# A CRITICAL ASSESSMENT OF INDIA'S NATIONAL MENTAL HEALTH PROGRAM (2014)

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***Abstract***

*This essay critically analyses the Government of India's (GOI) National Mental Health Program (2014) through the lens of modernisation theory and human development theory. By delineating the historical trajectory of this Program and judging its efficacy in contemporary times, this essay outlines the Program's drawbacks and offers recommendations for its better implementation in the future.*

*Key Words: domestic violence, power, the role of men, systemic oppression, traditional masculinity*

## Program Background

Quite surprisingly, The National Health Portal (2016) managed by the government of India (GOI) states that the National Mental Health Program (NMHP) was launched in the year 1982 and cites Wikipedia as a reference. Cross-checking this information with Murthy (1989) shows that while the year was accurate, it was still irresponsible for the GOI to provide an unreliable reference like Wikipedia. The NMHP was indeed adopted in August 1982 by the Council of Health and Family Welfare (central government). And to address the question of why the Program was adopted that year, historical reasons exist. Murthy (1989) points out that the decade of 1978-1988 began with the Alma Ata Declaration (AAD) (1978) which identified primary health care as the preferred approach for the universal coverage of health in nations across the globe. This declaration eventually led to the Indian parliament's adoption of the National Health Policy (1983) which emphasised decentralised community healthcare. That decade witnessed a slew of progressive rights-based legislation1 and saw a rise in the institutionalisation of mental hospitals as well. All these changes precipitated the promulgation of the NMHP in 1982. The Program was eventually scaled up and The District Mental Health Program (DMHP) was launched under the NMHP in 1996 (in the IX Five Year Plan). In April 2011, the plan was further revamped when the GOI set up a policy group to create a new mental health agenda for India. Recommendations from this newly instituted policy group helped constitute what is now known as the NMHP (2014) 2 and it was overseen by Dr. Harsh Vardhan of the Ministry of Health and Family Welfare.

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The broad development issue that the NMHP (2014) aims to address is that of the burgeoning mental illness crisis in India- a crisis that is also global in nature. The NMHP (2014) focuses on five things: promoting mental health; preventing mental illness incidence; enabling recovery; promoting de-stigmatisation and desegregation; and ensuring socio-economic inclusion- all whilst applying a rights-based approach (National Health Mission, 2020). Although the NHMP's (2014) preamble (p.ii) states that accurate figures for mental illness and suicide rates in India are not available, such data for India do exist (for example, with organizations like SPIF3). The NHMP (2014) also states in its preamble (p.ii) that 10% of the global population suffers from mental illnesses, but the NMHP (2014) website4 states that the official figure is between 6-7% (yet provides no citations for the same). This inconsistent reporting of data is disconcerting.

The NHMP (2014) cites the causes of mental health issues in India as follows: social stigma, violation of human rights, poverty, homelessness, and internal displacement (pp. 6-9); and some of the target groups that the policy aims to assist are children (school going and out of school), women, economically and socially deprived persons, older persons, people with physical disabilities, the poor and homeless, persons in custodial institutions, orphans, children of persons with mental illnesses, elderly care-givers, internally displaced people, people affected by natural disasters, war and conflict, sex workers and their children, sexual minorities and victims of human trafficking (NHMP, pp.7-9).

As far as implementation is concerned, Sinha and Kaur (2011) point out India currently faces an acute manpower crunch in the mental healthcare sector. In 2005, World Health Organization (WHO) reported that the median number of psychiatrists in India was only 0.2 per 100,000 population compared to a global median of 1.2 per 100,000 population. And the situation was worse in rural India. To address these concerns, the 11th 5-year plan undertook two schemes: scheme A and scheme B. Scheme A focused on establishing "centres of excellence" in the mental healthcare field. The table below highlights the year-wise breakup of the financial support per centre of excellence- with a total of 300 million crores was earmarked per centre.

**Table 1: Year-wise break-up of support for a center of excellence [ Rs 10 million (in crores)]:**

| Components | Years | | | | | Total |
|---|---|---|---|---|---|---|
| | 2007-08 | 2008-09 | 2009-10 | 2010-11 | 2011-12 | |
| Capital work | 0 | 1.25 | 4 | 7.75 | 5 | 18 |
| Technical equipments | 0 | 0 | 0 | 3 | 2 | 5 |
| Non-technical equipment | 0 | 0 | 1 | 1 | 1 | 3 |
| Library including books, journal and equipments | 0 | 0 | 0.5 | 0.5 | 0 | 1 |
| Additional faculty and technical staff as per regulatory requirements | 0 | 0 | .78 | 1.06 | 1.16 | 3.0 |
| Total for one center | 0 | 1.25 | 6.28 | 13.31 | 9.16 | 30 |

Year-wise break-up of support for a center of excellence [Rs. 10 million (in crores)]

Source: Sinha and Kaur (2011)

The overall goal of this plan was to set up at least 11 centres and produce 616 qualified mental health professionals from these centres annually (Sinha and Kaur,2011). Scheme B focused on working with government medical colleges/government general hospitals/state-run mental health institutes to set up more post-graduate Programs (in fields like psychiatry, clinical psychology, social work, and psychiatric nursing) and concomitantly scale up training capacities. This scheme aimed at generating about 60 psychiatrists, 240 clinical psychologists, and 600 psychiatric nurses per year (Sinha and Kaur, 2011).

**Philosophical/Theoretical underpinning of the Program**

Two theories that closely relate to the ethos of the National Mental Health Program (2014) are the modernisation theories and human development theory. The modernisation theories were essentially prescriptions of how societies should transition from traditional to modern. Theorists like Talcott Parsons, Rostow, and Daniel Lerner all defined modernity differently and offered different suggestions for carrying out the modernisation project. While reading the NMHP (2014), I am specifically reminded of Huntington's (2002) idea of reformism. Huntington defined reformism as an attempt to initiate the modernisation process whilst upholding traditional cultural values and norms. And we see examples of this in our mental health policy. For instance, the document talks about institutional care (pp.10-11) and community participation (pp.19-20), both of which are modern approaches to dealing with mental healthcare. In the same breath, the document also describes Ayurveda and yoga as valuable resources for mental wellness (p.14)- both of which are indigenous systems of healing. Thus, combining the modern with the traditional.

Murthy (1993) talks about the social evolution of mental healthcare in the chapter, Evolution of the Concept of Mental Health: From Mental Illness to Mental Health. The western approach first saw mental illness as "deviant' or 'abnormal" and an "act against God". The next phase saw mental illness as "criminal", during which time those with mental illnesses were routinely imprisoned. And with the advent of scientific thought, the focus shifted from criminality to insanity and saw the birth of the lunatic asylum. Eventually, community healthcare systems were set up, and they focused specifically on socially including the mentally ill as opposed to socially excluding them in asylums. This idea prevailed and is the dominant mental healthcare paradigm today. It is also reflected in the NMHP (2014).

In his theory of modernisation, Lerner (1958) talks about the mobile, modern society characterised by greater choice, urbanisation, literacy, and media participation; and although Indian society is far from modern, this Program aspires to be modernist. And fails. For instance, the Department of Health & Family Welfare's, annual report (2013-14) 5 states that the GOI conducted "an intensive national level mass media campaign" to address mental health stigma (p.142). Yet, Shidhaye and Kermode in a 2013 paper point out that such initiatives were ineffective. Expressions of stigma and discrimination were still very high in India at the time of the study, and one of the reasons for this was the staggered rollout of the mental healthcare plan at the district level. If we consider literacy, pages 13-14 of the NMHP (2014) elucidate 15 guidelines to increase mental health literacy, which include training Anganwadi workers, introducing a Life Skills Education (LSE) Program, and updating existing curricula. However, the results of these initiatives have also been dismal. In a 2016 cross-sectional study of mental health literacy among adolescents in South India, Ogorchukwu et al. found very low rates of literacy vis-à-vis mental health awareness; out of the 916 respondents studied, depression was recognised by only 29.04% and schizophrenia/psychosis was recognised by only 1.31% of the respondents. Moreover, most respondents did not trust formal mental health services owing to social stigma. This begs the question- why have formal mental healthcare institutions under the NMHP (2014) failed to capture the confidence of the rural populace? The 2013-14 annual report also states that during this time, 123 districts in 30 states and union territories were covered under the NMHP and by 2015, the number of districts increased to over 220 (Wig & Murthy,2015). Yet, multiple reports suggest that rural India is grossly neglected. In an interview with DNA India, mental health activist Neerja Birla slammed India's mental healthcare infrastructure as being "urban centric" and inaccessible to those in tier-2, tier-3 cities, and rural areas. So, why is there still an urban bias in mental healthcare access? And what is being done about it?

To conclude, while the NMHP (2014) does aspire to modernise India's mental healthcare infrastructure, it fails on multiple accounts, chief of which is its shoddy Program implementation and inability to address prevailing cultural and social taboos associated with mental illness in rural areas.

The second theoretical underpinning of this Program is the human development approach, which sees development as a holistic process of widening people's freedoms and choices and improving their capabilities so that they do what they want to do and be who they want to be (Sen,2012). The four pillars of this paradigm are equity, sustainability, productivity, and empowerment (Ul Haq, 1995). Page 19 of the NMHP (2014) states that "*Mental health should be recognised as everybody's business while the bio-medical approach to understanding mental health problems is undoubtedly important there are equally important psycho-social interventions.*" This approach looks at mental health holistically- by considering the social and cultural determinants of mental illness- and not just its bio-medical determinants. Moreover, the executive summary states: "*the need to address the social determinants of mental health are duly recognized*" (p.1). And the vision statement further emphasises the importance of adopting a rights-based approach by underscoring values such as equity, justice, and integrated care in mental healthcare delivery (pp.3-5). Although some of these core values mirror Ul Haq's pillars of Human Development (namely equity, productivity, and empowerment), there exists a massive gap between theory and practice. For instance, pg.9 of the document states that the marginalisation and exclusion of sexual minorities is a major determinant of mental illness- but if this is the case, why did the union government not take proactive measures to scrap IPC Section 377 when in power? And why does it oppose petitions to legalise same-sex marriage in India today? During the hearings for the IPC Section 377 case, the union government maintained a neutral stand. It neither supported the scrapping of the colonial-era law nor endorsed retaining it. Rather, it decided to leave the matter to the "wisdom of the courts" (Navtej Singh Johar v. Union of India). It is alleged that the Union government did not take any stand due to the polarising and sensitive nature of the issue, and this is precisely the problem: how can one talk about protecting the mental wellbeing of a marginalised minority community if one isn't bold enough to stand against those archaic laws that unjustly criminalised them in the first place?

Also, why did the union government never take any proactive measures to ban the inhumane and pseudo-scientific practice of gay conversion therapy? On May 12, 2020, Anjana Hareesh - a student in Brennen College, Goa died by suicide. Before killing herself, she came out as bisexual to her parents, and was allegedly subjected to inhumane "conversion therapy". Anjana

shared her trauma in a Facebook video a few days before her death. The United Nations has described conversion therapy as "unethical, unscientific and ineffective and, in some instances, tantamount to torture"- indeed it harbours great malice towards the LGBTQ+ community. Various countries around the world have already banned this practice, however, India still has not; and it was Anjana's suicide that put this issue in the spotlight in 2020. It is indeed disheartening to not see the Ministry of Health & Family Welfare take cognisance of this issue (Cris, 2020; United Nations General Assembly, 2015). Although the policy document rightly acknowledges the various forms of unfreedoms that chain vulnerable people, very little has been done to challenge them head-on. Even the annual report (2013-14) fails to address these issues by maintaining radio silence on sensitive issues like homosexuality.

**Conclusion: Program Evaluation**

Although the NMHP (2014) is ambitious and well-intentioned, its implementation has been lamentable. The lack of political will, inadequate leadership at the central, state, and district levels, persistent funding issues, and service delivery issues are but some of the reasons for its lacklustre performance (van Ginneken et al., 2014). Even though the Program correctly takes a participatory rights-based approach, it doesn't go far enough, which is why I prescribe the following alternative ways of redefining the Program's approach. First, the NMHP (2014) should identify key social groups that are extra vulnerable and experience disproportionate socio-economic-cultural and political deprivation- such as the queer community, Dalit, Adivasi, and Bahujan people, Muslims in India, migrant workers, Kashmiris, small farmers, people with disabilities and so on. Next, it should create specialised plans to address the mental health issues of these groups by taking inputs directly from community members themselves. A one-size-fits-all approach to mental health is not appropriate in a country like India. Third, the central government must prioritise attitude and mindset change before anything else with the cooperation of state and district officials. The number one goal should be to destigmatise mental health through innovative campaigns. Audio and visual storytelling, for instance, is one way to change mindsets.

Finally, the issue of funding also needs to be addressed. Only 0.05% of the total healthcare budget is allocated to mental health, out of which most of the funds remain unused (please see the table below and note the gap between the funds allocated and funds expended)- no wonder India is called the suicide capital of Asia! (Lohar, 2019; Munjal, 2020; Wig & Murthy, 2015).

| Financial Year | Allocation (Rs. in crore) | Expenditure (Rs. in crore) |
|---|---|---|
| 2007-08 | 38 | 14.57 |
| 2008-09 | 70 | 23.45 |
| 2009-10 | 55 | 52.27 |
| 2010-11 | 101 | 90.90 |
| 2011-12 | 130 | 113.66 |
| 2012-13 | 130 | 54.72 (including Rs. 45.18 crore of Grant in aid) |

**Table 2: Allocation and expenditure of funds in the NHMP over the years**

*Source: Department of Health & Family Welfare's, Annual Report (2013-14).*

A robust, well-researched, community-specific mental health Program benefits all. If we look at the issues plaguing queer people, we find that they are at a disproportionate risk of suicide, depression, and self-harm owing to the rampant homophobia and transphobia in society. A leader in queer mental healthcare is the Canadian Mental Health Association Ontario (2020) and it has not only compiled a list of mushrooming mental health issues plaguing the queer community but has also provided factsheets, resources for parents, helpline numbers, and information on free-community based mental health services. Their approach is factual, well-researched, and intersectional. We need something similar in our mental healthcare plan. Thus, one could be Muslim and gay, or be a paraplegic small farmer, or a lesbian Kashmiri woman, or a transgender Dalit man- and yet, not be understood by mental health practitioners in this country because even the NHMP (2014) cannot comprehend such complex identities. Even the newly passed Mental Healthcare Act (2017)6, hailed by some as progressive, isn't progressive enough because even it doesn't factor in these kinds of intersectional identities.

Beyond a community-specific intersectional approach, the central government also needs to take stock of its own executive actions that have unintended- and often devastating- consequences on the mental health of Indian citizens. Actions such as the sudden abrogation of Article 370, routine police violence on protestors, the systematic cracking down of dissent, the jailing of anti-government voices in the middle of the COVID-19 pandemic, the passage of

the horrific Transgender Bill 2019, and the massive COVID-19 management crisis (both in the first wave and the second wave) have not only divided the nation, but also induced feelings of undue stress, anxiety, depression, and suicidal thoughts in the minds of many in the public. Drawing from Dr. Harsh Vardhan's own words in the NMHP's (2014) opening statement "*Indian culture from time immemorial recognises the relationship between the mind, body and soul and its impact on mental health*", I wonder- where is this recognition today?

**Notes**

1. The notable policy changes in the 1978-1988 decade are The National Education Policy (1986); The Narcotic and Psychotropic Substance Act (1985); The Mental Health Act (1987); The Child Labour Act (1988); The Juvenile Justice Act (1986) and the National Policy for Mental Handicap (1988) (Murthy, 1989).

2. Link to the NHMP (2014) policy document: https://bit.ly/2Xibggc

3. Organisations like SPIF (Suicide Prevention India Foundation, n.d.) collect data on suicide incidence in India and could have been included in the NMHP. Various other NGOs in India have also collected data on different forms of mental health and illness incidence which could have also found a place in the final Program document.

4. Link to the NMHP (2014) website: https://bit.ly/3djsMWU

5. Link to the Department of Health & Family Welfare's, Annual Report (2013-14): https://bit.ly/2ZUSi0U

6. Softcopy of the Mental Healthcare Act (2017): https://bit.ly/3eNuGQ3
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