Future directions for mental health care in India

D Nagaraja & Pratima Murthy

Introduction

'Brain disorders', neurological, psychiatric, and developmental, now affect at least 250 million people in the developing world, and this number is expected to increase as more people live to old age. Yet public and private health systems in developing countries have paid relatively little attention to these disorders, concentrating instead on the major communicable diseases. The Institute of Medicine (1) recommends the following strategies for reducing the burden of 'brain disorders':

- Increase public and professional awareness and intervene to reduce stigma and ease the burden of discrimination;
- Extend and strengthen existing systems of primary care to deliver health services for these disorders;
- Make cost-effective interventions available to those who will benefit;
- Conduct operational research to demonstrate cost-effectiveness of specific treatments and health services in local settings;
- Create national centres for training and research;
- Create a programme to facilitate cost-effective funding for research and for the development of new and enhanced institutions devoted to brain disorders in developing countries.

Common themes that run through three recent global publications with reference to public health (1-3) are the following:

- Need to develop adequate human resources (at the primary care level, specialised staff as well as trained service providers in the non-formal sectors);
- Extend and improve care in the community;

- Inter-sectoral collaboration for effective mental health care delivery;
- Strengthen other mental health components that improve provision of care (policy, programmes, legislation, community participation, advocacy).

The Lancet series on Global Mental Health refers to several barriers to improvement of mental health services in low-income and middle income countries (4). Such barriers include the prevailing public-health priority agenda and its effect on funding, the complexity of and resistance to decentralisation of mental health services; challenges to the implementation of mental health care in primary-care settings; the low numbers and few types of workers trained and supervised in mental health care; and the frequent scarcity of public health perspectives in mental health leadership. Mental health investment in primary health care is important but is unlikely to be sustained unless preceded by the development of community mental health services to allow for training, supervision and continuous support for primary care workers. Community members need to partake in advocacy and service delivery (4).

In developing countries, there is a great mismatch in the areas of mental health research, practice, policy and services in comparison to developed countries. There have been few studies that have investigated major mental health problems prevailing in these countries, but such studies have tended to be more donor-driven and conducted in tertiary centres (5). The low priority accorded to mental health by the policy makers, scarcity of human resources, lack of culture-specific study instruments, lack of support from scientific journals have been some of the impediments to mental health research in these countries. In addition, lack of community participation and absence of sound mental health policies have deprived the vast majority of the benefit of modern psychiatric treatments (5).

Developments in India

In the previous chapters, various developments in India in the area of mental health have been discussed. These can be summarised as follows (6):

- Indigenous post-graduate training which eliminated the need for training abroad, at least at the basic DPM and MD levels
- Development of general hospital psychiatry in the 1960s
- The emergence of community psychiatry initiatives in the 1970s

- Change in the laws pertaining to mental illness in the 1980s
- Powerful judicial interventions for the rights of the mentally ill in the 1990s
- Greater availability of a range of psychotropic medication for the effective treatment of mental illnesses in the last two decades

In more specific terms, there have been serious attempts to improve care and expand the scope of functioning of government run psychiatric facilities and to expand the National Mental Health Programme under the 11th Five-Year Plan (7), with a broad-based approach focused on mental health promotion, early diagnosis and treatment in primary and general care settings, extension of the district mental health programme to all districts in the country, and a significant budget allocation for mental health research (8). Policy reform has included the integration of mental health in the National Health Policy (2002), the drafting of a proposed National Mental Health Policy in 2001 with a clear roadmap for activities in the 10th (2002-2007), 11th (2007-2012) and 12th (2012-2019) five year plans (7).

A range of effective medical treatment options are available and the treatment cost is comparable with costs of other chronic medical illnesses (9). A large number of psychotropic medications have become available in district settings. The costing of treatment of mental disorders like depression, schizophrenia and alcohol and drug dependence have been included in the budgeting exercise undertaken by the government of India to improve financial allocation for such care at the solo physician, primary, secondary, and tertiary health care levels (10).

Simultaneous with these developments is the development of a range of community level approaches to mental health care. Community based models of care in both the government (11-14), and non-governmental sector (15-17) have been shown to be acceptable and effective models of health care delivery for the last three decades.

The problem is not in the demonstration of efficacy of these models, but their systematisation. The generation and demonstration of workable models involves a great degree of motivation, a desire to demonstrate change, and a willingness to put in the necessary effort to make such change possible. When attempts are made to systematise such models within the community, the lack of human resources, motivational barriers,

inadequate or dysfunctional mechanisms for service delivery, non-existent or ineffective monitoring mechanisms, inadequate measurement of deliverables in real world settings become practical difficulties.

Challenges for effective mental health service delivery

In order to make specific recommendations for future action, we need to reconsider local barriers to effective mental health service delivery. Many of these have been raised in the preceding chapters.

The need for services and efforts to reduce the treatment gap

It is estimated that about 500 lakh for common mental disorders (7) and about 200 lakh individuals in the country need treatment for severe mental disorders. Thirty lakh people need long-term care, and between 30 and 35 lakh need hospitalisation at any given time. Only about 29,000 beds exist in both government and private sectors. There is a huge treatment gap with nearly 50-90% of persons not being able to access services.

Human resource: scarcity of specialists

Even after nearly six decades of indigenous post-graduate training there is an acute shortage of psychiatrists. To have a desirable ratio of 1 psychiatrist for every 1 lakh population, we need to train a further 7000 psychiatrists (7). At the present rate of training (about 250 annually through MD, Diploma and DNB training programmes), it would take a further 30 years to achieve this. Moreover, nearly half the physicians in high-end institutions, including psychiatrists, migrate (18).

Other mental health professionals like clinical psychologists, psychiatric social workers and psychiatric nurses are also very scarce. To have a desired ratio of 1 clinical psychologist per 1.5 lakh population, 2 psychiatric social workers per lakh population 12,000 and 17,000 professionals respectively need to be trained (7). Psychiatric nurses are limited to a few hospitals.

Training of primary health care doctors and general physicians

Training of primary health care doctors and general physicians in mental health care has occurred sporadically in the country and it is difficult to speculate how many of them have been adequately trained and can deliver basic mental health care. The proportion is likely to be negligible.

Training of primary health care workers

Training of primary health care workers was initiated under the NMHP in the 1980s, but this was not expanded and does not represent a well-trained sector for integrating mental health into general health care.

Human resources in the non-governmental sector

In the early 2000s, there were about 50 non-governmental organisations (NGOs) throughout the country working in the area of mental health (excluding those working in the area of mental handicap and commercially run long-stay rehabilitation centres), which again represents a motivated but small human resource pool (19).

A poorly informed public

Very little information is available to the public on any of the issues relating to mental health, whether it is on mental well being, protecting against depression or identifying symptoms of serious mental illness. They are even less aware of treatment facilities and their rights. Without information, there is no advocacy. Without advocacy, there is not enough demand for services and system accountability to provide equitable and good quality mental health care. Stigma and misconceptions related to mental illness are present among sufferers, their families as well as among untrained service providers.

Systems for effective service delivery

Mental health has always suffered from a lack of financial resources in the past. For the first time in history, under the NMHP, the mental health sector has received more generous funding. While this is exciting, it is also a sobering fact. Unless accountable systems for effective service delivery emerge, and bureaucratic hurdles and apathy of state administrations is overcome, quality mental health service delivery will remain an Utopian dream, despite all the available financial resources.

Recommendations

The following recommendations are made particularly recognising that the philosophy of mental health care in India has now moved from a custodial to a therapeutic approach, from a social cause to a rights based approach, from a tertiary care approach to community care, primary and secondary care.

1. Mental health services should be accessible, equitable and affordable

Community care is the best approach for providing broad-based mental health services in the country, especially given the shortage of trained human resources. All the districts of the country should be covered under DMHP.

The Government should ensure that cost of drugs used in the treatment of psychiatric disorders do not become prohibitive.

Psychosocial interventions should be available at all levels.

2. Government should downsize large psychiatric hospitals

Efforts should be made to reduce hospital beds to manageable numbers. Duration of admission should be as short as possible. More open ward treatment facilities must be created.

3. Human resources for mental health must be systematically enhanced through both short-term and long-term strategies

Each state must have at least one training institute that provides multidisciplinary training in psychiatry, psychology, social work and mental health nursing.

For a period of 10 years, the Medical Council of India should relax faculty student ratio for PG intake from 1:1 to 1:2. Teachers with DPM qualification and 8 years of teaching experience should be considered as post graduate teachers.

The Central and State governments should encourage short-term training programmes in psychiatry of 3 to 12 months duration for their medical officers in established training institutions so that every district can be provided with a trained person where there are no psychiatrists.

Every state should undertake short-term training programmes for all their medical officers in the identification and management of common psychiatric disorders.

The State and Central governments should encourage training of general practitioners through agencies like the Indian Medical Association.

The government should fix minimum CME credits in psychiatry to be obtained for renewal of license.

Undergraduate training in psychiatry must be strengthened and a clinical case examination in psychiatry must be introduced.

Other mental health professionals

Since adequate MPhil trained candidates are not available, candidates with MA/MSc in psychology and social work should be trained for three months in PG centres, so that they can be recruited to provide psychosocial interventions at the district level.

Psychiatric institutions as well as general hospital departments must be encouraged to develop multidisciplinary teams and offer post-graduate courses for other mental health professionals.

Training of lay counselors

In view of the acute shortage of trained manpower, lay counselors need to be trained to manage common psychological problems which require counseling. Every state should have a training centre, preferably in each district. Where available, local NGOs can be involved in providing such training.

Curriculum and training materials can be obtained from NIMHANS for the above activities.

All professionals must be provided adequate remuneration as well as conducive work conditions, including administrative support.

4. **There should be a national data base of services and human resources available for mental health care in the country and this should be periodically updated.**

5. **The State and Central Governments should follow a stepped care approach to mental health services as follows:**

- Health education
- Health promotion through school health programmes
- Counseling centres
- Early diagnosis and effective management/emergency services
- Short periods of hospitalisation when required

6. **After care rehabilitation and reintegration within the society**

The approach to mental health care must shift from hospitals to families and efforts should be made to address issues of care givers. Care givers must be provided adequate support including facilities for short-term respite care for their chronically ill wards whenever required. For individuals for whom family care is not feasible, there should be operational co-ordination between the Ministry of Health and Ministry of Social Justice and Empowerment for establishment and effective management of after care homes and rehabilitation centres.

7. **Mental health must be converged with the social, education, labour and legal sectors. Translational research must be encouraged in all areas**

8. **Law review and reform needs to occur periodically**

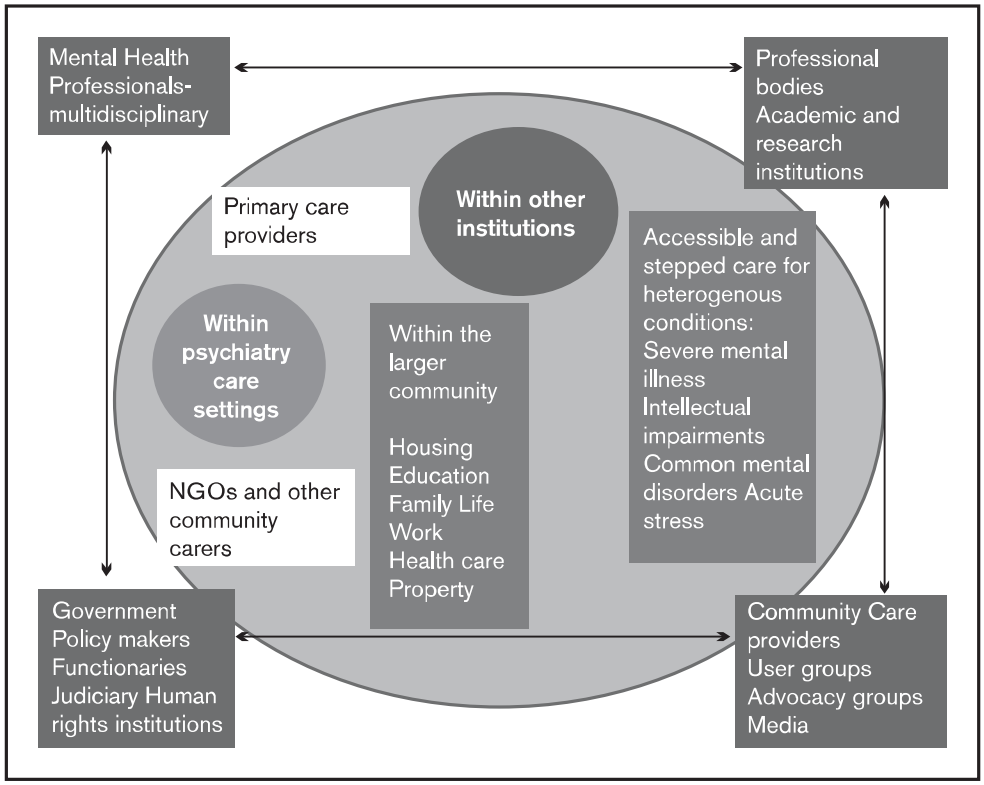
Mental health acts/rules must be periodically reviewed. They must emphasise community care, rehabilitation and aftercare. Various rules and regulations with reference to mental illness reflected in different acts and rules of the Centre/State must be harmonized.

9. **Limitations imposed on mentally ill in the area of insurance should be rectified.** Mental illness treatment should be covered under simple schemes like the Yeshaswini scheme.

10. **The mental health care of vulnerable groups like children, elderly, women subject to domestic violence should receive priority attention.**

Translational research in all the above areas must be strongly encouraged and feed into further policy and programme development.

Towards integrated mental health service delivery and inter-sectoral convergance



Conclusion

Mental well-being and the care of mental illness cannot be the concern and responsibility of mental health professionals alone. There are now several well recognised players involved in the mental health field. However, mental health is everyone's concern. Every government should provide mental health services. Every citizen should assert his/her right to such services in the community. Working together, we can hopefully address the mental health care of our country in a more meaningful manner.

References

1. Institute of Medicine. Neurological, psychiatric and developmental disorders: meeting the challenge in the developing world. Washington, DC: National Academy Press, 2001
2. Desjarlais R, Eisenberg L, Good B, Kleinman A. World mental health: problems and priorities in low-income countries. New York: Oxford University Press, 1995
3. World Health Organization. World Health Report 2001; mental health: new understanding, new hope. Geneva: World Health Organization, 2001

4. Saraceno B, Van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, Sridhar D, Underhill C. Barriers to improvement of mental health services in low-income and middle-income countries. Series, Global Mental Health, The Lancet 2007; 370:1164-1174.

5. Isaac M, Chand PK, Murthy P. Research, Empiricism and Practice in Low Income Countries. International Review of Psychiatry 2007; 9: 559-571.

6. Wig N.N. Vision 2020. Road map for the future-II. Mainstreaming mental health. In Agarwal SP (Ed). Mental Health: an Indian perspective 1946-2003. Directorate General of Health Services. Elsevier 2004; 341-346.

7. Goel DS, Agarwal SP, Ichhpujani RL, Shrivastava S. Mental Health 2003: the Indian scene. In Agarwal SP (Ed). Mental Health: an Indian perspective 1946-2003. Directorate General of Health Services. Elsevier 2004; 3-24.

8. Murthy S. Mental Health in the new millennium: Research strategies for India Indian J Med Res 120, August 2004; 63-66

9. Girish K, Murthy P, Isaac M. Drug treatment in schizophrenia. Issues of comparability and cost. Indian J Psychiatry 1991; 41:100-103.

10. Armed Forces Medical College. Standard treatment guidelines and costing. Developed in collaboration with the World Health Organization country office for India and Ministry of Health and Family Welfare, Government of India 2007.

11. Wig NN, Murthy RS, Harding TW. A model for rural psychiatric services- Raipur Rani experience. Indian J Psychiatry 1981; 23: 275-90.

12. Murthy RS, Wig NN. The WHO collaborative study on strategies for extending mental health care, IV: A training approach to enhancing mental health manpower in a developing country. Am J Psychiatry 1983; 140: 1486-90.

13. Shamsundar C, Krishna Murthy S, Prakash O, Prabhakar N, Subbakrishna D. Psychiatric morbidity in a general practice in an Indian city. BMJ 1986; 292:1793-5.

14. Isaac MK, Chandrasekar CR, Srinivas Murthy R, Karur BV. Decentralised training for PHC medical officers of a district - the Bellary approach. In: Continuing Medical Education, vol. VI, Verghese A, editor. Calcutta: Indian Psychiatric Society, 1986.

15. Ranganathan S. The empowered community: a paradigm shift in the treatment of alcoholism. Madras: TTR Clinical Research Foundation, 1996.