work, education, and the right to enjoy the benefits of scientific progress. Such vulnerability is obvious in the Indian context. In *Sheela Barse vs Union of India* (17) pertaining to the admitting of non-criminal mentally ill persons to prisons in West Bengal, the Supreme Court has held that admission of non-criminal mentally ill persons to jails is illegal and unconstitutional. The judicial magistrate will, upon a mentally ill person being produced, have him or her examined by a mental health professional/ psychiatrist and if advised by such MHP/psychiatrist, send the mentally ill person to the nearest place of treatment and care. In many instances, members of the judiciary have neither known about nor utilised the provisions of the Mental Health Act of 1987. Many of the law enforcement agencies are ignorant of the special admission and treatment procedures under this Act. In many instances, mentally ill persons are arrested by the police and detained in custodial care for petty crimes (creating public nuisance, destruction of property, trespassing, assault etc). They are then lost in the judicial procedure, do not receive psychiatric treatment, and have prolonged incarceration for what was a petty crime. In a recent incident, an undertrial prisoner Mr. ML, had been languishing in the mental institute in Tezpur, Assam for 54 years. Detained at the age of 23, he could secure his release only when he was 77 years old, only after the intervention from the Honourable Supreme Court of India (18)

There was also the shocking inhuman incident involving the death of 25 mentally ill persons in *Erwadi, Ramnathapuram District* (19) as they were chained to poles or beds and could not escape from a fire that broke out. Following this incident, the Supreme Court directed the state to implement the provisions of the Mental Health Act, and also undertake a survey of all institutions that provide mental health facilities to ensure that they are maintaining certain minimum standards of care.

The general public is unaware that health is a fundamental right and that 'mental health' is an integral part of health. Protection and provision of this right rests upon the state. Each citizen has a right to be listened to, to request and demand access to appropriate, acceptable and affordable comprehensive health services. This knowledge gap will narrow with increasing social and economic empowerment through awareness, education and rights legislation. Promoting the right to health care involves reorganisation, reorientation and redistribution of health care resources on a societal scale. Enjoyment of the human right to health is vital to all

aspects of a person's life and well-being, and is crucial to the realization of many other fundamental human rights and freedom.

Mental health burden

A meta-analysis of 13 epidemiological studies on mental illness in India reported a psychiatric morbidity of 58.2 per 1000 general population (20). Similarly, another meta-analysis of 15 epidemiological studies reported a total morbidity of 73 per 1000 general population (21). When we consider prevalence of individual mental disorders and add the overall prevalence rate will be approximately 115-130/1000 population (22). Even if we consider (average of above two meta-analysis) 65/1000 population as the prevalence rate for mental illness, about 6.5 crore of persons require professional help. If each patient requires INR 300 per month for treatment, the total cost required per month will be 1,950 crore, which translates to 23,400 crore INR per year. If we do not address this issue by investing in mental health, the indirect costs in terms of loss of wages from the person's illness and consequent disability and the intangible costs of social isolation, burden, stigma and psychological strain will be enormous (22).

Barriers in help seeking

Even in situations where treatment is available, patients get the benefits 6 to 24 months after the onset of the severe mental disorder. Nearly 50% of patients with schizophrenia remained never treated in a taluk that had a practicing psychiatrist from the private sector. The main reasons for non-treatment included low levels of help seeking, perceived stigma, poverty, ignorance, illiteracy, non-availability of mental health facilities, lack of insight into the illness, lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of treatment.

Psychiatric hospitals continue to carry stigma. Most patients who seek psychiatric consultation approach general hospitals for psychiatric consultation. However, more than 70% of the developing world's population in rural areas still depends on complementary and alternative systems of medicine (23). A majority of the mentally ill in rural areas still go or are taken to faith healers and other alternative systems. Hence, emphasis should be on training faith healers and professionals in alternative medicine for identifying mental illness and referring them (24). At the same time, emphasis should also be given to improving the manpower that can

cater to the needs of the referred cases at the general hospital. This can be achieved only by proper training of undergraduate medical professionals in treating common mental disorders. Ultimately, initiatives like integrating mental health care with general health care at primary health care and the development of general hospital psychiatry units in each district hospital through the National Mental Health Programme will yield desired results of taking basic mental health care to the doorstep.

Innovative steps: The National Mental Health Programme

The National Mental Health Programme (NMHP) for India was initiated in 1982. NMHP was operationalised as the **District Mental Health Programme** (DMHP) and pilot tested in the district of Bellary, Karnataka to understand the feasibility and logistics of providing mental health care by NIMHANS.

Objectives of the NMHP were a) To ensure availability and accessibility of minimum mental health care in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population, b) To encourage application of mental health knowledge in general health care and in social development, c) To promote community participation in mental health care development in the country and to stimulate efforts towards self-help in the community.

Over a period of time, NMHP has undergone a complete review and re-orientation. A major achievement has been the increase in funds. The budget allocated for comprehensive mental healthcare delivery during the 9th Five-Year Plan was Rs 28 crore and Rs 190 crore during the 10th Five-Year Plan. For the current 11th Five Year Plan, the allocation has made a quantum jump to Rs 1000 crore. Various innovative approaches adopted in the current NMHP include rural and urban mental health, school mental health, adolescent mental health, suicide prevention and public private partnership. Following are the salient features of the revised NMHP:

1. The District Mental Health Programme (DMHP)

This programme was developed as an approach to deliver mental health care through primary health care for the entire district. Based on the mid-term review and two national consultative meetings, the existing DMHP programme is being strengthened by adding the adolescent mental health programme that includes health promotion for high school students, intervention for students with

emotional problems, counseling for out of school children and college based counseling services Apart from continuing the existing programmes, in the present five-year plan, it is envisaged that 443 more districts will be brought under the DMHP activities. Urban Mental Health Programme (UMHP) is a new addition to the NMHP.

2. Preparatory phase

This is a new concept introduced in the 11th plan. Each State should map the mental health resources in the private and public sector before applying for the project. The state has to identify the nodal officer and programme officer and get their written consent. They should undergo sensitisation and the programme officer should undergo training for three months before the total grants are released.

3. Adolescent and School Mental Health Programme

This involves health promotion through life skills education for development of psycho-social competence. This model, using teachers as trained resource staff has been approved as an accepted strategy internationally both in developing and developed countries. It is envisaged that 500 rural blocks and 100 urban blocks will be taken up for the adolescent mental health programme that includes life skills education for adolescents and intervention for emotional problems in the 11th plan. Adolescents' mental health programme for out of school adolescents in both rural and urban districts in the country is also envisaged. Networking with department of youth and sports, NGOs and other voluntary organisations will be established to provide appropriate interventions for this population. This programme will cater to 30,000 schools covering 1,00,00,000 adolescents.

4. College mental health programme

Emotional distress, adjustment and substance use problems are significant issues in college students that need attention. Trained teachers can effectively handle such problems within the context of the college. It is planned to cover all the pre-university and degree colleges in all the districts in the country. One hundred college teachers in each of the 500 rural districts and 300 college teachers

in each of the 50 urban districts will be trained to provide counseling services in the college. The programme will cover approximately 2, 65, 65,312 college students (seventh education survey India 2002).

5. **Improvement in health manpower status:** During the 11th Five-Year Plan, it is envisaged to support the development of 11 regional Institutes of Mental Health with a one time grant of Rs 30 crore for infrastructure development. It is also proposed to equip 30 medical colleges to start/strengthen their post graduate programme in mental health. The running cost for 5 years will be met in addition to the initial support for infrastructure development.

6. **Research and mental health**

This may be implemented under the following headings:

a. Biology of mental disorders

b. Early intervention for mental disorders

c. Improving long-term outcomes in drug and alcohol dependence

d. Social factors / support systems to minimise disability in chronic psychosis.

e. Health behaviour research

f. Psychological and social factors contributing to mental disorders and disability

g. Interventions to improve functional outcome, reduce disability and stigma

h. Interventions for prevention of illness and promotion of mental health.

i. Levels and limits of mental health care by primary care doctors.

j. Outcome of mental disorders treated in primary care settings.

7. **IEC activities**

Under this head, the following issues require to be addressed:

a. Development of public awareness material such as video clippings, posters radio/ TV messages and wall writings. Projects may be awarded for developing such material with an

incentive of a cash prize for the best product. Scientific methods to evaluate the impacts of these on the public have to be initiated.

b. Training material for under-graduate/post-graduate training in the form of video, interactive CD for use on the net/distant education have to be developed.

8. Support money for implementation of the Mental Health Act 1987

It is proposed to allocate separate funds to assist both the Central and the State Mental Health Authorities.

9. Public-Private Partnership

This is a key concept. Government alone is inadequate to realise all the goals of NMHP. The role of NGOs and related organisations in all components of NMHP has been recognised. Appropriate linkages between NGO activities as well as NMHP components by matching them can increase efficiency. A substantial part of NMHP can be contracted to established NGOs/private bodies of standing. For example, the entire life-skill programme (school mental health) can be run by NGOs with checks and balances and monitoring from the professionals; this would also apply to the components of IEC. NGOs can be involved in spreading awareness about mental disorders, organisation of self-help groups, day care centres, support for families and conduct of mental health camps.

10. Monitoring

Monitoring the implementation of DMHP in the country is very critical to plan mid-course correction. This aspect is a new addition in the 11th Plan. It is proposed that a Central and State level monitoring committee be formed to monitor DMHP on a monthly basis.

11. Suicide prevention

Suicide is a growing cause of premature morbidity. The causes include psychiatric disorders as well as socioeconomic reasons. Recognition of any underlying psychiatric disorder and early

treatment has the potential to prevent suicide. Several vulnerable populations require life skills training and/or counseling to prevent suicides – school and college populations are two examples. Varied social factors need to be addressed that are regionally relevant. Several other sectors have to be linked for networking resources for suicide prevention. Special IEC activities will target specific populations. Each state's nodal officer will be responsible in implementing suicide prevention programme in one or two chosen districts and the state in this plan period (first phase). The budget is proposed for 50 districts (one or two in each state). If the state needs to implement this in more districts, the same may be done through grants for NGOs or state's own resources.

12. Stress management

Stress is a physiological response of the body to changes within and outside an individual. It is important to recognise that stress responses are an inevitable part of human existence. Stress affects people irrespective of their age, gender, socio-economic, occupational and educational status. Many empirical studies have established the relationship between stress and illness. Studies based in the United States report that 80-90% of all illnesses are stress related. It is also estimated that 7-8 out of every 10 individuals who consult general practice doctors, do so because of stress and anxiety related symptoms. Studies conducted in India regarding prevalence of psychological distress suggests that nearly one third to one half of executive officers report symptoms of psychological distress and nearly one in four of them suffer from stress related disorders like diabetes, hypertension, arthritis, various skin and respiratory disorders. It is important to note that prevalence of psychological distress is distinctly more in women compared to men. This difference in psychological distress seems to be related to cultural factors, ability to verbalise emotions, willingness to reliably report symptoms rather than differential vulnerability. It is encouraging to find that a small proportion of individuals have made initiatives to start incorporating life-style changes to limit damages due to stress. Most often, the individual makes life style changes after the onset of illness but not before it. Hence, it is clear that the need for stress management is beyond doubt-but the crucial question is the conviction to incorporate and to adopt necessary specific life-style changes.

Realising the goals of NMHP

In India, the number of formal treatment facilities is far too few. Mental health care can best occur in community settings. The current development of implementing national mental health programme in a phased manner is indeed very positive. Developing a mechanism to monitor the programme and institutionalise the process so that the local district authorities carry on the task is an important outcome of this activity. DMHP seeks to implement mental health care using the public approach. The most important aspect of the DMHP is to train doctors, multi-purpose workers and other functionaries in task oriented mental health skills. The doctor is expected to evaluate patients attending his/her clinic, diagnose and treat the referred cases from the field. The multi-purpose workers are expected to follow up the treated patients, monitor the side effects of medication as the case may be, educate the families about the nature of the illness, support the family during crisis. The doctor is expected to actively support and encourage the multi-purpose workers to visit the field and carryout the above mentioned tasks. The District Mental Health Programme officer is available to provide clarification and support to the primary care physician as needed. The primary care physician can refer a case for opinion or inpatient care to the district psychiatrist.

Thus, a paradigm shift in strategy from institutional treatment to a holistic community approach has been adopted in the NMHP keeping the aims of promotion, prevention, early detection and treatment. Such an approach would also minimise disability.

Conclusion

Community care of persons with mental illness has moved a long way from the institution to community settings. This has been possible because of the commitment on the part of the government, professionals, institutional policies, legislations and, in some instances, judicial activism. Community is not a cheap alternative to a hospital but a realistic alternative to fill the wide treatment gaps that exists.

Community care has been accepted as the most suitable and realistic alternative to care for the mentally ill all over the world. Most of the mentally ill are being treated at the level of general hospital practitioners and primary health care settings in the community so that patients get the benefit of being in the community and avoid custodial care in mental hospitals, which have their own demerits, especially from the human rights perspective.

NMHP promises to provide easy access to mental health care without any discrimination. Realised into action, it will reduce disability, lower family distress and burden, and reduce the stigma of mental illness. Ultimately, it will integrate mental health care with primary health care a main objective of the National Mental Health Programmemme. Taking basic and free mental health care to the doorstep of every member in our society will realise the vision of health as a fundamental right.

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