Realising the objectives of the national mental health programme: a look at states and innovations

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Introduction

Mental health care must be easily available, affordable and accessible to everyone in the community. While the National Mental Health Programme (NMHP) suggested this in 1982 (1), it was only in 1996 that a strong recommendation was made for the activation of the NMHP. This expansion occurred across the 9th and 10th five year plans. Under the 11th five year plan, the NMHP has been re-strategised and strengthened (2). The need to mainstream mental health has never before been felt so strongly.

It is the right time therefore, to take stock of the situation as well as innovative approaches across States, so that we may have ideas to develop a road map for a truly integrated, multiple level, easily accessible, mental health care delivery system in the country.

Mental Health Care Resources

Table 1 indicates the health care facilities and specialised mental health resources within each State (3). It is immediately apparent that specialised mental health services are extremely deficient in comparison to the general health care facilities.

Table 1: State-wise health care and specialised mental health resources

Resources	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Medical College	36	25	18	32	39	8	16	13	4	9	8	3	4	8	7	5	2	1	3	3	0
District Hospitals	24	29	14	20	35	47	74	25	14	15	25	20	32	28	20	9	11	2	22	21	11
Referral Hospitals	57	100	0	0	0	0	0	409	0	0	70	0	0	0	0	0	0	0	0	0	0
City Family Welfare Centre	2	104	0	0	0	0	0	106	0	0	12	0	0	0	0	0	0	0	0	0	0
Rural Dispensaries	176	1421	0	0	0	0	0	8347	0	0	366	0	0	0	0	0	0	0	0	0	0
Ayurvedic Hospitals	122	9	124	8	51	34	1768	48	2	4	11	1	8	99	15	10	24	1	1	8	0
Ayurvedic Dispensaries	589	32	740	620	490	1427	340	493	265	295	311	393	624	3496	507	148	1105	11	122	472	0
Unani Hospitals	13	1	0	6	5	3	204	0	3	1	4	0	0	3	0	2	0	0	0	1	0
Unani Dispensaries	51	21	1	193	25	50	49	0	235	3	144	1	9	92	35	25	3	0	30	19	0
Homeopathic Hospitals	20	0	35	6	44	21	1	14	0	1	11	3	0	5	6	2	1	1	2	1	0
Homeopathic Dispensary	42	43	580	283	0	146	1482	216	0	1220	179	75	603	147	107	98	14	3	54	20	0
Number of DMHPs	4	16	5	6	6	6	12	8	4	4	0	6	8	1	3	5	2	1	3	3	0
Number of government psychiatric hospitals	2	1	3	2	5	2	4	7	2	7	0	1	1	2	1	1	1	1	3	1	1

1= Karnataka, 2= Tamil Nadu, 3= Kerala, 4= Andhra Pradesh, 5= Maharashtra, 6= Madhya Pradesh, 7= Uttar Pradesh, 8= Gujarat, 9=Jammu and Kashmir, 10= West Bengal, 11= Bihar, 12=Assam, 13= Orissa, 14= Rajasthan, 15= Punjab, 16= Delhi, 17=Himachal Pradesh, 18=Goa, 19= Jharkhand, 20= Haryana , 21= Nagaland

Psychiatrists : a precious commodity

The mental health resource mapping in India (2) calculated that there were 2219 psychiatrists available in 2002, as against a required 9696 professionals. The more recent figures reveal a marginal increase in the total number to about 2800. In chapter 8, it has been suggested, that after counting in many different ways, the total number is still less than 3000. This small number shows an inequitable distribution across the country, with the South having a much larger number despite the smaller geographical spread, the metropolis having many more psychiatrists than non-metropolis and the private sector having a relatively larger number of professionals compared to the government sector (Tables 2 and 3)

Table 2: Regional distribution of psychiatrists

North	560
East	390
West	725
South	1125
Total	2800

Source: Doctors of India 2007 (4)

Table 3: State-wise distribution of psychiatrists and government/ private ratio

	Name of the State /UT	Number of psychiatrists*	Ratio of government/private psychiatrists**
1	Andhra Pradesh	250	1:5.2
2	Assam	20	1:0.68
3	Bihar	125	1:5.3
4	Goa	46**	1:14**
5	Gujarat	125	1:7.5
6	Haryana	46	1: 3.2
7	Himachal Pradesh	10**	1: 0.1
8	Jammu & Kashmir	12**	1:1.4
9	Jharkand	44**	1: 1.3
10	Karnataka	350	1:1.5
11	Kerala	150	1:4.9
12	Madhya Pradesh	125	1:2.0
13	Maharashtra – Mumbai	200	1:9.6
14	Maharashtra – Rest	275	
15	Orissa	20	1:1.7
16	Punjab	108	1:3.9
17	Rajasthan	60	1:2.5
18	Sikkim	3**	All in govt
19	Tamil Nadu – Chennai Tamil Nadu- Rest	150 225	1:3.8
20	Uttar Pradesh	250	1:3.3
21	Uttarachal	4**	1:0.3
22	West Bengal –Kolkata West Bengal – Rest	150 75	1:5.1

23-28	North-East (excluding Assam)	26**	1:0.4
29	Andaman & Nicobar	2	Both in govt
30	Chandigarh	34	1:1.6
31	Dadra & Nagar Haveli	0	0
32	Daman & Diu	0	0
33	Delhi	175	1:2.8
34	Lakshadweep	0	-
35	Puducherry	8	All in govt

based on *Doctors in India (4) ; **Directory of the Indian Psychiatric Society 2007(5), ***website of Goa Psychiatric Society (6).

Given the scenario of psychiatrists and their distribution in the different States and regions, each State government will have to evolve a policy of how it will provide mental health care to its constituents.

Pragmatic Response

The shortage of trained mental health human resources will be addressed in detail in the chapter on human resources. Integrating basic mental health care into the diverse health care facilities available appears to be the pragmatic direction ahead.

The District Mental Health Programme

The District Mental Health Programme was first pilot tested in the District of Bellary in Karnataka, way back in 1980. Although the feasibility and usefulness of decentralised mental health care was demonstrated in the Bellary DMHP programme, there was a long lull for nearly 15 years. Subsequently, following a meeting of the Central Council of Health in 1995, and the Workshop of all the health administrators held in February 1996 at Bangalore, the activation of the National Mental Health programme was recommended. A District Mental Health Programme was to be implemented at each State/UT (7).

The objectives of the DMHP as reformulated in 1996 were to:

- Provide sustainable basic mental health services to the community and integrate these services with other health services;
- Early detection and treatment of patients in the community itself;
- See that patients and relatives do not have to travel a long distance to government hospitals or facilities in cities;
- Take the pressure off the mental hospitals;
- Reduce stigma attached to mental illness through change of attitude and public education;
- Treat and rehabilitate mental patients discharged from mental hospitals in the community.

Between 1996 and 1997, the DMHP was launched in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu.

Mid-course evaluation of DMHPs

A team of experts from NIMHANS evaluated the DMHP being carried out in 27 districts in 2003. The report (8) concluded that programmes were functioning at different levels of efficiency contributing to different levels of outcome. Many of the DMHPs in most states had shown satisfactory progress at various stages of implementation. Where the programme had been successful, the objectives of decentralising mental health services from the cities to the district level, from the mental hospitals to the medical college hospital and partial integration of mental health services with general health had been achieved; the possibility of early detection of mental illness in the community had been enhanced; distances that patients and families had to travel had reduced; there were indications to suggest that the case-load of mental hospitals where the programmes were being implemented was declining. It attributed the success of the programme to the motivation and commitment of the nodal officer and programme staff, the interest and support of the administrative staff and senior state health authorities.

The report also expressed concern about the lack of any meaningful work in a few districts. It emphasised the need for an effective central support and monitoring mechanism. It highlighted that funds were not a constraint, but accessing funds was.

The restrategised National Mental Health Programme

The Government of India held a national consultative meeting (9) in June 2006 at NIMHANS to expand the scope of the NMHP under the 11th Five Year Plan. This meeting was attended by 29 mental health professionals from different states, the government and private sectors and representatives of professional bodies. The recommendations at this meeting included managing the DMHP under the public health system, having a nodal officer at each state, short-term training of medical officers in mental health at PG training centres, adequate public private partnership for all components of the DMHP, separate budget allocation for the NGO sector, regional training institutions on the model of NIMHANS, attention to special populations under the DMHP, a dedicated central monitoring cell, a common minimum education (IEC) kit, separate funding for an urban mental health programme and earmarked grants for research in the NMHP.

Table 4: Sites of the DMHP

Sl. No	States	Year of Initiation	District
1.	**Andhra Pradesh**	1996-97	Medak
2.		2000-01	Vizianagaram
3.		2004-05	Cuddapah
4.		2004-05	Prakasham
5.		2006-07	Nalgonda
6.		2006-07	Mahaboob Nagar
7.	**Arunachal Pradesh**	1997-98	Naharlagun
8.		2006-07	East Siang
9.	**Assam**	1996-97	Nagaon
10.		1999-00	Goalpara
11.		2004-05	Darrang
12.		2004-05	Morigaon
13.		2004-05	Nalbari

14.		2004-05	Tinsukia
15.	**Chandigarh**	1999-00	Chandigarh
16.	**Chhattisgarh**	2004-05	Bastar
17.		2004-05	Bilaspur
18.		2004-05	Dhamtari
19.		2006-07	Raipur
20.		2006-07	Raigarh
21.		2006-07	Durg
22.	**Dadra Nagar Haveli**	2006-07	Silvassa
23.	**Daman & Diu**	1998-99	Daman & Diu
24.	**Delhi**	1999-00	Chhattarpur
25.		2006-07	North –West District
26.		2007-08	West District
27.		2007-08	South West District
28.		2007-08	North District
29.	**Goa**	1998-99	South Goa
30.	**Gujarat**	1998-99	Navsarai
31.		2004-05	Amreli
32.		2004-05	Godhara
33.		2004-05	Surendranagar
34.		2006-07	Dang
35.		2006-07	Porbander
36.		2006-07	Junagarh
37.		2006-07	Banaskantha
38.	**Haryana**	2004-05	Gurgaon
39.		2004-05	Hissar
40.		1997-98	Kurukshetra

41.	**Himachal Pradesh**	1997-98	Bilaspur
42.		2004-05	Kangra
43.	**Jammu & Kashmir**	2004-05	Jammu
44.		2004-05	Kathua
45.		2004-05	Rajauri
46.		2004-05	Udhampur
47.	**Jharkhand**	2004-05	Dumka
48.		2007-08	Daltonganj
49.		2007-08	Gumla
50.	**Karnataka**	2004-05	Chamrajnagar
51.		2004-05	Gulbarga
52.		2004-05	Karwar
53.		2004-05	Shimoga
54.	**Kerala**	1998-99	Thiruvananthapuram
55.		1999-00	Thrissur
56.		2004-05	Idukki
57.		2004-05	Kannur
58.		2006-07	Wayanad
59.	**Madhya Pradesh**	1997-98	Shivpuri
60.		2003-04	Dewas
61.		2003-04	Sehore
62.		2004-05	Mandla
63.		2004-05	Satna
64.	**Maharashtra**	1997-98	Raigard
65.		2003-04	Amravati
66.		2003-04	Buldhana
67.		2003-04	Parbhani

68.		2004-05	Jalagaon
69.		2004-05	Satara
70.	**Manipur**	1999-00	Imphal East
71.		2003-04	Imphal West
72.		2003-04	Thoubal
73.		2007-08	Churachandpur
74.		2007-08	Chandel
75.	**Meghalaya**	2003-04	Jaintia Hills
76.		2003-04	West Garo Hills
77.	**Mizoram**	1999-00	Aizwal
78.		2006-07	Lunglei
79.	**Orissa**	2003-04	Mayurbhanj
80.		2003-04	Puri
81.		2004-05	Balangir
82.		2004-05	Dhenkanal
83.		2004-05	Karaput
84.		2004-05	Keonjhar
85.		2004-05	Khandhamal
86.		2004-05	Khurda
87.	**Punjab**	1997-98	Muktsar
88.		2006-07	Sangrur
89.		2006-07	Hoshiarpur
90.	**Rajasthan**	1996-97	Seekar
91.	**Sikkim**	2001-02	East Gangtok
92.	**Tripura**	2001-02	West Tripura
93.		2003-04	North Tripura
94.	**Tamil Nadu**	1996-97	Trichy

95.		2000-01	Ramanathapuram
96.		2000-01	Madurai
97.		2003-04	Kanyakumari
98.		2003-04	Theni
99.		2004-05	Dharampuri
100.		2004-05	Erode
101.		2004-05	Nagapattinam
102.		2007-08	Kancheepuram
103.		2007-08	Thiruvallur
104.		2007-08	Cuddalore
105.		2007-08	Perambalur
106.		2007-08	Virudhunagar
107.		2007-08	Thiruvarur
108.		2007-08	Namakkal
109.		2007-08	Chennai
110.	**Uttar Pradesh**	1997-98	Kanpur
111.		2004-05	Azamgarh
112.		2004-05	Banda
113.		2004-05	Faizabad
114.		2004-05	Gazipur
115.		2004-05	Ghaziabad
116.		2004-05	Itawah
117.		2004-05	Mirzapur
118.		2004-05	Moradabad
119.		2004-05	Muzaffarnagar
120.		2004-05	Raibareli
121.		2004-05	Sitapur

	West Bengal	1998-99	Bankura
122.		2003-04	Jalpaiguri
123.		2003-04	West Midnapur
124.		2006-07	South 24 Parganas

Currently the DMHP has been extended to 124 districts. Under the 11th Five-Year Plan (2007-2012), it will be extended to another 200 districts. It is expected that in the 12th Five-Year Plan (2012-2019) the remaining districts of the country would be covered.

The DMHP is one of the components of the restrategised NMHP. The NMHP also looks at strengthening general hospital departments of psychiatry and the existing government hospitals. Other components include adolescent and school mental health programmes, college mental health programmes, improving mental health human resources, IEC activities, public-private partnerhips, research in mental health, suicide prevention and stress management.

Given the fact that many of the specific components and activities in the scope of NMHP will involve public-private partnerships, it will be useful to summarise some of the innovative approaches to community mental health care that have occurred in the country. Some of these have occurred in the government sector, some in the non-governmental sector and some illustrate partnerships in mental health care.

Innovations/Initiatives in mental health in India

There have been several innovative community mental health care approaches in different parts of India. In this section we present some illustrative examples. These examples are limited and do not necessarily represent all the initiatives that may be present on the ground, but they help to provide an idea of the range of services that can be provided by the community, and considered under the NMHP programme by the States. It must be emphasised that these initiatives are few and concentrated in a few regions. Many of them have sustained because of human commitment. They are described under certain broad areas.

Children and Adolescents

Life skills education in schools – NIMHANS experience (Karnataka)

Health promotion in schools using life skills approach needs trained manpower resources. Teachers become the most important resource for this activity.

Life skills education was institutionalised into the education system in four Districts of Karnataka (10-12). The approach used was a cascading model where master trainers were trained by mental health professionals for one week. The master trainers are expected to train teachers in their respective District Institute of Education and Training (DIET) in a three-day training programme. The training is participatory and activity oriented.

School mental health – (Delhi)

A school mental health programme "Expressions" is being successfully run in Delhi schools since past six years (13). A team from Child Development and Adolescent Health Centre, VIMHANS, New Delhi started this programme. They have already conducted over 200 workshops in NCT region of Delhi schools and in a few satellite towns of Northern India (Amritsar, Ludhiana, Agra, Jodhpur, Banaras, Sikkim) for children and adolescents. The programme consists of a three-part module on comprehensive school mental health, and is entirely experiential in nature. The programme also evaluates the teacher's own mental well-being and stress levels, which can influence their professional output.

College mental health programme (Karnataka)

NIMHANS, Bangalore has developed many community-based prevention and promotion programmes to reduce mental morbidity and to improve mental well being of people. College students are a high-risk group to develop mental health problems. This programme involves college teachers in counseling students and they act as referral agents and support providers for those students with psychosocial problems and mental distress.

In 1995, the Department of Collegiate Education of Govt. of Karnataka and NIMHANS, Bangalore launched a short-term training course in students counseling for volunteer teachers. During 1995 to 2006, 661 teachers from all over the State of Karnataka underwent training in 26 batches of teachers.

Protecting children's mental health (Goa)

The Sangath Centre for Child Development and Family Guidance was started in Goa in 1997(14). The centre deals with diverse issues such as scholastic backwardness, family violence, postnatal depression and all areas of behavioural, developmental and emotional health of children, through a community mental health service. The organisation also works with schools as well as parents.

Children with intellectual difficulties

There are several organisations working with children with serious intellectual difficulties throughout the country. Many of them have done pioneering work in this area and are now well established in service provision, training and advocacy. A more detailed discussion of these organisations is outside the scope of this review.

Parents as change agents for children with learning disabilities– the ALDI (Kerala)

The Association for Learning Disabilities, India, (ALDI), was formed at Thrissur in 1990 (15) by two parents searching for help for their child with a learning disability - this resulted in the coming together of a few professionals (two psychiatrists, and a clinical psychologist), teachers and parents who had an interest in starting such services. Activities of this organisation has included conducting awareness programmes in schools, developing community based services for children with dyslexia and involvement in the Kamakshi Grama Panchayat programme to help children with scholastic backwardness through remediation.

Empowered, Enabled, Effective–the Samadhan approach (Delhi)

The operational strategy of Samadhan is based on the concept of the Self-Help Group but with a difference (14). They employ a Self-Help Group, whether mothers, women from the community or persons with mental handicap or other disabilities can take home a regular income each month. The women are also trained to function as community workers and home intervention workers to help families with mentally handicapped children.

Services for destitute children with mental illness (Tamil Nadu)

Anbaham (16) is a project of TERDOD, which is a registered public

charitable trust. Anbaham's mission is to provide shelter for mentally ill orphans, rehabilitate them through proper medication, training and reuniting them with their long lost families wherever possible, thus helping them to lead normal lives. Between 1999 and May 2006, Anbaham provided shelter to more than 300 individuals with mental health problems and has reunited 275 of these individuals with their families.

Counseling Services

Listening with the Heart–Helping Hand (Karnataka)

Helping Hand (17), founded by a housewife in Bangalore, welcomes any one who is interested in working for fellow humans. Volunteers range from 18 to 80 years of age. While a few are themselves medical professionals or psychologists, the vast majority are lay people from unconnected fields. There are many retired persons, a number of housewives, and also many busy professionals who desire to spend a few hours in the week giving back to society.

All the volunteers were initially trained in the basic skills of being non-judgmental listening and empathizing. There are many who have a special interest in learning how to deal with particular types of people. They are encouraged to get training and exposure in their area of interest. There are volunteers who work with alcohol and drug other drug addiction, others who assist families of mentally ill, and some who spend time with terminally ill cancer patients. Some of the volunteers befriend disabled children, while others work with battered women. Many of them work in government hospitals.

Helping with stress: Prasanna Counseling Centre (Karnataka)

Prasanna Counseling Centre was founded by an engineer. He took up social work as his lifetime job. In the beginning, the centre started with providing support to persons who had attempted suicide. More than 600 hundred lay volunteers have been trained over the past 26 years in Bangalore city. Hundreds of people who are psychologically distressed seek help from this centre.

Preventing suicide: Sneha (Tamil Nadu)

Sneha was started by a psychiatrist in 1986. A chosen band of volunteers were trained to run the centre. It uses the concept of "Befriending" to help

persons in crisis (14). This is done by trained lay people and is directed more towards addressing the feelings experienced (anger, fear, disappointment, hopelessness, etc.) rather than offering suggestions and advice, in attempting to solve their problems.

Crisis intervention centre: Aasra (Maharashtra)

Aasra (18) is a crisis intervention centre for the lonely, distressed and suicidal. Aasra functions as a unit of Befrienders India / Samaritans and is registered as a Public Charity under the Bombay Charity Act, 1960.

Emotional support for distressed persons: Maithri (Kerala)

Maithri is a voluntary organisation working to provide confidential emotional support to distressed persons, who may be in danger of taking their own lives (19). Maithri operates in Kochi (Cochin), in Kerala, which has a high suicide rate.

Services for the elderly

Utilising Senior Citizens as Effective Volunteers: The Dignity Foundation (Maharashtra)

Dignity Foundation was set up as a charity to promote "productive ageing" (20).

Various services are offered to the senior citizens and in each service delivery, another senior citizen plays a vital role. Activities include Dignity *Dialogue* (a monthly magazine), issue of senior citizens ID card to more than 4 lakh senior citizens, a help line offering a social support system for the elderly, dementia day care, companionship for the elderly and counseling and enrichment centres for the elderly. The Foundation helps 83 police stations through its senior citizen members. Some senior citizens offer voluntary service at banks and form vigilant groups.

Care for dementia (Kerala)

Alzheimer's and Related Disorders Society of India (ARDSI) is a registered, national, non-profit, voluntary organisation dedicated to the care, support, training and research for people with dementia (14). ARDSI was formed in 1992 by affected family members, interested professionals and social workers. It aims to improve the quality of life of people with dementia as well as the caregivers through support services, awareness

campaigns and a variety of other projects. ARDSI has 14 chapters spread across the country with its headquarters in Kerala. Through this network ARDSI implements a number of services like day care, home care, memory clinic, respite centre, helpline and training of community geriatric care workers. One of its important objectives is to empower people in the community to cope with the challenges caused by the illness.

Providing treatment for alcoholism through rural camps: The TTK Hospital (Tamil Nadu)

The TTK hospital in Chennai has a long tradition of providing care for alcohol dependence through rural camps conducted in six locations in Tamil Nadu since 1989 (14). The organisation works with voluntary agencies in the community, prepares the community for the camp, identifies potential participants and has a structured counseling programme. It offers comprehensive treatment for the 15-day camp duration. Follow-up is organised with the local community.

NGOs in training in alcohol and drug dependence rehabilitation

The National Centre of Drug Abuse Prevention under the Ministry of Social Justice and Empowerment has identified 8 NGOs with strong technical capabilities to provide training and information at regional levels, monitor programmes and implement the Drug Abuse Monitoring System. These NGO's are Galaxy Club (Manipur), Kripa Foundation (Maharashtra), The Calcutta Samaritans (West Bengal), Mizoram Social Defence and Rehabilitation Board (AP), Muktangan Mitra (Maharashtra), Society for Promotion of Youth and Masses (Delhi), the TT Ranganathan Clinical Research Foundation (Tamil Nadu) and Vivekananda Education Society (West Bengal).

Primary Care Initiatives in Mental Health

Multiple purpose workers in mental health care (Karnataka)

For mental health care to become accessible despite resource constraints, the primary care model allows a tremendous opportunity. It has many advantages. It provides an opportunity for early diagnosis and treatment, which has a better outcome. It is less stigmatizing. Being more accessible, it is likely to be more frequently utilised. It is less expensive for both service seekers and providers. Training primary health care staff in mental health care is both a challenge and an opportunity.There have been several studies

demonstrating the feasibility of training of health workers to undertake a limited amount of mental health tasks, as part of their routine health work (21-26).

Mental health care through Ashagram (Madhya Pradesh)

The mental health unit of Ashagram was initiated in 1996 (14) using an eclectic multi-disciplinary model, which emphasised enhancing awareness and providing accessible services relevant and acceptable to local people. Ashagram has demonstrated that trained mental health workers drawn from the community can deliver high quality care for chronically mentally ill.

An important role for Anganwadi workers (Delhi)

Community outreach clinics are being carried out by the Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi since the year 2000 under the District Mental Health. Anganwadi workers from Chattarupur village were involved to address the high rates of dropout of patients from follow-up. They were imparted knowledge about the common mental disorders (CMDs) including depression and anxiety disorders, drug and alcohol abuse, mental retardation and epilepsy. As they are well versed with the local geographical area, the mapping of the community became easier for carrying out the programme in an extensive manner.

Lay persons as partners in mental health management (Maharashtra)

The Schizophrenia Awareness Association (SAA) was founded in 1998 by a few individuals with compassion for persons with mental illness and their caregivers (27). Its objectives are to create awareness about schizophrenia and other mental disorders among the community, to promote self-help groups for patients (shubhartis) and their caregivers and to network with other NGOs offering mental health care. This group exchanges information about illness, members provide mutual moral support and instill hope of recovery in the carers. The group also provides a forum to professionals to share their expertise with the user group.

Care giver Initiatives

A care giver initiative (Maharashtra)

MANAV was started by the caregiver of a daughter with learning disability who went on to develop schizophrenia (28). Shocked at the dearth of

rehabilitation services, she set up the Manav Foundation in 2004. The Manav rehabilitation centre provides treatment support and care to persons with a mental illness, personality disorder and/or a mental condition that has rendered them non-functional, provides support to caregivers, offers counseling to distressed adults with emotional problems and encourages involvement of the community.

The KSHEMA Family: AMEND and ACMI (Karnataka)

The Association for the Mentally Disabled (AMEND) was initiated in 1992 (14). The KSHEMA project was started as a family to family peer sharing activity. Client families are provided awareness about mental illness and its treatment, encouraged to understand mental illness as a disability and supported through education, empowerment and enablement. An offshoot, 'Action For Mental Illness' (ACMI) is an advocacy initiative that was started in 2003. The ACMI adopts a four dimensional strategy–social, political, legal and media advocacy. This organisation has been able to get disability certification protocols into action, obtain income tax rebates for persons with mental illness and their family members. It filed a PIL in both the Karnataka High Court and Supreme Court to bring to attention the discrimination of persons with mental illness in the PDA Act, lack of a rights based legislation and political inertia in the implementation of the NMHP.

Rehabilitation for serious mental illness

The Richmond Fellowship Society (India) (Karnataka)

The RFS (14) provides care and psychosocial rehabilitation for persons with mental health needs in India and also for those in the neighbouring countries. It delivers its services through Asha, a halfway home functioning since 1989, Jyoti, a group home for persons with chronic psychiatric illness, Chetna, a day care centre with vocational training facilities and Pragathi, a community based rural multidisciplinary mental health project in the Kolar district of Karnataka.

Medico-pastoral association (Karnataka)

The medical pastoral association was founded in 1967(14). It was a movement initiated by volunteers to promote mental health and care in the community. During the initial period, the MPA volunteers provided counseling for persons with alcohol or drug problems, emotional problems,

psycho-social problems and suicidal patients. It started the AA groups in 1969 at NIMHANS and suicide prevention squad in 1971.

It developed a half way home in 1975 in response to needs of person with mental health problems. The growth of MPA is an ideal example of collaboration between an NGO and a governmental agency like NIMHANS. The Navajeevan hostel for working persons with mental health problems was developed in 1988 and a long-term care centre was established in 1997.

The SCARF Experience (Tamil Nadu)

Schizophrenia Research Foundation (SCARF) is a voluntary organisation based in Chennai (14). It was founded in 1984 by a group of philanthropists and mental health professionals. SCARF is one of the very few NGOs in the world to be named as a Collaborating Centre with the World Health Organization (WHO) for Mental Health Research and Training.

It was the first voluntary agency to provide rehabilitation free of cost for persons with severe mental disorders. It has a day care centre, residential rehabilitation centre, long-term care, child support programme and a community mental health programme. This organisation is also actively involved in research into the biological, social and psychological aspects of schizophrenia, enhancing public awareness about the disorder, conducting academic programmes on various aspects of mental health and lobbying for mental illness care and treatment.

Anand Rehabilitation Centre (Maharashtra)

This is a project of Prompt Care International Foundation (PCIF) and was established in 2002, because PCIF saw a growing need for "psycho-social rehabilitation for schizophrenia and a lack of such services in the western region of the country" (29). ARC's work is funded by its user fees. In 2007, it began providing outpatient services. This building also houses the Anand Care Centre, which is for individuals with Parkinson's disease, Alzheimer's disease, or dementia.

Chaitanya Mental Health Care Centre (Maharashtra)

Chaitanya Mental Health Care Centre (Chaitanya) was started in 1999 (30). It offers residential facilities to persons with a variety of mental health problems. Chaitanya's goal is to help people to regain the skills that they

lost during hospital stay so that they can be integrated back into society. This is done by providing medicine and a structured environment with a routine of activities such as art therapy and cultural activities. The average length of stay is nine to twelve months, but the period may be extended according to the need.

'Ashadeep'– the first NGO in Mental Health in the NE Region

The first initiative of this family based organisation was a day care centre in 1996 (31), with a stress on vocational activity. It conducts family support group meetings. Its sheltered workshop for recovering members now offers both day care and residential facilities. It has been conducting monthly outreach programmes along with another local NGO, Satra.

Paripurnatha (West Bengal)

Psychosocial rehabilitation of the mentally ill women in prisons of west Bengal was the main reason behind the founding of Paripurnatha (14). Its objectives were to start a half way home for non-criminal mentally ill women, to rehabilitate the women, to educate family members, to train its residents in gaining financial independence and encourage community participation in the care of the mentally ill. The most valuable contribution of Paripurnata is in demonstrating that it is possible for people with mentally illness to get back to the mainstream of society. It has provided a model for many mental hospitals in the country to work in partnership with the community to rehabilitate and reintegrate persons with mental illness into society.

Services for the Homeless Mentally ill

The Banyan Story (Tamil Nadu)

The Banyan was established in 1993 (14) by two just out of college young women concerned for the care of the mentally ill. The Banyan cares for and rehabilitates homeless women with mental illness found in the streets of Chennai at its home, Adaikalam. It provides shelter, medical care and a supportive environment for recovery and also supports the return of the women after recovery to their families and community, or helps them start a new life. It has taken a strong role in lobbying for the rights of the homeless mentally ill in order to facilitate localised access to mental health care.

Mental health care for the homeless mentally ill (Karnataka)

The department of psychiatry, NIMHANS, Bangalore and the Ministry of Social welfare, Government of Karnataka initiated a collaborative effort to address the needs of the destitute men and women in Bangalore city. The warders and the support staff including the superintendent of the destitute centre have been trained in mental health skills to provide basic mental health care in the centre. The local government was requested to hand over the nearby primary health unit to Karuna Trust, a non- governmental organisation headed by right livelihood awardee Dr.H.Sudharshan (32). The department of psychiatry, NIMHANS provided technical support to manage person with mental health problems, substance abuse problems and other brain disorders. The primary health care team implements case management plan for persons with severe mental health problems in the centre. Collaboration between two government departments and an NGO has been working well to provide mental health care for the destitutes in Bangalore.

Advocacy for Mental Health

Research advocacy support and help for the mentally ill (Delhi)

This organisation, RASHMI, holds regular public meetings to make people aware of problems related to mental health and advances in the area, family carers' meetings to provide support, address the problem of exclusion and stigma on account of mental illness. RASHMI played an important role in the formation of the National Federation for Mental Illness (NAMI). It presently works with the Department of Psychiatry at the Ram Manohar Lohia Hospital to provide care giver support.

Nodal alliance for mental illness

NAMI INDIA is a registered trust with the Charity Commissioner, Mumbai (33). It aims to provide help in the reduction and treatment of mental illness in India by integrating and involving consumers, mentally challenged people, doctors, healthcare workers, Government and other sections of society. It seeks to improve awareness on mental illness, conduct courses, network with support groups, set up an India-centric website on mental illness, serve as a nodal agency that interacts with government and NGOs in the area and to advocate better health care delivery systems for the mentally ill in the country.

The Bapu Trust (Maharashtra)

The Bapu Trust is engaged in social science and feminist research in the area of mental health (14). It attempts to convert academic work into ground level policy, social and legal activism. It is committed to bring about changes in societal attitudes to mental illness and fight for the rights of people with mental health difficulties, especially in terms of their right to good quality care. Its platform for action is "Enabling user assertion in mental health". It has set up a Centre for Advocacy in Mental Health (CAMH)

Other Activities

Rationalist Society (Punjab)

The Taraksheel Society was formed with the primary aim of developing a scientific temperament among people in 1984 (34). This society has been actively involved in creating awareness about mental illness and providing guidance to persons in need of psychiatric care.

ROSHNI (Punjab)

Roshni has been in existence since 2003 at Ludhiana in Punjab. It was formed by a group of like-minded persons who decided to come together to make a difference in the lives of persons who were undergoing extreme stress leading to a deterioration in their mental health. It works with the victims of domestic violence and has set up a 'Crimes against Women' police counseling cell at Ludhiana (35). A lot of domestic violence and crimes against women was seen to be associated with alcohol/drug abuse by their male family members. The counseling process and police protection together has helped in alleviating the emotional problems experienced by women and their children.

A club for women from slums (Chandigarh)

The Gangadevi Club (36) was started as an activity of an NGO under the project Atam Vishvas in 2004. The purpose is to provide a samuh (club) for the underprivileged women of the area, particularly the abandoned, old sick, needy and neglected women.

Notes from Jammu and Kashmir

The state of Jammu and Kashmir has undertaken serious measures for

capacity building for medical officers, paramedical workers, nurses, schoolteachers, volunteers and significant others to ensure psychosocial and mental health care for the affected population in partnership with NIMHANS. An outstanding example of networking is collaboration between mental health professionals and NGOs. Young mental health professionals have initiated mental health care services in the far-flung and remote areas of Kashmir region with help from Action Aid India and MSF (Doctors without borders). The professionals have been able to establish childcare centres in different locations of Kashmir region.

The police department in the Kashmir region has been able to establish a de-addiction centre in the police hospital, providing treatment to many young people with drug problems. This activity is entirely funded by the police administration. The medical and paramedical personnel associated with the police hospital manage the deaddiction services. The treating team receives periodic support from the faculty of the medical college, Srinagar.

Conclusion

In this section, we have highlighted the need to integrate mental health care into primary health care and traced the development of the district mental health programme. Given the much wider scope of the restrategised National Mental Health Programme and the focus on public private partnerships, we have provided some illustrative examples of work done by organisations in the community, hoping that these will provide ideas for community based, integrated and comprehensive mental health care. Each State will have to carefully understand its mental health care needs, map its resources for mental health care delivery, and plan programmes aimed at improving mental health and ameliorating mental health problems among its constitutents.

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