NHPP23- National Mental Health Programme

Quadrant – I

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Description of Module:

Items	Description of Module
Subject Name	Community Medicine
Paper Name	National Health Policies and Programmes
Module Name/Title	National Mental Health Programme
Module Id	NHPP23
Pre-requisites	Knowledge on mental health; Knowledge on national progammes in general
Objectives	At the end of this module the students will be able to: • Describe the problem of mental health. • Describe the objectives and strategies of the national programme on mental health
Key words	National Programme, mental health

Introduction

Mental health is an integral and essential component of health. World Health Organization defines mental health as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stressors of life and can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of the community.

Globally the mental health problems are rising and the burden of illness resulting from the psychiatric and behavioral disorders is enormous.[1]

Learning Outcomes

At the end of this module the students should be able to:

- Describe the problem of mental health.
- Describe the objectives and strategies of the National Mental Health Programme

Main Text

1. Burden of mental health problems

1.1 International Scenario

The prevalence of mental disorders as per World Health Report (2001) is around 10% and it is predicted that burden of disorders is likely to increase to 15% by 2020.[2]

WHO has given due recognition and importance to mental health as it is obvious from their theme for the World Health Day (7th April 2001), World Health Assembly (15th May 2001) and the World Health Report 2001 with Mental Health as the main focus. A separate day as the World Mental Health Day is observed on 10th October every year.

The WHO Mental Health Gap Action Program (mhGAP) was launched in 2008 with a main aim of scaling up services for mental, neurological and substance use disorders for countries with low and middle income.

The mental, neurological and substance use disorders account for 13% of the total global burden of diseases in the year 2004. Depression alone accounts for 4.3% of the global burden of diseases and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women. The gap between the need for treatment and its provision is large all over the world. WHO Mental Health Atlas 2011 provides data that demonstrate the scarcity of resources within countries to meet mental health needs. [3]

The Director General, World Health Organization launched the Mental Health Action Plan 2013- 2020 on 7th October 2013. The Action plan recognises the essential role of mental health in achieving health for all people. It aims to achieve equity through universal health coverage and stresses the importance of prevention in mental health.

The objectives of World Health Organization Mental Health action plan 2013-2020 are:

- More effective leadership and governance for mental health;
- The provision of comprehensive, integrated mental health and social care services in community-based settings;
- Implementation of strategies for promotion and prevention;
- Strengthened information systems, evidence and research for mental health.[3]

1.2 Indian Scenario

According to various community based surveys, prevalence of mental disorders in India is 6-7% for common mental disorders and 1-2% for severe mental disorders. In India the rate of psychiatric disorders in children aged between 4 to 16 years is about 12% and nearly one-third of the population is less than 14 years of age. With such a magnitude of mental disorders it becomes necessary to promote mental health services for the well being of general population, in addition to providing treatment for mental illnesses. Treatment gap for severe mental disorders is approximately 50% and in case of Common Mental Disorders it is over 90%.[4]

1.3 Social, environmental and economic determinants of mental health[5]

The various risk factors and protective factors related to mental health and mental disorders are as follows:

Risk factors	***Protective factors***
Academic failures and scholastic demoralization	Ability to cope with stress
Access to drugs and alcohol	Ability to face adversity
Attention deficits	Adaptability
Caring for chronically ill or dementia patients	Autonomy
Child abuse and neglect	Early cognitive stimulation
Chronic insomnia	Empowerment
Chronic pain	Ethnic minorities integration
Communication deviance	Exercise
Displacement, isolation and alienation	Feeling of security
Early pregnancies, substance use during pregnancies	Feelings of mastery and control
Elderly abuse	Good parenting
Emotional immaturity and dyscontrol	Literacy
Excessive substance use	Positive attachment and early bonding
Exposure to aggression, violence and trauma	Positive interpersonal relationships
Family conflict or family disorganization	Positive parent-child interaction
Lack of education, transport, housing	Problem solving skills
Loneliness	Prosocial behavior self esteem
Low birth weight	Skills for life
Low social class	Social and conflict management skills
Medical illness	Social participation
Neighborhood disorganization	Social responsibility and tolerance
	Social services
	Social support and community networks

Neurochemical imbalance
Parental mental illness
Parental substance abuse
Peer rejection
Perinatal complications
Personal loss-bereavement
Poor social circumstances
Poor work skills and habits
Poverty, poor nutrition
Racial injustice and discrimination
Reading disabilities
Sensory disabilities or organic handicaps
Social disadvantage, urbanisation
Social incompetence
Stressful life events
Work stress, unemployment
War, violence and delinquency

2. **Status of Manpower in Mental Health**

As per the National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Ministry of Health and Family Welfare during May and July 2002, the ideal required number of mental health professionals has been calculated and the details of present requirement and availability of mental health professionals in the country are given as:

Ideal required number of mental health professionals.

i. Psychiatrists: 1.0 per 1,00,000 population
ii. Clinical Psychologist: 1.5 per 100,000 population
iii. Psychiatric Social Workers: 2.0 per 100,000 population
iv. Psychiatric Nurses: 1.0 per 10 psychiatric beds.

The details of requirement and availability of mental health professionals in the country is as under:

Manpower	Requirement	Availability
Psychiatrists	11,500	3,800
Clinical Psychologist	17,250	898
Psychiatric Social Workers	23,000	850
Psychiatric Nurses	3,000	1,500

As against an estimated requirement of 11,500 psychiatrists, 17,250 clinical psychologist, 23,000 psychiatric social workers and 3,000 psychiatric nurses only approximately 3,800 psychiatrists, 898 clinical psychologists, 850 PSWs and 1,500 psychiatric nurses are available at present. The estimated figure is calculated using a norm of 1 psychiatrist per 100,000 populations, 1.5 clinical psychologists per

100,000 population, two psychiatric social workers per 100,000 population and one psychiatric nurse per 10 psychiatric beds.[6]

3. History of Mental Health Services and Initiatives [5,7,8]

3.1. Bhore Committee

The Bhore committee report in 1946 stated that the prevalence of mental illness during that period was estimated to be 2/1000 general population and India had only 10,000 psychiatric beds and 30 institutions for a population of over 400 million. The committee recommended that:

i. The hospital beds for mental diseases should be increased.
ii. Mental health organization should be created at centre as well as under DGHS in all the states.
iii. The training in mental health for all medical and ancillary personnel in India and abroad.
iv. Creation of a department of mental health in the proposed All India Institute of Mental Health.[7]

3.2. Mudaliar Committee

The Government of India appointed Health Survey and Planning Committee in 1959, chaired by Dr Mudaliar to assess the state of health care and review the progress after the implementation of Bhore committee's recommendation. Committee submitted their report in 1962 and identified that:

- Reliable statistics were not available regarding the burden of mental health problems/morbidity in India.
- There must be a huge number of patients requiring assistance and treatment.
- The provision for treatment of psychosomatic diseases was limited.
- There were no avenues for education of mentally sick.

The committee recommended --

i. The setting up of in-patient and outpatient departments at hospitals.
ii. Setting up of Independent Psychiatric and Mental health clinics and Institutions for mentally sick.
iii. To develop the Psychiatric clinics with 5-10 beds in each district[5]

3.3. Srivastava Committee

The Srivastava Committee (1974) recommended the Community Health Volunteer (CHV) scheme. The CHVs were supposed to provide their services to a population of 1000. The Committee recommended that the training of Community Health Volunteers should have a component on mental health. They also recommended that one of the manuals of these workers should deal with identifying and managing mental health emergencies and problems.[8]

3.4. Various milestones leading to development of NMHP

In the post independence time, the initial two decades were focused on increasing the number of beds for mental hospitals.[9] Some new mental hospitals were started and All India Institute of Mental Health was setup in 1954 which later became NIMHANS in 1974.This Institute is instrumental in developing various models of practice and influencing policies related to mental health.

The concept of community psychiatry was initiated by CIP Ranchi by starting a rural mental health clinic in 1967 at Mandar. Major community mental health initiatives were taken at NIMHANS Bangalore and PGIMER Chandigarh during 1970's.Community Psychiatry unit was established by NIMHANS.

The National Mental health Program (NMHP) has developed gradually. India is one of the first few countries in the developing world to formulate the NMHP. There are 5 important factors which contributed to the drafting of the National Mental Health Programme.[10]

a) *A set of recommendations by an Expert Committee of WHO- 'The organization of mental health services in developing countries*. The expert committee had endorsed the strategy of integrating the mental health services into the primary care services.

b) *Starting of "Community Mental Health Unit" at National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore- in 1975. Sakalwara Project.*
Community Mental Health Unit at NIMHANS carried out the mental health need assessment and situation analysis in nearly 200 villages around the Sakalwara rural mental health centre, covering a population of 100,000. Simple ways of identifying and managing persons with mental illness, epilepsy mental retardation were developed. The Mental Health education material was developed which could be used by the MPW in rural areas. Manuals for PHC personnel were developed and it was also decided that how the trainings provided to the PHC personnel can be evaluated.
The overall experience of Sakalwara Project led to development of strategy for provision of Mental Health care to the rural areas through the existing primary health care network.

c) *Multi – Country Project WHO, "Strategies for extending Mental Health Services into the Community (1976-1981).*
This model of care proposed the integration of mental health with general health services and provision of basic mental health care by trained health workers and doctors. This was executed as a multi-country project in 7 developing countries. The department of Psychiatry at PGIMER Chandigarh was the centre in India and the model was developed in Raipur Rani Block of Haryana.

d) *The "Declaration of Alma Ata" to achieve "Health for all by 2000" (1978).*
The increasing awareness regarding the mental health problems and the Alma-AtaDeclaration in 1970, which emphasises on the health for all by 2000 led to the launching of NMHP by the Government of India in 1982.

e) *ICMR-DST Collaborative Project on "Severe Mental Morbidity".*
In late 70's and early 80's this project was done to evaluate the feasibility of training of PHC staff to provide mental health care as part of their routine work.

In 1982, the highest policy making body in the field of health in the country, the Central Council of Health & Family Welfare (CCHFW) adopted as well as recommended the implementation of NMHP in India. NMHP was launched in 1982 with very comprehensive objectives which stand true even today.

4. National mental health program (NMHP)[11]

4.1 Objectives

- To ensure the availability and accessibility of mental healthcare for all in the foreseeable future, particularly to the most vulnerable and most underprivileged sections of the population.
- Encourage application of mental health knowledge in general health care and social development.
- Promote community participation in mental health services development and stimulate efforts towards self –help in community.

4.2 Strategies

- Integration of mental health with primary health care through the NMHP.
- Provision of tertiary care institutions for treatment of mental disorders.
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority and State Mental Health Authority.

4.3 Specific Approaches

- Diffusion of mental health skills to the periphery of health services.
- Appropriate appointment of tasks.
- Equitable and balanced distribution of resources.
- Integration of basic mental health care with general health services.
- Linkage with community development. [12]

4.4 Service Component

The service component comprised of: [13]

4.4.1. Treatment

The treatment component was planned to be provided at various levels

i. Village and sub-centre level---Multipurpose Workers (MPW) and Health Supervisors (HS) under the supervision of Medical doctors(MO) to be trained for--

a. The management of psychiatric emergencies
b. Administration and supervision of maintenance treatment for chronic psychiatric disorders
c. Diagnosis and management of Grand –mal epilepsy

d. Liaison with local school teachers and parents regarding mental retardation and behavior problems in children
e. Counseling in problems related to alcohol and drug abuse

ii. Primary health centre(PHC):MO aided by HS to be trained for –
a. Supervision of MPW's performance
b. Elementary diagnosis
c. Treatment of functional psychosis
d. Treatment of uncomplicated cases of psychiatric disorders associated with physical diseases
e. Management of uncomplicated psychosocial problems
f. Epidemiological surveillance of mental morbidity

iii. District hospital: The district hospital must have 30-50 psychiatric beds. There should be at least 1 psychiatrist attached to every district hospital.The psychiatrist is entrusted with the responsibility of clinical care of patients and training and supervision of non-specialist health workers.

iv. Teaching psychiatric unit and mental hospital:Their main role of would be ---
a. Providing help for difficult cases
b. Teaching
c. Specialised facilities such as occupational therapy units, psychotherapy, counselling and behavior therapy.

4.4.2. Rehabilitation

The subcomponents of rehabilitation include maintenance treatment of epileptics and psychotics at the community levels and development of rehabilitation centers at both the district level and the higher referral centers.

4.4.3. Prevention

This component was community based, with the initial focus on the prevention and control of alcohol related problems and later on other issues like addictions, juvenile delinquency and suicides.

4.5. Features of the NMHP [12]

- Decentralised and phased training courses were conducted for all the health personnel of the district so that they would deliver basic mental healthcare services to the needy.
- The services covered a population of 1.5 million distributed in seven talukas.
- A programme officer for mental health was appointed in the district health and family welfare office, who organised a mental health clinic in the premises and also toured the entire district to monitor the programme.

- A simple recording and reporting system was developed. The district health officer monitored the progress every month during the monthly review meetings along with other health programs.
- Five essential drugs were made available for distribution in all the health centres in the district.
- During the first three years of the project (1985-88), 1200 patients with psychosis, 3525 patients with epilepsy, 750 patients with neurosis and 380 mentally retarded (learning disabled) persons were registered. Forty-two percent of patients with psychosis and 53% of those with epilepsy took treatment regularly and showed improvement. Seventy percent of patients came from places within a five-kilometer range of the health center. Thus, distance and availability of free care facilities appear to be important factors in good compliance.
- Good performers in the mental health care programme of the system were good in all other health programmes. Poor performers appeared to have had many personal and psychosocial problems which came in the way of their performance.
- As the mental health services became popular, patients reached the centres within a few days/ weeks of the onset of the illness and took a short and straight path instead of taking a long path by visiting various faith healers and other agencies.
- The district programme gave professionals an idea as to how to organise services in a cost effective manner and maintain a reasonable quality.

The main *strength* of NMHP document drafted in 1982 was that it envisaged the integration of mental healthcare with the general primary healthcare.

On the other hand there was some inherent weaknessesof this model of care. These were:

- The programme emphasised more on curative components rather than the preventive and promotive components;
- Role of support of families in the treatment of the patient was not given due importance;
- Short term goals were given priority over the long term planning;
- The administrative structure of the programme was not clearly outlined;
- No estimates of budgetary support were made.[13]

After reviewing the progress made during 1982-88, it was concluded that although the developments in this area raised the hopes for beginning a big programme in the country, the financial constraints somehow restricted it. In the Ninth five year plan Rs 28 crores were allocated to NMHP.In-depth analysis and consultation with the stakeholders led to a major change in NMHP and was launched with certain changes in 2003. [14]

NMHP Tenth five year plan was launched, with a plan to extend the DMHP to 100 districts. Tenth plan allocated Rs 139 crores and emphasised---

- The need to broaden the scope of existing curriculum for undergraduate training in psychiatry and to give more exposure to psychiatry in undergraduate years and internship.
- Need for DMHP to be spread to the entire country in a more effective manner.
- Streamlining /modernising mental hospitals to overcome their custodial role.
- Strengthening the Central and State mental health authorities with a permanent secretariat.
- Appointment of MO at state headquarters.

- Research and training in the field of community mental health, substance abuse and child/adolescent psychiatric clinics.[15]

During the Eleventhfive year plan in NMHP the focus was on establishing centers of excellence in mental health, increasing intake capacity and starting postgraduate courses in psychiatry, modernisation of mental hospitals and up-gradation of medical college psychiatry departments, focus on non-government organisations (NGOs) and public sector partnerships, media campaign to address stigma, a focus on research and several other measures.[13]

The emphasis of NMHP-1982 was primarily on the rural sector. It is being realised that the urban mental health needs should also be addressed under the ambit of NMHP.

4.6 District Mental Health Programme (DMHP)

NIMHANS developed a programme to operationalise and implement the NMHP in a district. DMHP was launched in 1996 with an aim to achieve the objectives of NMHP.
Pilot of District mental health programme was done at Bellary district in Karnataka. Bellary is located about 350 kms away from Bangalore and the total population of Bellary was about 20 lakhs at that time.

The main components of the DMHP at Bellary were:

- Training for all primary care staff,
- Provision of 6 essential psychotropic and antiepileptic drugs (Chlorpromazine, amitryptaline, trihexphenldyl, Injection fluphenazine deaconate, phenobarbitone and diphenylhydantoin) at all PHCs and sub centres,
- A system of simple mental health case records,
- A system of monthly reporting
- Regular monitoring and feedback from the district level mental health team

The main objectives of DMHP were

- To provide sustainable basic mental health services in the community and integration of these with other services,
- Early detection and treatment in community itself to ensure ease of care givers,
- To take pressure off mental hospitals,
- To reduce stigma, to rehabilitate patients within the community,
- To detect as well as manage and refer cases of epilepsy.

The main approaches of DMHP were training of medical, paramedical personnel and community leaders, Community mental health care through existing infrastructure of the health services and the most important component being the Information, Education and Communication (IEC) activities.

Initially the community based mental health care at district level was initiated in four districts in 1996. It was extended to 27 districts across 22 states/UTs in the Ninth five year plan. NMHP was re-strategised during the Tenth five year plan, DMHP was expanded and more components were added to make it more comprehensive. There was expansion of DMHP to 100 districts all over the country, modernisation of state-run mental hospitals, up-gradation of Psychiatry wings in the Government medical colleges/general

hospitals, IEC activities, research and training in mental health for improving service delivery. At the end of the Tenth five year plan, DMHP was extended to 110 districts, and upgradation of psychiatric wings of 71 medical colleges, modernisation of 23 mental hospitals and general hospitals was funded. In the Eleventhfive year plan DMHP was spread to 123 districts in 30 states /UTs. [16]

The team of workers at the district under the programme consists of a Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatry/Community Nurse, a Program Manager, a Program/Case Registry Assistant and a Record Keeper.

Based on the evaluation conducted by Indian Council Of Marketing Research in 2008[17] and feedback received from a series of consultations DMHP has now incorporated promotive and preventive activities for positive mental health which includes:

- School mental health services: life skill education in schools, counseling
- College counseling services: Through trained teachers/ counselors
- Work place stress management: Formal and informal sector, including farmers, women etc.
- Suicide prevention services: Counseling center at district level, sensitisation workshops, IEC, helpline

4.7. Manpower Development Scheme[18]

In the Eleventh five year plan there was an effort to address the main barrier in the mental health service provisions i.e. the shortage of manpower. A component of manpower development scheme was developed.

- To improve the training infrastructure in mental health, Government of India had approved the Manpower Development Components of NMHP for the Eleventh five year plan.
- It has two schemes:
  i. Centres of excellence (Scheme- A)
  ii. Setting UP/ Strengthening PG Training Department of Mental Health Specialties (Scheme B)

4.7.1. Centers of Excellence (Scheme – A)

Under Scheme-A, at least 11 Centers of Excellence in Mental health were to be established by upgrading existing mental health institutions/ hospitals. A grant of Rs. 30 crores for each centre (total 338 crores) was made available for undertaking the capital work, equipment, library, faculty induction and retention.
At present the academic sessions have already started in 8 out of 11 centers and the process in the rest have been initiated.

4.7.2. Setting Up/Strengthening PG Training Department of Mental Health Specialties (Scheme-B)

Under Scheme-B, the Government Medical College/Hospitals were supported to start PG Courses in Mental Health or to increase the intake capacity for PG training in Mental Health. The Support also involved establishing/improving mental health departments (30 departments of Psychiatry, 30 departments of Clinical Psychology, 30 departments of Psychiatric Social work, and 30 departments of Psychiatric Nursing); Equipments tools and basic infrastructure; support for engaging required/ deficient faculty for starting / enhancing the PG Courses. The support of Rs. 51 lakhs to Rs. 1 crore per PG Department was made available. As of now the 27 PG departments in 11 institutes have been taken up.

The manpower development and the expansion of DMHP services will gradually lead to increase in number of mental health professionals in the districts and in the Institutions which have been given grant for manpower development schemes.

4.8 IEC Activities[19]

The awareness regarding mental illness, availability of treatment and provisions of Mental Health Act, 1987 is very low among the masses. NMHP has got sufficient funds for IEC activities for the purpose of increasing awareness and removal of stigma for mental illness by mass media campaigns through audio-video and print media.. The funds are allocated at central and state levels for IEC activities. At the district level the IEC activities are conducted under the District mental health program. Under the NMHP mass media campaign and activities are conducted on World Mental Health day and World Suicide Prevention day. In 2013 the WHO Mental Health day theme was 'Mental health and older adults'. In view of this, a variety of IEC activities were done in various districts of the country.

4.9 Research and Training [19]

There is a paucity of research in the field of mental health in our country. Under this component of NMHP, the support would be provided to various institutes and organizations for carrying out basic, applied and operational research in the field of mental health. As it has been obvious in various evaluations of the programme that one of the main problems is the shortage of skilled mental health manpower therefore in order to overcome this problem short term skill based training will be given to the DMHP teams at some identified institutes. Financial support would also be provided for Standard treatment guidelines, training modules, CME, distance learning courses in mental health, surveys etc.

4.10 Support for Central and State Mental health authorities [19]

According to Mental Health Act 1987, there is a provision for constitution of Central Mental Health Authority (CMHA) at the central level and State Mental Health Authority (SMHA) at the state level. They have been assigned the responsibility of development, regulation and coordination of mental health services in a State/UT and also the implementation of Mental Health Act 1987 and the operationalisation of mental health activities.

4.11 Monitoring and Evaluation[19]

There is a financial support under NMHP for strengthening the component of monitoring and evaluation. National level institutions are entrusted with the responsibility to evaluate the models of care, training of different categories of personnel and monitoring the mental health programs. A survey was conducted by NIMHANS, Bangalore to ascertain the number of mentally ill patients and availability of mental health resources in the country.

4.12 Mainstreaming NMHP into NRHM and NUHM[20]

There has been an intensified effort to mainstream the components of NMHP under the National Health Mission so as to enable the states to plan requirements concerning mental health services for their specific areas. The existing district where the DMHP is presently under implementation continues to be supported under the NRHM on the existing norms.

The advantages of mainstreaming the NMHP through NRHM are:

- Optimal use of existing infrastructure at various levels of the health care delivery system.
- Use of the NRHM platform for transfer /flow of funds to the states/UTs for better accountability and flexibility in implementation of program
- Integrated IEC activity under NRHM
- Involvement of NRHM infrastructure for training related to the mental health in the district
- Use of NRHM machinery for procurement of drugs for NMHP
- Using improved linkages /communication under the NRHM for MIS (Management Information System) in NMHP
- Sustaining DMHP after the expiry of the period of central assistance in the district by its integration in the district health system

NUHM would ensure---

- Resources for addressing the health problems in the urban areas
- Partnership with the community for a proactive involvement in planning, implementation and monitoring of health activities

4.13 Role of NGO in NMHP

There is an immense role of NGO's in the mental health program. They can contribute inIEC Activities; Support for health promotion using life skill approach; Support for follow up of severely mentally ill persons in community; Support for mentally retarded children and their families.; Organisation of mental health camps; Networking with primary health care team; Facilitation of disability welfare benefits for the mentally ill and mentally challenged, and also for Home care of severely mentally ill persons.

4.14 National Mental Health Program in the Twelfth plan

The National Mental Health Program in the Twelfth plan will focus special attention on psychiatric problems specific to certain vulnerable sections of the population who are often marginalised and neglected owing to lack of effective advocacy.

Special issues

- Senior citizens suffering from severely disabling diseases such as depressions of late onset and other psycho geriatric disorders.
- Victims of child sexual abuse, marital/ domestic violence and dowry related ill-treatment, rape and incest.
- Children and adolescents affected by problems of maladjustment of other scholastic problems, depressions, psychosis of early onset, attention deficit hyperactivity disorders and suicidal behavior resulting from failure in examination or other environmental stressors.
- Victims of poverty, destitution and abandonment of such women thrown out of the marital home or old and infirm parents left to fend for themselves.
- Victims of natural or man-made disasters such as cyclones, earthquakes, famines, war, terrorism and communal/ ethnic strife, with special attention to the specific needs of children orphaned by such disasters.

4.15 DMHP in Twelfth five year Plan[21]

Goal

The goal of DMHP is to improve the health and social outcomes related to mental illness.

The key principles of DMHP in Twelfth plan are –

- A *life course perspective* with attention to the children,adolescents and adults
- A *recovery perspective* through continuous care provision and empowerment of people with mental illness and also their care givers.
- An *equity perspective* which includes specific attention to vulnerable groups and ensuring the geographical access to mental health services.
- An *evidence based perspective* by following the established guidelines for treatment and delivery model.
- A health *system perspective* defining clear roles and responsibilities for each level.
- A *rights based perspective* to ensure the protection of rights of persons with mental illness

Primary Objective

- To reduce the distress, disability and premature mortality related to mental illness and enhance recovery from mental illness by ensuring the availability and accessibility to mental health care for all, particularly the most vulnerable and underprivileged sections of the population.

Secondary objectives

- To reduce stigma towards mental illness
- To promote community participation in the mental health service development and to stimulate efforts towards self help in the community
- To increase access to preventive services to the population at risk,in particular, addressing the risk of suicide and attempted suicide
- To inform the persons with mental illness, their care-givers, professionals and other stakeholders of the rights of persons with mental illness and ensure that rights are respected during the provision of care and services
- To broad base mental health into other related programs such as RCH, SSA, work place intervention and similar
- To ensure a motivating and empowering work place for staff by allowing an opportunity to improve their skills and recognition of their work
- To generate knowledge and evidence related to delivery of mental health care and services
- To establish governance, administrative and accountability mechanisms to realise the above objectives

During the Twelfth five year plan ---

- DMHP will be extended to the remaining 161districts and the gains made in the previous plans will be consolidated

- Up gradation of the remaining 39Medical College Psychiatry Departments will be undertaken and 20Mental Hospitals will be taken up for disinvestments/reconstruction
- Central and state mental health authorities will be further reinforced and long term research projects will be initiated in selected institutions along with continuing support to community based research
- Augmentation of IEC activities to cover all sections of the population covering entire country.
- Comprehensive assessment and performance appraisal would be done at the national and state level by independent agencies.

5. Mental Health Care Bill, 2013[22]

The United Nations Convention on the rights of persons with disabilities, which was endorsed by the Government of India in October 2007, made it obligatory on the Government of India to align the policies and laws of the country with the convention.

The need was felt to amend the Mental Health Act 1987 as the related law i.e. the Persons with Disabilities Act 1995 was also undergoing amendment. Also the Mental Health Act, 1987 could not protect the rights of persons with mental illness and promote their access to mental health care in the country.

Due to the above mentioned reasons it was proposed to bring a new legislation which would ---

- Protect and promote the rights of persons with mental illness during the delivery of health care in institutions and in community.
- Ensure health care, treatment and rehabilitation of persons with mental illness, is provided in the least restrictive environment possible, and in a manner that does not intrude on their rights and dignity. Community based solutions, in the vicinity of the person's usual place of residence, are preferred to institutional solutions
- Provide treatment, care and rehabilitation to improve the capacity of the person to develop his or her full potential and to facilitate his or her integration into community life
- Fulfill the obligations under the constitution and the obligations under various international conventions endorsed by India
- Regulate the public and private mental health sectors within a rights framework to achieve the greatest public health good
- Improve accessibility to mental health care by mandating sufficient provision of quality public mental health services and non –discrimination in health insurance
- Establish a mental health system integrated into all levels of general health care
- Promote principles of equity, efficiency and active participation of all stakeholders in decision making.

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Quadrant III. Self-Assessment Exercise:

1. MCQs

1. Currently the DMHP is being implemented in the country in
    a. 123 districts
    b. 20 districts
    c. 12 districts
    d. 70 districts
    ANS: a

2. In which district was the model of community based mental health care fled tested by NIMHANS
    a. Bangalore
    b. Thirussar
    c. Ernakulam
    d. Bellary
    ANS: d

3. The components of the National Mental Health program are:
    a. Treatment of mentally ill
    b. Only prevention
    c. Prevention and promotion of positive mental health
    d. All of the above
    ANS: d

4. Which of the following are the services provided under the DMHP
    a. Daily OPD services
    b. OPD services along with 10 bedded IPD
    c. Referral and follow up services
    d. Creating community awareness for stigma of mental illnesses
    e. All of the above
    ANS: e

5. The NMHP was launched in the year
    a. 1982
    b. 1996
    c. 1990
    d. 2005
    ANS: a

6. The thrust areas for NMHP in the 12th five year plan (2012-2019) are :
    a. DMHP will be extended to remaining 193 districts

b. 20 mental hospitals will be taken up for reconstruction
c. DMHP will be extended to another 20 districts and IEC Training programs will be conducted
d. Only c
e. a, b and c
ANS: e

2. **True and False**

1. The committee which recommended that there should be creation of a department of health in the proposed All India Institute of Mental Health was Srivastava committee----T/F
ANS: False

2. The ideal number of psychiatrists required in our country is 2 per lakh population----T/F
ANS: False

3. The main strength of NMHP document drafted in 1982 was that it envisaged the integration of mental healthcare with the general primary healthcare.
ANS: True

3. Short questions

1. Enumerate 5 important factors which contributed to the drafting of NMHP
2. What are the manpower development schemes under NMHP?
3. What are the objectives and strategies of NMHP?

Quadrant – IV Learn more/Web Resources/Supporting Materials/Interesting Facts:

Year	Milestone
1946	Bhore committee Recommendations in Mental Health
1962	Mudaliar Committee recommendations in Mental Health
1975	Srivastava Committee recommendation that Mental Health should be included in the scope of work of Community Health Volunteer (CHV)
1975	Training of General practitioners in psychiatry started at NIMHANS
1975	Starting of "Community Mental Health Unit" at NIMHANS, Bangalore - in 1975. Sakalwara Project.
1975-80	Needs of rural population studied by NIMHANS in one primary health centre
1976-81	Raipur Rani project as part of WHO multi centric project on strategies for extending mental health care
1982	NMHP launched and Implemented
1980-86	Pilot experiment to integrate Mental Health into primary health care at one Primary health centre of population of 1 lakh at select talukas of Bellary district.
1982-84	Indian Council of Medical Research (ICMR) project at three sites tests out the NIMHANS material for training of GP in psychiatry
1984	Bellary model up-scaled to entire Bellary district
1985-90	DMHP Pilot test in Bellary district
1985-87	ICMR Project-Mental Health in PHC- Solur, Karnataka
1987	ICMR-DST project at four locations in the country (Collaborative study on severe mental morbidity)
1995	Meeting of Central Council of Health
1996	Recommendation on starting mental health program at a workshop of all health administrators in Bangalore
1996-97	DMHP launched in 4 districts of the country
1997	Quality Assurance in Mental Health care services report by National Human Rights Commission
1997-2000	Phased expansion of DMHP districts
1999	Mental Health agenda of World Health Organization set; MH identified as priority for WHO's work
2001	World Health Day theme based on Mental Health
2001	World Health Report with focus on Mental Health
2003	NMHP re-strategizsed,DMHP to be spread to the entire country in a more effective manner
2007-2012	NMHP in X Plan with focus on manpower development schemes

2007-08	**DMHP in 123 districts**
2008-09	**Evaluation of DMHP by Indian Council of Marketing Research (ICMR) in 20 of 127 districts**
2011	**A review of 23 districts of four southern state DMHP conducted by NIMHANS**
2012-2017	**National Mental Health Program in the XIIth plan will focus special attention on psychiatric problems specific to certain vulnerable sections of the population** **During the XIIth five year plan ---** **DMHP will be extended to the remaining 161-districts**
2013	**The Director General, World Health Organization launched the Mental Health Action Plan 2013- 2020 on 7th October 2013.**
2013	**Mental Health Care Bill**