The birth of national mental health program for India

Narendra Nath Wig, Srinivasa R. Murthy
Department of Psychiatry, PGIMER, Chandigarh, 1Department of Psychiatry, Association for the Mentally Challenged, Dharmaram College, Bengaluru, Karnataka, India

ABSTRACT

The adoption of the National Mental Health Programme (NMHP) in August 1982 was a milestone in the history of Indian psychiatry. Such an ambitious program was formulated at a time where there were <1000 psychiatrists in the country. The story of the NMHP, both in terms of the technical forces and the personalities need to be recorded for posterity. The current article recalls the community mental health initiatives of Bengaluru and Chandigarh centers providing the reason for integrating mental health care with general health care and the support of the World Health Organization, along with the role of mental health professionals and the health administrators. The lesson that comes through is the value of working together with different professionals for the common good. Recording the events for posterity is especially timely in view of the formulation of a new mental health policy and the revision of the national health policy during the last few months.

Key words: Health policy, integration of mental health, national mental health programme

INTRODUCTION

The adoption of National Mental Health Programme (NMHP) by the Government of India in August 1982, was in many ways a landmark event in the history of psychiatry in this country. Recently, in 2012, we crossed the 30th anniversary of this important event.

During the last year, 2014, the revised National Mental Health Policy of India and the draft National Health Policy, 2015 have been released. A number of exhaustive reviews of the mental health program over the last three decades have been undertaken by professionals.14-11

It would be appropriate and useful to put on record our impressions of those eventful days which led to this crucial development. It is important because many of the stalwarts who played a central role in this development are no more on the scene, and others are also moving on in life. The idea of developing National Programmes of Mental Health started with World Health Organization (W.H.O.), Mental Health Division under the leadership of the then Director Dr. Norman Sartorius. The expert committee meeting on “organization of mental health services in developing countries” held in 1974 at Addis Ababa marked an important expression of the W.H.O. about its priority for mental health care in developing countries.12 This was followed by the launch of the seven country (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan), project “Strategies for Extending Mental Health Care (1975–1981),” to implement the 1974 recommendations at the level of general health care.13,14 A formal resolution, urging all member countries to develop NMHP was first time adopted in 1979 meeting of the W.H.O. Mental Health Advisory Group in Manila, Philippines. Some initial efforts to develop national programs were started in some African countries.15,16 The birth of the National Mental Health Programme (NMHP) in August 1982 was a milestone in the history of Indian psychiatry. Such an ambitious program was formulated at a time when there were <1000 psychiatrists in the country. The story of the NMHP, both in terms of the technical forces and the personalities need to be recorded for posterity. The current article recalls the community mental health initiatives of Bengaluru and Chandigarh centers providing the reason for integrating mental health care with general health care and the support of the World Health Organization, along with the role of mental health professionals and the health administrators. The lesson that comes through is the value of working together with different professionals for the common good. Recording the events for posterity is especially timely in view of the formulation of a new mental health policy and the revision of the national health policy during the last few months.

Key words: Health policy, integration of mental health, national mental health programme

INTRODUCTION

The adoption of National Mental Health Programme (NMHP) by the Government of India in August 1982, was in many ways a landmark event in the history of psychiatry in this country. Recently, in 2012, we crossed the 30th anniversary of this important event.

During the last year, 2014, the revised National Mental Health Policy of India and the draft National Health Policy, 2015 have been released. A number of exhaustive reviews of the mental health program over the last three decades have been undertaken by professionals.14-11

It would be appropriate and useful to put on record our impressions of those eventful days which led to this crucial development. It is important because many of the stalwarts who played a central role in this development are no more on the scene, and others are also moving on in life. The idea of developing National Programmes of Mental Health started with World Health Organization (W.H.O.), Mental Health Division under the leadership of the then Director Dr. Norman Sartorius. The expert committee meeting on “organization of mental health services in developing countries” held in 1974 at Addis Ababa marked an important expression of the W.H.O. about its priority for mental health care in developing countries.12 This was followed by the launch of the seven country (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan), project “Strategies for Extending Mental Health Care (1975–1981),” to implement the 1974 recommendations at the level of general health care.13,14 A formal resolution, urging all member countries to develop NMHP was first time adopted in 1979 meeting of the W.H.O. Mental Health Advisory Group in Manila, Philippines. Some initial efforts to develop national programs were started in some African countries.15,16

How to cite this article: Wig NN, Murthy SR. The birth of national mental health program for India. Indian J Psychiatry 2015;57:315-9.
countries, but India was the first major country to adopt it at the national level.

The experiences of Bengaluru and Chandigarh psychiatric centers provided the technical support for decentralizing and deprofessionalizing mental health care. These studies from these two centers demonstrated the large numbers without essential mental health care, their impact on the ill individuals, families and community. Further, the efforts of the two centers also demonstrated the feasibility of integrating mental health care with general health care. A number of training tools/manuals were prepared by the two centers.

All of these efforts provided the background to the development of the NMHP in 1982.[15-26] Soon after these initial efforts other centres and professionals demonstrated the relevance of the approach in their centres.[27-31] One of us (Wig) was active in W.H.O. programs for many years, including contributions to the meetings in Addis Ababa, 1974, and Manila, 1979. He was also heading the W.H.O. collaborating center in mental health, Chandigarh. In 1980, he moved to A.I.I.M.S. New Delhi as Professor and Head of Psychiatry Department. His presence in Delhi helped to give a new focus on the development of the NMHP. W.H.O. SEARO in New Delhi specially sanctioned some funds for this activity in India. Dr. Helmut sell was the regional advisor in Mental Health in W.H.O. SEARO at that time. A small working group was constituted in 1980 for this purpose. The members of this group were Dr. Bisht, Director General of Health Services, Dr. Wig (New Delhi), Dr. Sethi (Lucknow), Dr. Venkoba Rao (Madurai), Dr. Sharma (Ranchi), Dr. Kapur (Bengaluru) and Dr. Helmut sell (W.H.O., SEARO). The group met a number of times and discussed the broad outlines of the NMHP. The number of psychiatrists at that time were around 1000 and many of the medical colleges did not have full Departments of Psychiatry. The mental health legislation was the Indian Lunacy Act 1912.

PREPARING THE DRAFT OF THE PROGRAMME

Following the meetings, finally in February 1981 a major effort was made to write down an outline of the proposed NMHP. A meeting was organized in Lucknow which was attended by Dr. Sethi, Dr. Wig, Dr. Bisht and Dr. Sell. The other three members Dr. Venkoba Rao, Dr. Sharma and Dr. Kapur could not attend. The meeting in Lucknow was very crucial in the development of the NMHP. There were intensive interactions between members (along with sometimes staff members of Dr. Sethi’s department). Each member produced a draft of a separate chapter, which was discussed in detail by the group and modified in the light of the group discussions. At the end of 3 days, we had the draft of the NMHP. After the meeting in Lucknow, the draft was circulated to other three members and their view incorporated.

THE FIRST NATIONAL WORKSHOP TO FINALIZE THE PROGRAMME

The next major event was a 2 days workshop of about 70 leading mental health professionals of India in New Delhi in July, 1981. In this meeting, the draft of the NMHP was presented. The draft document, chapter by chapter, was discussed in detail. As expected there was not total unanimity on various provisions of the program. While almost everybody favored the national initiative in this matter and more financial support by Government of India, there were sharp differences about the model to be adopted for the extension of mental health care to the total country. There were some professionals who felt that all mental health care should occur through the psychiatrists. We recall, one senior psychiatrist expressing the view, “if necessary we will go by helicopters to see patients in villages to start treatment.” There were others in line with the thinking of the W.H.O. expert committee recommendations, for extending the mental health services through the network of existing primary health care centres by training general doctors and health workers in recognition and treatment of common mental disorders. Some senior members strongly felt that it will dilute the importance of psychiatry as a medical specialty if all health personnel can treat psychiatric patients with drugs. Other participants felt equally strongly that if we have to provide at least a minimum of essential mental health services to majority of our population, there is no alternative but to extent mental health services through primary health care services. The choice was between an ideal psychiatric care for only a limited few in the urban areas or at least essential services for major serious and common mental disorders for vast majority of the population of India both in the rural and urban areas. Ultimately the consensus was in favor of the second alternative. The experiences of both Bengaluru and Chandigarh centers to integrate mental health care with general health care at Sakalawara and Raipur Rani centers provided support for the latter approach as both feasible and useful. A revised NMHP document emerged from this meeting for further consideration of the Ministry of Health and Family Welfare.

THE SECOND WORKSHOP OF NATIONAL MENTAL HEALTH PROGRAMME

In August 1982, the second national workshop was convened in New Delhi to take forward the program. This was to coincide with the 2 yearly meeting of the Central Council of Health and Family Welfare, which was attended by Health Ministers of all the States of India. The second workshop was more selective than the first one. There were about 30 participants which included apart from leading psychiatrists of India, representative of Directorate of Health Service, Indian Council of Medical Research, Indian Medical Council, W.H.O., SEARO, National Institute of
Mental Health and Neuro Sciences Bengaluru, Indian Medical Association, leading Clinical Psychologists, Sociologists and representative from Ministries of Health, Social Welfare, Labor, Planning Commission, University Grants Commission etc., It was certainly one of the mostly widely representative group of experts ever assembled in the country to consider the mental health issues and approve the draft of the NMHP, which had already been discussed and agreed by leading mental health specialists 1-year earlier in July, 1981.

There were broad agreement and appreciation of this mental health initiative at the national level. Some new suggestions were made for interdisciplinary coordination, which were incorporated. Armed with the support of the second workshop, we were now ready to take this draft program to Central Council of Health and Family Welfare which was meeting a fortnight later and which was the highest national body to give Government of India’s approval to the program. We were feeling very happy and confident not realizing that there were still many beaurecratic hurdles to cross before reaching the goal.

**MEETING OF THE CENTRAL COUNCIL OF HEALTH**

We were informed by the Central Directorate of Health that once the draft of the NMHP has been finalized and approved by two workshops, it will be put before the Central Council of Health which was meeting on 18–20 August, 1982 and there should be no difficulty in that. Dr. Sethi and Dr. Wig were present in Delhi to steer this program till the end. The Central Council of Health is the highest body in the country, and the meeting is attended by the health ministers and Directors of Health of all states of India with other high health officials. However, in the evening before the meeting, we got the bad news that the item of mental health program has not been even included in the agenda. It was heart breaking news that in spite of all our efforts this item would not be considered, a hurried meeting was held between Dr. Wig and Dr. Sethi on how to proceed further. The time was running out. The crucial person was the Health Secretary Mr. Sidhu who was responsible for making the agenda of the meeting. First we thought of ringing Secretary Health and taking time to meet him. Dr. Sethi advised against it. He reasoned that if the secretary declined to meet us next day we will have no option left. It will be better to take the risk and reach secretary health’s residence unannounced early morning and persuade him to include the item in the agenda. Dr. Wig and Dr. Sethi did accordingly and next morning at 7 a.m. reached his residence. Health Secretary was Mr. Sidhu who was taking his morning tea when Dr. Wig and Dr. Sethi barged into his drawing room. He was visibly upset at this intrusion into his privacy but politely asked the purpose of this visit. It was explained that it was not for any personal work but we feel very strongly that item of NMHP was very important for the country and that is why we have come to seek his help to put it on agenda in that morning meeting of Central Health Council. After a brief discussion, Mr. Siddhu said that he cannot promise anything as the agenda for the meeting is already very heavy, but he will see what can be done. We came back unsure of the success of our mission.

We attended the meeting as observers. When the meeting started at 11 a.m., the item of mental health was still not in the agenda. At lunch time, Joint Secretary Health Ms. Adarsh Misra brought the good news that the item has been listed for discussion at 3 p.m. She also showed us the draft resolution. The language was not clearly stating the approval of the NMHP but was supportive and appreciative by saying “mental health must form an integral part of the total health programme.” We waited with baited breath when the item came for consideration toward the end of the day. Surprisingly there was not much discussion, and the proposed resolution was unanimously adopted. We felt overwhelmed by the importance of this momentous decision, which was to shape the mental health movement in this country for next many decades.

Looking back, there were many people who played crucial roles in the development of the NMHP which include the committee which drafted the first document in Lucknow in February 1981, the participants in the two large workshops in New Delhi in July, 1981 and in August 1982. However, a particular mention must be made of Dr. Sethi’s initiative to reach Mr. Sidhu, Health Secretary’s residence on the morning of the meeting and the generosity and foresight of Mr. Sidhu to include the item in the agenda at the last minute for the meeting of the Central Council of Health. Incidentally, Mr. Sidhu is currently (2012) Governor of Manipur State since 2004.

**Importance of the national mental health programme, 1982**

It is important to recognize that in India, there were earlier efforts at developing mental health care as part of the general health care, starting with the Bhore committee report, Under the leadership of Dr. Sushila Nayar, in the 1960’s as part of the Mudaliar committee report a detailed plan of district mental health units, school mental health program, training of health personnel and most importantly, public mental health education were planned. The Srivatsava committee report, which was a precursor to the village level community health worker program included mental health at the most peripheral level of health care in the country.

The significance of the NMHP with its three broad objectives, namely,

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged of the population;
There is also need for the growing private sector psychiatry to be involved in the NMHP. An approach of recognizing the needs of the total population, utilizing the available community resources and fully involving the different sectors of the society.

It is important to recognize that the new Mental Health Policy, 2014[2] and the National Health Policy, 2015,[3] both recognize the basic premise of the NMHP, 1982, namely, integration with the primary care approach so as to identify those in need of such services and refer them to the appropriate site and follow-up with medication and tele-medicine linkages (3, section 4.6.3). The Indian developments have been in line with the international developments in mental health care.[45,46]

Against this background of developments, mental health professionals have the responsibility of continuing to provide leadership in this area of mental health care to reach the total population. Here lies the challenge and opportunities for all of us.

Progress
There are a large number of documents recording the progress of NMHP in the last three decades,[4,11-36] and new research to demonstrate the feasibility, cost-effectiveness of the community care approach has been published.[37-41]

It speaks of the commitment of the professionals and planners that there has been a continuous focus as well as revision of the NMHP during this period.[2,3,11] Briefly, gradually, from the two centers pioneering the community mental health programme, the program has been extended to include >220 districts, with the involvement of almost all psychiatric institutions in the implementation of the NMHP. The strengthening of the mental hospitals and setting up of centres of excellence for training of mental health professionals is another important development.

The voluntary organizations have brought rich approaches to address the mental health needs in the areas of rehabilitation, drug dependence, family support, suicide prevention, disaster mental health care, school mental health care, and public mental health education.[42] A new mental health legislation was enacted in 1987 and already a more progressive mental health bill is in the Parliament. The funding for NMHP has grown over the three decades, with a significant proportion of the funds remaining unutilized.

Looking to the future
The formulation of the NMHP, in 1982, was an important milestone in the development of mental health care in the country.[43-46] The experiences have not only benefitted the country but also influenced the development of mental health services in countries of Asia and Africa. However, India has changed in its political, social, economic, demographic and medical care areas. There is a need for the current approaches to NMHP to reflect these changes. There is also need for the growing private sector psychiatry to be involved in the NMHP. An approach of recognizing the needs of the total population, utilizing the available community resources and fully involving the different sectors of the society.

REFERENCES
1. Director General of Health Services. National Mental Health Programme for India. New Delhi: Ministry of Health and Family Welfare; 1982.
2. Ministry of Health (MOH). National Mental Health Policy of India: New Pathways, New Hope. New Delhi: Ministry of Health, Government of India; 2014.
3. Ministry of Health (MOH). National Health Policy 2015 (draft). New Delhi: Ministry of Health, Government of India; 2014.
4. Aganwal SP, Goel DS, IChpujani RL, Salhan RN, Shrivatsava S. Mental Health – An Indian Perspective (1946-2003). New Delhi: Directorate General of Health Services, Ministry of Health and Family Welfare; 2004.
5. Jain S, Jadhav S. Pills that swallow policy: Clinical ethnography of a Community Mental Health Program in Northern India. Transcult Psychiatry 2009;46:60-85.
6. Murthy RS. Mental health initiatives in India (1947-2010). Natl Med J India 2011;24:98-107.
7. Goel DS. Why mental health services in low- and middle-income countries are under-resourced, underperforming: An Indian perspective. Natl Med J India 2011;24:94-7.
8. Mehta M, Gupta D. Therapeutic practices in mental health: Changing perspectives. In: Mistra G, editor. Handbook of Psychology. New Delhi: Oxford; 2011. p. 254-72.
9. Shidhaye R, Patel V. Improving access to mental health care in India: Opportunities and innovations, in India Infrastructure Report 2013-2014. The Road to Universal Health Coverage. Hyderabad: Orient Blackswan; 2014. p. 223-35.
10. van Ginneken N, Jain S, Patel V, Bertridge V. The development of mental health services within primary care in India: Learning from oral history. Int J Ment Health Syst 2014 16:8:30.
11. Ministry of Health (MOH): Government of India. Annual Report of Ministry of Health and Family Welfare, 2013-2014. New Delhi; 2014.
12. WHO. Organisation of Mental Health Services in Developing Countries, Technical Report Series, 564. Geneva: WHO; 1975.
13. Sartorius N, Harding TW. The WHO collaborative study on strategies for extending mental health care. I: The genesis of the study. Am J Psychiatry 1983;140:1470-3.
14. Srinivas Murthy R, Wig NN. Evaluation of the progress in mental health in India since independence. In: Purinima M, Gandevia K, editors. Mental Health in India. Mumbai: Tata Institute of Social Sciences; 1993. p. 387-405.
15. Wig NN, Murthy RS, Harding TW. A model for rural psychiatric services-raipur rani experience. Indian J Psychiatry 1981;23:275-90.
16. Suman C, Baldev S, Murthy RS, Wig NN. Helping the chronic schizophrenic and their families in the community-initial observations. Indian J Psychiatry 1980;22:97-102.
17. Srinivas Murthy R, Kaur R, Wig NN. Mentally ill in a rural community: Some initial experiences in case identification and management. Indian J Psychiatry 1978;20:143-7.
18. Murthy RS, Wig NN. The WHO collaborative study on strategies for extending mental health care, IV: A training approach to enhancing the availability of mental health manpower in a developing country. Am J Psychiatry 1983;140:1486-90.

19. Chandrashekar CR, Isaac MK, Kapur RL, Sarathy RP. Management of priority mental disorders in the community. Indian J Psychiatry 1981;23:174-8.

20. Isaac MK, Kapur RL, Chandrashekar CR, Kapur M, Pathasarathy R. Mental health delivery through rural primary care-development and evaluation of a training programme. Indian J Psychiatry 1982;24:131-8.

21. Isaac MK, Chandrasekar CR, Srinivasa Murthy R. Decentralised training for PHC medical officers of a district - The Bellary approach. In: Verghese A, editor. Continuing Medical Education. Vol. VI. Calcutta: Indian Psychiatric Society. 1988.

22. Parthasarathy R, Chandrashekar CR, Isaac MK, Prema TP. A profile of the follow up of the rural mentally ill. Indian J Psychiatry 1981;23:139-41.

23. Isaac MK, Chandrasekar CR, Srinivasa Murthy R. Manual of Mental Health Care for Medical Officers. Bangalore: National Institute of Mental Health and Neurosciences; 1984.

24. Kapur RL. The role of traditional healers in mental health care in rural India. Soc Sci Med Anthropol 1979;13B: 27-31.

25. James S, Chisholm D, Murthy RS, Kumar KK, Sekar K, Saeed K, et al. Demand for, access to and use of community mental health care: Lessons from a demonstration project in India and Pakistan. Int J Soc Psychiatry 2002;48:163-76.

26. Chisholm D, Sekar K, Kumar KK, Saeed K, James S, Mubbashar M, et al. Integration of mental health care into primary care. Demonstration cost-outcome study in India and Pakistan. Br J Psychiatry 2000;176:581-8.

27. Gautam S. Development and evaluation of training programmes for primary mental health care. Indian J Psychiatry 1985;27:51-62.

28. Naik AN, Parthasarathy R, Isaac MK. Brief report: Families of rural mentally ill and treatment adherence in district mental health programme. Int J Soc Psychiatry 1996;42:68-72.

29. Sharma SD. Psychiatry in Primary Care. Ranchi: Central Institute of Psychiatry; 1986.

30. Wig NN, Parhee R. Manual of mental disorders for primary health care physicians. New Delhi: Indian Council of Medical Research; 1984.

31. Wig NN, Srinivasa Murthy R. Manual of Mental Disorders for Peripheral Health Personnel. Chandigarh: Published by Department of Psychiatry, PGIMER; 1980, 1993.

32. Patel V, Thara R, editors. Meeting Mental Health Needs in Developing Countries. New Delhi: NGO Innovations in India, Sage (India); 2003.

33. Bhore J. Health Survey and Development Committee. New Delhi: Government of India; 1944.

34. Mudaliar AL. Health Survey and Development Committee. New Delhi: Government of India; 1962.

35. Srinivasa A. Report of the Group on Medical Education and Support Manpower, 1974. New Delhi: Ministry of Health and Family Welfare, Government of India; 1975.

36. Reddy GN, Channabasavanna SM, Srinivasamurthy R. Implementation of National Mental Health Programme. NIMHANS J 1986;4:77-84.

37. Srinivasa Murthy R, Kumar KV, Chisholm D, Thomas T, Sekar K, Chandrasekar CR. Community outreach for untreated schizophrenia in rural India: A follow-up study of symptoms, disability, family burden and costs, Psychol Med 2004;34:1-11.

38. Chatterjee S, Patel V, Chatterjee A, Weiss HA. Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. Br J Psychiatry 2003;182:57-62.

39. Chatterjee S, Pillai A, Jain S, Cohen A, Patel V. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. Br J Psychiatry 2009;195:433-9.

40. Chatterji J, Venkatesh BK, Kishorekumar KV, Arunachala U, Venkatasubramanian G, Subbakrishna DK, et al. Prospective comparison of course of disability in antipsychotic-treated and untreated schizophrenia patients. Acta Psychiatr Scand 2009;119:209-17.

41. Thirthalli J, Venkatesh BK, Naveen MN, Venkatasubramanian G, Arunachala U, Kishore Kumar KV, et al. Do antipsychotics limit disability in schizophrenia? A naturalistic comparative study in the community. Indian J Psychiatry 2010;52:37-41.

42. Thara R, Padmavati R, Aynkran JR, John S. Community mental health in India: A rethink. Int J Ment Health Syst 2008;2:11.

43. Wig NN. The future of psychiatry in developing countries – The need for national programmes of mental health. NIMHANS J 1989;7:1-11.

44. Singh AR. The Task before Psychiatry Today Redux: STSPIR*. Mens Sana Monogr 2014;12:35-70.

45. World Health Organisation. World Health Report 2001 – Mental Health-New Understanding, New Hope. Geneva: World Health Organisation; 2001.

46. WHO-WONCA. Integrating Mental Health in Primary Care – A Global Perspective. Geneva: World Health Organisation and World Organisation of Family Doctors; 2008.

Source of Support: Nil, Conflict of Interest: None declared