INTRODUCTION

In a country of 1.33 billion people spread across 29 states and 7 union territories (UTs), 630 districts (with more than 23,000 primary health-care centers - the primary unit for health care), 22 official languages and over a 1000 dialects, a population that is 70% rurally located, nearly 25% illiterate, and about one in five below the poverty line, the challenges faced in the delivery of mental health care can be extremely complex. Added to this complexity, there is yet another often cited reason – that as per the Constitution of India, health is a state subject and not under the control of the central government.[1]

There are three broad themes that illustrate the landscape of mental health services in India in contemporary times. First is the theme of judicial activism driving the development of mental health services in the country. The second is the governmental response. The third and overwhelming theme is one of polemics-public or private, community or specialized care, health or social welfare, stand-alone mental health services or integrated services, and finally perhaps, most importantly, center or state.

PUBLIC INTEREST LITIGATION AND JUDICIAL INTERVENTION

The most notable initiatives that have to some extent shaken off the inertia in mental health-care reform are the public interest litigations (PILs) and the judicial responses that occurred over the last three decades.[1] The first such in the 1980s (Upendra Baxi vs. State of UP and others) concerned the “inhuman treatment of inmates” of a protection home in Agra and argued for their “right to live a life of dignity” as enshrined in Article 21 of the Constitution of India. A number of PILs subsequently followed the issues that were raised included concerns about mentally ill prisoners languishing in jails (Veena Sethi vs. State of Bihar 1982), the state of the public Shahdara Mental Hospital in New Delhi (BR Kapoor and others vs. Union of India 1983 and PUCL and others vs. Union of India and others 1983), the detention of abandoned children and those with mental retardation “in jails for safe custody” (Sheila Barse and others vs. Union of India and Ors 1986). In response, the Supreme Court ordered the monitoring of such homes, directed the National Human Rights Commission (NHRC) to monitor specific mental hospitals, and declared keeping of mentally ill in jails as illegal and unconstitutional, leading to the release of many “noncriminal lunatics” from jails. Another resulting development was the formation of the Institute of Human and Behaviour and Allied Sciences, where the Shahdara Mental Hospital was earlier. The philosophy of care in mental health institutions was perhaps best illustrated in the case of Chandan Kumar Bhanik versus the state of West Bengal in 1988 where the apex court observed: “Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons. These aspects are far more important than a routinized, stereotyped, and bureaucratic approach to mental health issues.”[2,3]

MENTAL HOSPITAL MONITORING

As part of the mandate of the Supreme Court in 1997, the NHRC began monitoring the functioning of the mental hospitals at Agra, Gwalior, and Ranchi. The NHRC “used monitoring as a tool of correction and promotion of human rights of persons with mental illness”.[3] In addition to monitoring the functions of the three assigned hospitals, the NHRC also supported an initiative on quality assurance in mental health. This evaluation, undertaken by the National Institute of Mental Health and Neurosciences (NIMHANS) in 1998, included an evaluation of the mental hospitals in the country through questionnaires and personal visits, as well as a review of the existing general hospital psychiatry units and private psychiatric institutions.[4] This landmark project involved sending out questionnaires to directors and superintendents of government and private mental hospitals, principals and heads of departments of psychiatry of medical colleges and general hospitals, personal visits to individual facilities including 37 government psychiatric institutions, 7 private psychiatric institutions, and 23 general psychiatric units throughout the country, and interaction with administrators, staff, patients, and their
families. This culminated in a meeting of health secretaries and development of minimum standards of care in mental hospitals.\[9\]

The visits were a déjà vu and déjà lu (already read) of the Bengal Enquiry of 1818, Edwin Mapother’s eye-opening report of 1938, and Moore Taylor’s survey report of 19 mental hospitals in 1946,\[8\] all rolled into one. Some of the comments of over a century ago were still pertinent. Many of them “bore more resemblance to a prison than an asylum,” had “open air cages,” and were “disgracefully understaffed.” It was as if “time had stood still.” The blame for the state of the hospitals did not seem to lie with the superintendents, who had met in 1960 in Agra, 1986 in Ranchi, 1988 in Bengaluru, and 1990 in New Delhi, and had raised the same old concerns. The visits to the mental hospitals in 1998 reflected the same. The NIMHANS/NHRC report\[4\] revealed glaring deficiencies in the infrastructure and functioning of the mental hospitals. High walls, prison nomenclature and practices, poorly maintained premises and gardens, overcrowding, paltry budgets particularly for diet (as low as Rs. 5 per day), lack of cots, toilets, fans, inadequate water, electricity, lighting, predominantly closed wards, cells in operation, lack of specialized services, poor outpatient and emergency services, poor supportive services, mainly involuntary admissions through the courts were the salient findings. Very few had a semblance of organized psychosocial intervention or rehabilitation. Although the hospitals were not rated on a scale of “badness” as Moore Taylor had done about 50 years earlier, they were nevertheless rated as very poor (7), poor (8), average (11), and good (6). Recommendations from this report included conversion of closed to open wards, rearrangement into smaller wards, streamlining of admission and discharge procedures in accordance with the Mental Health Act, 1987, upgradation of facilities, enhancement of human resources and in-service staff training and sensitization, improvement in the diet, better patient amenities, recreational and rehabilitation facilities, encouragement of voluntary admissions and development of specialized services for children, elderly, substance use, and prison populations.

The report noted that general hospitals had the potential for taking over the primary locus of psychiatric care. However, the limited review of general hospital psychiatry units (only 27 of the 87 facilities contacted responded to the questionnaire and 23 were visited) also revealed many lacunae, including the lack of human resources, poor infrastructure, low priority for psychiatric facilities and patient amenities, lack of inpatient beds, lack of emergency care, frequent staff transfers, and a lack of collaborative engagement between different specialties. The team visited only seven private psychiatric facilities, four of which were managed by a religious order or nongovernmental organizations (NGOs). These generally showed better standards of functioning compared to the government facilities.

In summary, the NIMHANS/NHRC report of 1999\[4\] argued for “enlarging the scope of mental health services through the expansion of general hospital psychiatric facilities and community care, a continuum of services from primary to tertiary care, community participation in policy and service development, and intersectoral collaboration.” It urged that mental hospitals transform from custodial to therapeutic centers from closed institutions to postgraduate training centers by affiliation with medical colleges/universities so that they could become more open, transparent, and progressive in their functioning. The report envisaged that mental hospitals would remain an essential locus of care, along with general hospital psychiatric units, community-based mental health services, and nongovernmental agency involvement. It mentioned the important role of professional mental health bodies, the need for training and research in mental health, and the need for periodical review of legal provisions. At that time, the Mental Health Act of 1987 and the Persons with Disabilities Act of 1995 had been operational (and are still).

The NHRC report of 1999 was a “defining moment”\[3\] in highlighting the state of mental health services in India. However, the report, like many others before it may have disappeared into oblivion, had it not been for the Erwadi tragedy. On August 6, 2001, a fire extinguished 25 mentally ill persons who had been chained and kept in confinement in a faith-based institution in the Ramanathapuram district of Tamil Nadu. The Supreme Court took Suo Moto notice and directed the Union Government to conduct a survey on an all-India basis to identify registered and unregistered facilities and ascertain if the NHRC recommendations had been followed. A PIL (Erwadi–Saarthak) followed soon after.\[2\]

**GOVERNMENTAL STOCKTAKING AND THE NATIONAL MENTAL HEALTH PROGRAMME IN A NEW AVATAR**

Pursuant to the orders of the Supreme Court, the Directorate General of Health Services (DGHS) undertook a stock of the mental health services in the country. This report\[4\] reiterated some of the earlier concerns: human resource shortages, poor infrastructure, poor facilities, and lingering custodial atmosphere in the psychiatric institutions. It urged that “we rid ourselves of the obsolete notions of the inevitability of institutionalized psychiatric treatment and think innovatively.” The DGHS report also reviewed the National Mental Health Programme (NMHP), launched in 1982 and re-strategized in 2003. The original programme envisaged making mental health care available, accessible, and affordable to all; utilization of the primary health-care infrastructure and integrating mental health care with general health care and with existing community development and welfare.\[6\] The re-strategized NMHP was intended to be multi-dimensional, have a nodal agency...
co-ordinate the District Mental Health Programme (DMHP), strengthen medical colleges’ departments of psychiatry, modernize and streamline mental hospitals to make them tertiary centers of excellence with “a dynamic social orientation,” strengthen Central and State mental health authorities, and strengthen research and training aimed at building actionable databases. This report concluded that the picture emerging from the database with respect to mental health laws and services across the country is “not a happy one.” To reach a goal of one psychiatrist and 1.5 clinical psychologists/psychiatric social workers/100,000 population, this report indicated a deficit of 7477 psychiatrists, 12,926 clinical psychologists, and 17,118 psychiatric social workers. To ensure 1 psychiatric nurse per 10 psychiatric beds, the report calculated that 4036 psychiatric nurses were required, but the availability and deficit of qualified psychiatric nurses were unclear.

The financial allocation to mental health increased across successive 5-year plans (5-year economic plans by the Government of India). There was a nearly 8-fold jump in the budget between the 9th and 10th 5-year plans. However, in the absence of systematic, particularly administrative planning, the funds were not adequately utilized.

MENTAL HOSPITAL REFORM: CHANGES OVER A DECADE

The NHRC continued to be engaged with the mental hospitals, particularly the ones mandated to its care. A decade after the quality assurance study, a re-evaluation of the state of mental hospitals through a follow-up questionnaire, review of the reports of the special rapporteurs of the NHRC and DGHS reports indicated several positive trends. These included a reduction in involuntary admissions, better living conditions, greater budgetary allocations, and relatively more engagement with the community. However, human resource shortages, inadequate rehabilitation facilities, “closed ward” structures, and mentalities were persisting in some of the hospitals. Hospitals with continuous monitoring did significantly better than those that were not under the gaze of overseeing bodies in the state or by the NHRC.

ADDRESSING THE HUMAN RESOURCE CRUNCH

Meanwhile, the Government of India, during the 11th 5-year plan, funded 11 centers of excellence (“upgrading and strengthening identified existing mental health hospitals/institutes for addressing the acute workforce gap and providing state-of-the-art mental health care facilities”). It funded several postgraduate departments of psychiatry across the country and offered upgradation of the psychiatric departments of government medical colleges and general hospitals. Twenty-nine state-run hospitals received budgets for modernization. The last decade also witnessed an increase in postgraduate MD seats to produce more psychiatrists (with the engagement of the Medical Council of India and special relaxation of norms).

However, while the initiatives were laudable, the “slow work of projects funded under the manpower development schemes and a lukewarm response in taking up the scheme of manpower development points towards dearth of leadership in the mental health sector in the country and the danger of continuing with business as usual.”

RIGHTS: COMPLIANT LEGISLATION

The United Nations Convention on the Rights of Persons with Disabled (UNCRPD) was ratified by India in 2007 and this had ripple effects in the country. The Mental Health Care Bill with a greater emphasis on the rights of persons with mental illness was formulated to replace the Mental Health Act of 1987, introduced in the Rajya Sabha in 2013, where it has been passed with amendments on August 8, 2016 and is in the process of ratification by the Lok Sabha. The Rights to Persons with Disabilities Bill, for compliance of existing disability legislation with the UNCRPD, was introduced in the Upper House in 2015.

India was the first country in the South-East Asian region to release a mental health policy in 2014. The results of the first National Mental Health Survey are to be released later this year.

Although there were occasionally blowing winds of change, the pace of change was slow and inconsistent. The first PIL, more than three decades old in the Supreme Court of India, has continued to be the basis for continuing directions of the Supreme Court. The apex court had directed the NHRC to monitor the mental health institutions/systems in the country and advised that it could be approached again, if further directions were needed in the matter. The NHRC approached the Supreme Court in 2013, requesting direction to overcome the deficiencies that existed in mental health care despite its interventions.

NEWER JUDICIAL INITIATIVES

In response to the appeal from the NHRC (a continuation of the Upendra Baxi PIL of 1981), the apex court directed the states to fill out a proforma questionnaire with questions on the overall aspects of mental health care in the state, along with information about psychiatric institutions, medical college and general hospital departments of psychiatry, NGOs, and the DMHP. These questionnaires had been prepared by NIMHANS and submitted by the NHRC.

A four-member technical committee (TC) comprising three psychiatrists was constituted by the NHRC to appraise the
apex court of the deficiencies in mental health care in the states, based on the analyzed questionnaires and two other inputs. These included an update on the mental health care services by the special rapporteurs of the NHRC who visited different states to ascertain the issues pertaining to the care of the mentally ill, as well as the report of the inspection committees (set up at the behest of the Supreme Court by the Ministry of Health and Family Welfare and constituted by a union Joint Secretary, the State Health Secretary, representatives of the state mental health authority, state human rights commission, women’s commission in some states, and senior psychiatrists).[2]

**SALIENT OBSERVATIONS OF THE TECHNICAL COMMITTEE OF THE NATIONAL HUMAN RIGHTS COMMISSION**

The most striking finding of the TC based on the sworn affidavits submitted by the states was the lack of adequate and reliable information on the burden as well as resources for mental health care in many states and UTs. The report observed, “One can assume that the priority to mental health is low. But if a directive from the Apex Court in the country and a sworn affidavit can still not shake off the lethargy and swing the system into action, one wonders what else can.”

Based on conservative estimates from the existing epidemiological studies of a 7% prevalence of mental illness, the TC report calculates that there may be at least approximately 80 million persons with diagnosable mental illness in need of psychiatric care, apart from many others in psychological distress not amounting to mental illness. Based on the state records of persons receiving care, just a miniscule proportion of the population is receiving treatment in standard settings. A part of the problem was the proper documentation of service utilization. This did not permit accurate treatment gaps to be calculated, though one can assume that the gap is even more than 85%, as estimated by the WHO for developing countries.[11] As per the affidavit, the bed/100,000 population ratio was 2.15, well below the global bed ratio of 6.5. The beds in the private sector, medical colleges, and district hospitals had not been accurately counted. This may be offset by the fact that some of the larger psychiatric institutions have downsized their beds.

A relatively high private sector presence is recorded from four large states. This continues to be a largely unregulated sector, and its participation in the health-care structure is not well defined. The aggregated number of NGOs working in the area of mental health is upward of 325, better than a decade ago, but grossly insufficient for the country.

The inadequate ownership of mental health services is also illustrated by a lack of recording of state-wise suicide data, information on the homeless mentally ill, which is gradually emerging as a population of concern. While there are a few rehabilitation facilities in the private sector, these continue to be unaffordable to most, and there are scarce facilities in the public sector.

Another glaring deficiency is the virtual absence of formally trained professionals in correctional settings such as prisons and correctional homes which have high levels of mental health morbidity. This was pointed out in earlier reports.[13]

The effort to strengthen postgraduate training in psychiatry has led to an annual addition of approximately 500 psychiatrists. This would mean an existing pool of about 6220 psychiatrists, extrapolating from the 2008 report which counted 2800 psychiatrists, translating to a ratio of 0.45 psychiatrists per 100,000 population. The ratios of trained clinical psychologists, psychiatric social workers, and psychiatric nurses are far lower.[2] All the ratios are far lower than global ratios for human resources in mental health.[11]

The need for undergraduate psychiatry has been emphasized time and again.[11] The TC noted that although the Medical Council of India in 2011 had enhanced the curriculum and posting, this was not being uniformly followed.[2]

With respect to mental hospitals, a small but sizeable proportion of beds (18,307) lie in the 47 psychiatric institutions throughout the country. Many have been downsized to improve patient care. The inspection committee noted massive transformations in many hospitals, with improved infrastructure, food, hygiene, living facilities, and adequate drugs.[6] Outpatient services had improved, and about one-third of the specialized services had been developed. However, shortage of human resources, lack of recreation and rehabilitation, and variability in the monitoring by statutory bodies continued to persist. While the last two decades have witnessed visible improvement in most hospitals, the fact that some still continue to have serious deficiencies is reflected in the scathing reports of human rights violations by the Human Rights Watch.[14] The persisting problem of destitution and need for carefully planned rehabilitation is evident by the recent initiative of the National Commission for Women.[13]

Although states such as Gujarat have successfully reduced the long-stay population in psychiatric institutions through effective rehabilitation, availability of medication, shorter admissions with family members, self-help groups, outreach, closer family involvement and NGO engagement, and innovative programs such as the INCENSE programmes[9] in Yerawada and Tezpur are promising, what is evident is a lack of systematic planning for rehabilitation with careful oversight of the process. It is to be cautioned that violations of the rights of persons with mental illness can occur in multiple loci and contexts.
Mental health governance, leadership, and high-level commitment are key indicators for successful national level programming. Although the Mental Health Act has been in existence since 1987, and each state was expected to enact the rules thereafter, there are still states which have not done so, or have no knowledge if they have the rules, almost 20 years later and at a time when a new mental health-care bill is already on the horizon. While nodal authorities for mental health (State Mental Health Authority) have been identified in most states, state mental health plans have not been formulated.

One of the main objectives of the NMHP was to integrate mental health care with general health care. India is said to have put up a lone fight at the ministerial conference on healthy lifestyles and noncommunicable disease (NCD) in Moscow in 2011 to include mental health in the list of NCDs. However, much needs to be done on the ground in this respect, with the increasing recognition that physical NCDs are associated with a significant mental morbidity and chronic mental illness is associated with an increased prevalence of physical NCDs. It is important that these relationships are recognized and translated into integrated and continued care.

THE STORY OF PRIMARY HEALTH CARE

It was envisaged that the DMHP would cover all the districts (630) in the country by 2025. In 2002, the DMHP was reported to have been present in 4% of districts, 18% in 2008 and 27% in 2015. Reviews of the DMHP have been both appreciative and critical. Reviews of the DMHP in 2003, 2009, and 2012 concluded that the programme was partially successful at the district level (though not at the primary health-care level) with better awareness of mental illness in implemented districts compared to nonimplemented districts. However, several criticisms have been made of the DMHP which include inadequate leadership at the central, state, and district levels, political neglect, inaccessible funding, and various other administrative and programmatic problems. It has also been suggested that mental health care delivery needs to have diverse narratives and also needs to be looked at through the lenses of the social sciences.

A BIGGER SLICE OF THE PIE OR “THE COMMON GOOD”

Nearly, three decades after the launching of the NMHP in India, the philosophy of mental health care and the roadmap remain inchoate. While there have been some debates about “the common good,” most have tended to be polemical between the service providers (psychiatrists) and service users (users and families), between pro-user activists and carers, and between psychiatrists in the public and private sectors. Patient needs for a continuum of care have been overshadowed by rigid boundaries of the playing fields of different ministries. Proponents of community care models decry the spending of resources on psychiatric institutions. Those skeptical of existing community care models believe that good psychiatric institutions are a legitimate shelter, and diminishing their relevance will lead to other problems such as trans-institutionalization.

MENTAL HEALTH CARE NEEDS IN REALITY

In a large country like India, people fail to see that there needs to be a plurality of services, inter-sectoral co-ordination, support to families in the absence of any alternative social security system, and establishment of plural systems of care, all embedded in a rights-based framework to assure patients of an acceptable quality of care. Genuine caregiving of mentally ill will make a significant difference to the recipients and reduce stigma for both patients and mental health-care professionals. In India, majority of the persons with mental illness are still cared by family members.

The introspection and dialogue, thus, needs to move from treatment gaps in mental health services to bridging chasms and moving beyond the polemics in mental health service delivery in India. Establishment and oversight of a comprehensive, seamless, and well-networked system need vision, leadership, multi-sector engagement, co-ordination, commitment and persistence, time-bound goals, and regular monitoring. Responses need to be proactive, participatory, need-based, and goal-oriented.

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