It was in November 1983, Prof. Wig and I, published an article in the American Journal of Psychiatry titled “A training approach to enhance the availability of mental health manpower in a developing country” (Srinivasa Murthy and Wig, 1983). This article presented the case for involving the peripheral health workers in providing essential mental health care, as a way of addressing the problem of limited number of mental health specialists. This was a follow up of an earlier article on the rural model for mental health care (Wig et al, 1981). Twenty years later, the issues addressed by us have a greater urgency for two reasons. Firstly, ideas that appeared very innovative, that is to integrate mental health care with general health care, is now the accepted national model for mental health programme (Agarwal et al., 2004). Secondly, there is so much more of awareness of mental health issues and the demand for services, far beyond the health sector, that the need to relook at human resources for mental health care is even more urgent (Patel and Thara, 2003, Goel et al, 2004). It is in this context that the current article presents the needs for human resources and suggests a broad approach to address the need.

The Need:

Today, there is wide recognition of the importance of mental health in the public life of the country (Agarwal et al., 2004b, Srinivasa Murthy, 2004 a and b). However, at the level of the mental hospitals, though they form a very small part of the overall services, there is recognition that the human resources are inadequate. The National Human Rights Commission report noted “The state of mental hospitals surveyed is not satisfactory. The situation with regard to staffing has improved since NHRC Report, but there are still significant gaps. Significant deficiencies or complete absence of psychiatric nurses, psychiatric social workers, clinical psychologists, occupational therapists and laboratory technicians were found in a majority of the mental hospitals surveyed” (Agarwal et al, 2004). This observation takes us back to the situation 60 years ago when Col. Taylor noted “every mental hospital which I have visited in India, is disgracefully understaffed. They have scarcely enough professional workers to give more than cursory attention to the patients” (Taylor, 1946).

On the other hand, there is wide recognition of the need to provide services to the total community “the benefits of modern scientific psychiatry should be available to all sections of the population in India, rich or poor, urban or rural, male or female” (Wig, 2004); “in order to address the needs of the patient and family and reduce the stigma of mental illness, rehabilitation programmes will have to be community – based rather than hospital centered” (Murali and Rao, 2004); “the mental health problems as health problems should be allowed to be defined and dealt with by the communities. Grass root understanding should be defined and dealt with by the communities” (Chakraborty, 2004); “the need to reach such high-risk individuals (for suicide) through outreach programmes should be a high priority” (Venkoba Rao, 2004); “it is abundantly clear that mental health professionals alone cannot meet the mental health needs of the country” (Srinivasan, 2004). A reflection of this recognition of the need and the gap is seen in the likely solutions offered - “many NGOs are involved in training lay counselors, who offer a helping hand to be unable to handle stressful conditions. Their contribution should be welcomed and they should be offered consultation services, whenever required” (Bhaskaran, 2004); “there should be a network of non-professional counselling services, training courses for lay counsellors and better monitoring of the services they provide” (Kapur, 2004); “in addition to the programmes (for clinical psychology training), several other programmes need to be considered which are of shorter duration and may deal with a circumscribed function of the clinical psychologist. These programmes may equip successful candidates to provide services at different levels of functioning in a country with a dearth of trained professionals” (Prabhu and Shankar, 2004); “the Ministry of social Justice (has) prepared a manual on the minimum standards of care of services of NGOs (in the field) of de-addiction services” (Ray, 2004). In addition, Patel and Thara (2003) present the wide range of initiatives by the voluntary sector to address the needs of a wide variety of mental health problems ranging from severe mental disorders to suicide, substance abuse and women’s health. In the recent times courses on counselling (eg. Christ College, Bangalore) have been started. It is also salutary to recall that one of the important recommendation of the Bhore Committee.
(1946) was “the provision of training facilities for medical men in India and abroad and for other types of personnel in India” (Bhore, 1946).

International developments:

There are two developments in the area of human resources at the international level, namely, the need and the impact of the “brain drain” from poorer countries to richer countries. The importance of adequate human resources in health care is under intense focus internationally (WHO, 2001, WHO, 2003, WHO, 2004, Hongoro and McPike, 2004, Anand and Barnighausen, 2004, Chen et al., 2004). For example, WHO noted that

“The most critical issue facing health care systems is the shortage of the people who make them work. Although this crisis is greatest in developing countries, particularly in sub-Saharan Africa, it affects all nations. Furthermore, all countries are now part of the global marketplace for health professionals, and the effects of the demand–supply imbalance will only increase as trade in health services increases. Accordingly, new models for health workforce strengthening must be developed and evaluated.”

Recent studies have also shown that even specific health programmes “depend upon the strength of the health system responsible for its implementation” (Gwatkin, 2004). Further, “in addition to other determinants, the density of the human resources for health is important in accounting for the variation in rates of maternal mortality, infant mortality and under-five mortality across countries” (Anand and Barnighausen, 2004). There is a universal call for “investment in human resources for health” (Chen et al., 2004).

The debate about the “brain drain” of psychiatrists is under active debate in India and elsewhere. The recruitment of psychiatrists from low and middle income countries has brought to focus a number of issues, specially relevant to developing countries. In countries rich and poor, there is a big gap between the need for mental health services and the availability/utilization of the services. The World Health Report 2001 and the WHO Atlas project (WHO, 2001) have recorded extremely low level of services available in most of the developing countries. In an unusual way the barriers to mental health care appear to be universal, which is not true for the other health conditions. The issue was covered in October 2004 and January 2005 issues of the Bulletin of International affairs of the Royal College of Psychiatrists (Ndetei et al., 2004, Jenkins, 2004, Srinivasa Murthy, 2005, Holsgrove, 2005). This issue will not be covered in the current article.

Mental Health resources in India:

India, (for a population of about 20 times the size of UK), has less number of psychiatrists than in UK. This situation is made worse by the unequal distribution of mental health professionals and psychiatric beds across India. The data collected by the government of India in 2001 present a picture of contrasts. (Agarwal et al., 2004, Goel et al., 2004). There are states like Kerala, Goa and Delhi with high numbers but equally there are states like Himachal Pradesh (about 5 million population with 4 psychiatrists and Chattishgarh with about a dozen psychiatrists for 20 million population (see Figure 1). The situation of Himachal Pradesh is significant as it is one of the states recognized as socially most progressive and ranks number 2 in the recent ranking of states (India Today, 2004). However, it is very poor in mental health services, to the extent that the state has not been able to recruit a full time psychiatrist for its district mental health programme till 2003. Without doubt, most of India is resource poor for specialist human resources for mental health care.

Distribution of Psychiatrists, Ps. Social Workers, Ps. Nurses, Clin. Psychologists and Psy. Beds across States

The Way Ahead

If we recognize mental health care for all as a reasonable goal, and there are so few specialist professionals, what is the mechanism to bridge the gap? The opportunities for India is to develop a fresh approach to human resources development for the country. Can we shift from specialist professionals to a wide range of mental health care providers? Very often such a suggestion, raises two important reactions, namely, the question of dilution of quality of the service (providing second rate care for the poor).
and the problem of monitoring of the services. These questions continue to be raised, in spite of the large numbers of innovative programmes, utilizing a wide variety of human resources in mental health care activities in operation in the country (Patel and Thara, 2003).

I view the sharing of mental health skills with non-specialist mental health personnel differently. The involvement of non-specialists for mental health care should not be seen as “replacing“ the specialists, either psychiatrists, clinical psychologists, psychiatric social workers or psychiatric nurses. They will not be substitute to the professionals. As noted by Prabhu and Shankar (2004) they “deal with circumscribed functions”.

The wide range of functions in mental health care can be considered under the following 7 broad categories: categorization of mental health problems; non-pharmacological therapies; pharmacological therapies; certification for legal purposes; training of other personnel; working without supervision and having a legal licence to practice.

There are a number of mental health care activities that can be undertaken by the patients themselves, family members, volunteers, general health personnel, others in the service sectors like education, police, prison staff, persons trained specifically for a limited range of tasks.

1. There will be at one level people who will be trained for 1-2 weeks to undertake very specific and limited activities like crisis intervention in disasters, manning the suicide prevention hotlines or training for support to people going through bereavement and other crisis.

2. The second category of people will be personnel who are doing other activities like general health work, school teaching, child care of pre-school children, who would be trained for varying periods (of few days to weeks) to integrate mental health with their ongoing work.

3. The next category would be people who are full time mental health workers with a graduate degree who would be given training in mental health for periods of about 3 months to undertake specific tasks like counselling and working with primary health care physicians. This is occurring not only in developing countries but also in developed countries. These are very much similar to the physician assistants in USA.

4. Postgraduate level personnel of psychology, social work, who are given training from 3 to 6 months to be able to function and supervise settings under the supervision of psychiatrists to carry out a wide variety of mental health services.

5. This next group would be fully qualified non-medical mental health professionals like clinical psychologists, psychiatric social workers, psychiatric nurses, who would be able to function with proper licensing independently except for use of pharmacological and biological interventions.

6. Medical doctors with general medical education, who are trained for periods of 3 to 6 months to be able to meet the urgent human resource needs to work in middle level health facilities like district hospitals. These persons would have both diagnosing and treatment responsibility but may not include certification and initiation of training other than the lowest level of workers.

7. Fully qualified psychiatrists would be able to take care of all responsibilities including training and research.

The crucial questions for the involvement of “non-specialist mental health personnel” are:

1. To what degree should the workers be involved in early identification and diagnosis?

2. To what degree they should be given the responsibility for non-pharmacological methods of treatment?

3. To what degree the worker should be given pharmacological and biological interventions?

4. To what degree these workers can work independently or only under the direct and continuous supervision of other professionals?

5. To what degree can they be involved in training of other workers?

6. To what degree should these people be given the responsibility for certification of various types for legal as well as welfare benefits?

7. To what extent should these workers come under the system of licensing for taking up the work?

In addition, in the involvement of non-specialist personnel, the following safeguards are essential: (i) the scope of the programme should be clearly spelt out to the users and
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providers of help (in writing); (ii) all the providers of help should receive essential training for the task to be carried out; (iii) the providers should be given skills to do what they are expected to do (knowledge alone is not enough); (iv) there should be a supportive mechanism to support the providers of care—preferably with some trained professionals once a week and not less than once a month; (v) there should be clear lines for referral to professionals so that inappropriate actions are not taken when more acute need is there (e.g., suicidal risk, violence); (vi) there should be clear documentation of the process at all stages, to allow for review both internally and externally and (vii) lastly there should be an annual audit, preferably by an outsider to guide the group in its work.

In view of the wide variations in the specialist human resources available in the country, each state will need to examine its human resources and identify tasks on the 7 areas and allocate responsibilities to the different categories of personnel. In addition, these programme need to be periodically reviewed and the experience utilized for upgrading, modifying or abolishing the educational training of different categories of personnel.

The broad framework presented above can be operationalised by four steps (Srinivasa Murthy, 2005). First of these is need to enhance the training in psychiatry as part of the undergraduate medical education (Srinivasan, 2004). Currently the amount of training (few hours of lectures and few clinical sessions) does not reflect the amount of mental health work a general medical doctor has to provide and the skills for meeting the service needs are not provided as part of the training. In some of the countries like Pakistan, Sri Lanka and Oman major changes have been made in the undergraduate training of psychiatry. Similarly, there are undergraduate and postgraduate training programmes for the training of psychologists, psychologists, social workers, nurses and other therapists. Most of these courses are largely academic and do not provide the trainees opportunities for the acquisition of knowledge and skills relevant to practical work of mental health care. Most of the training programmes do not have practical training in clinical settings. By suitably modifying the curriculum and developing a more practical approach to the training programmes, there offers the possibility of increasing human resources for mental health care. This can be specially achieved by linking the training to the developing national programmes and the emerging roles of the voluntary organizations.

The Second approach is to develop short training for non-specialists like the medical officers, general psychologists and general social workers and nurses. These training programmes can be shorter than the traditional full-time courses of 2-3 years. The usual period of training can be 3-6 months. The training can emphasize the clinical and practical aspects to suit the specific situation of the country or region or a programme like school mental health or rehabilitation.

The third approach, specifically relevant to mental health care is the use of a wide variety of non-professionals. Mental health programmes have pioneered the use of volunteers in suicide prevention, patients functioning as therapists in drug dependence programmes like alcoholic anonymous, family members becoming therapists to other family members. The principle is the limited role in a specific situation, especially based on their own personal life experiences. The strength of these personnel is in their focused expertise and their acceptance by other help seekers.

The fourth approach refers to the involvement of staff of other sectors. As part of deprofessionalisation, the utilization of personnel working with different sectors like health sector, education sector, police etc has been a frequently used measure. Here the health worker, preschool teacher, schoolteacher, police etc, add on a component of mental health to their other regular activities. These additions can be at the level of identification of persons needing care, referral, first aid, care of a particular level, depending on the type of programme.

The shortage and “migration” of specialists personnel can be seen as an opportunity to think of organising mental health care in a very different way using the variety of community resources (Srinivasa Murthy, 2000). India should set up a multi-disciplinary task force to collect all the experiences of utilizing the different types of human resources to provide mental health care in the country (their educational background, the training received, the tasks performed, the impact of their service, the problems met etc) and identify the tasks for different categories of mental health personnel, their training needs as well as mechanisms to support and supervise them. The approach is to define the “level of care” and “limits of care” for each of the categories of personnel.

It was 30 years back, Prof. Allen German, while working in Africa wrote the following;

“The psychiatrist in a developing country, in contrast to one
in a more industrialized setting, does not have to face the same degree of frustration resulting from attempts to dismantle an existing inert and cumbersome administrative structure; to determine how to include large numbers of mental hospitals into more efficient and human psychiatric programs; or to deal with large armies of mental health personnel from various disciplines, each of which is preoccupied with and defensive about its own status and intent on holding onto its traditional role. The absence of these barriers provides the psychiatrist in a developing country with a fairly clean canvas on which to develop the themes” (emphasis added).

India has made tremendous progress in mental health care in the last 50 years. The current high recognition of mental health among the professionals, planners and the public requires that suitable measures are developed to meet the needs of the total population. It is rightly said that human resources are the “heart of the health system in any country”, “the most important part of health care system” and “a critical component in health policies” (Hongoro and McPike, 2004). We, in India, have an opportunity to use a wide range of community resources for mental health care and thus meet the needs of the population and bridge the gap in mental health care in the country.

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