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Mental health services in rural India: challenges and prospects

Anant Kumar

Department of Rural Management, Xavier Institute of Social Service, Dr. Camil Bulcke Path, Ranchi, India;
pandeyanant@hotmail.com

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ABSTRACT

Mental health services in India are neglected area which needs immediate attention from the government, policymakers, and civil society organizations. Despite, National Mental Health Programme since 1982 and National Rural Health Mission, there has been a very little effort so far to provide mental health services in rural areas. With increase in population, changing life-style, unemployment, lack of social support and increasing insecurity, it is predicted that there would be a substantial increase in the number of people suffering from mental illness in rural areas. Considering the mental health needs of the rural community and the treatment gap, the paper is an attempt to remind and advocate for rural mental health services and suggest a model to reduce the treatment gap.

Keywords: Mental Health; Policy; Rural; India; Services; Treatment Gap; NMHP; DMHP; NRHM

1. INTRODUCTION

Health is "a state of complete physical, social, and mental well being and not merely the absence of disease or infirmity" [1,2]. Nevertheless, our health system is pre-occupied with curative health care services and disease prevention, with little attention on social and mental well being. Among these, mental health and well being is the most neglected one [3,4], particularly in rural areas [5,6]. Silence on mental health services in rural India [7] in the National Rural Health Mission (NRHM) [8] is a serious matter of concern. The omission of mental health in the NRHM mission document becomes even more serious in the backdrop of the uneven performance of the National Mental Health Program (NMHP, 1982) [9-11] and District Mental Health Programme (DMHP) [12] which is operational in only 125 districts out of 626 districts of India. With various flaws and implementation constraints in the NMHP and DMHP [13,14], there has been a very little effort so far to improve the rural mental health services.

2. ISSUES AND CONCERNS

Mental illness constitutes nearly one sixth of all health-related disorders [15]. With the population increase, changing values, life-style, frequent disruptions in income, crop failure [16], natural calamity (drought and flood), economic crisis [17], unemployment, lack of social support and increasing insecurity, it is fearfully expected that there would be a substantial increase [18, 19] in the number of people suffering from mental illness in rural areas. Among priority non-communicable diseases in India, mental illness constitutes 26 percent share in the burden of disease and available data suggest that there would be a sharp increase in this in coming years [20-22]. Projections suggest that the health burden due to mental disorders will increase to 15% of DALY by 2020 [23]. The study by the National Commission on Macroeconomics and Health (NCMH) shows that at least 6.5% of the Indian population has some form of serious mental disorders, with no discernible rural–urban differences [24]. Epidemiological studies done in last two decades shows that the prevalence of mental disorders range from 18 to 207 per 1000 population with the median 65.4 per 1000 at any given time. Most of these patients live in rural areas, far away from any modern mental health facilities [25]. The overall individual burden for rural areas cannot be estimated with the available studies. Nevertheless, considering the fact that 72.2 percent of population lives in rural areas, with only about 25 percent of the health infrastructure, medical manpower and other health resources, it may be surmised that the number of people affected with any mental and behavioural disorder would be higher in rural areas [26].

Despite NRHM initiatives and improvements, general health services in rural areas are not adequate and are struggling with infrastructural, human resources and

other problems. Only 31.9 percent of all government hospital beds are available in rural areas as compared to 68.1 percent for the urban population. At the national level the current bed-population ratio for Government hospital beds for urban areas (1.1 beds/1000 population) is almost five times the ratio in rural areas (0.2 beds/ 1000 population) [27-29]. There is a shortfall of 8% of doctors in Primary Health Centres (PHC), 65% of specialist at Community Health Centres (CHC), 55.3% of male health workers, and 12.6% of female health workers [30].

3. CHALLENGES

The epidemiological situation and available health service system shows that providing mental health services in rural areas is a challenging task, which needs infrastructural, architectural, and programmatic correction in the existing National Mental Health programme and District Mental Health programme. Lack of trained human resource for mental health care and treatment is another challenge [31], considering few institutions available for mental health professional training. Besides these, major challenge is lack of political commitment and realization that mental health is an important aspect of our health system which has far reaching implication for the development of the country.

4. NEEDS AND THE TREATMENT GAP

Considering the limited or no service availability; the treatment gap is huge in rural areas. According to one estimate, even if all 3000 psychiatrists available in the country are involved in face to face patient contact and treatment for 8 hours a day, five days a week, and see a single patient for a total of 15 - 30 minutes over a 12 month period, they would altogether provide care for about 10% - 20% of the total burden of serious mental disorders. Surprisingly, it is almost similar to the estimated 'treatment gap' of ninety percent.

5. BARRIERS IN SEEKING HELP

Barriers in seeking help in rural area are many. Major barriers in seeking help are unavailability of mental health services, low literacy, socio-cultural barriers, traditional and religious beliefs, and stigma [32] and discrimination associated with mental illness. Unavailability of mental health services and lack of resources, particularly in terms of human resources, financial constraints, and infrastructure are one of major barriers which makes access to mental health services in rural areas more difficult. The services available in urban areas are far and costly; and difficult to utilize and access due to various reasons. Lack of awareness and recognition of CMD (common mental diseases) with prevailing stigma and discrimination is an important issue and barrier which is closely associated with low literacy in rural areas.

Other barriers are low political will of Central and state governments and unclear plan of action and policy. Another barrier is resistance to decentralization [33], and resistance by mental health professionals and workers, whose interests are served by large hospitals. Above all, major barrier is difficulties in integrating mental health in Primary Health Care. Primary health care workers are overburdened with lack of supervision and specialist support. Other barrier is that medical students and psychiatric residents are often trained only in mental hospital settings with inadequate training of general health workforce and lack of infrastructure for supervision in the community.

Another important barrier is mental health leadership of the country which often lacks public health skills. Those who are in leadership positions are psychiatrists, trained in clinical management, without formal Public health training. Besides, the major barrier and challenge is resistance by psychiatrists to accept others as leaders.

6. HUMAN RESOURCES AND INFRASTRUCTURE GAP

The people in rural areas are unable to access the services of the qualified doctors and other mental health professionals, where just 0.2 psychiatrists, 0.05 psychiatric nurses, 0.03 psychologists per 100,000 people (see **Table 1**), and 0.26 mental health beds per 10,000 populations, 0.2 in mental hospital and 0.05 in general hospitals (see **Table 2**) [34] are available for the whole coun-

Table 1. Professional per 100,000 populations.

	2001*	2005**
Number of psychiatrists	0.4	0.2
Number of neurosurgeons	0.06	0.06
Number of psychiatric nurses	0.04	0.05
Number of neurologists	0.05	0.05
Number of psychologists	0.02	0.03
Number of social workers	0.02	0.03

Source: *Atlas, Country Profile, 2001. World Health Organization. **Mental Health Atlas, 2005. World Health Organization.

Table 2. Psychiatric beds per 10,000 populations.

	2001*	2005**
Total psychiatric beds	0.26	0.26
Psychiatric beds in mental hospitals	0.2	0.2
Psychiatric beds in general hospitals	0.05	0.05
Psychiatric beds in other settings	0.01	0.01

Source: *Atlas, Country Profile, 2001. World Health Organization. **Mental Health Atlas, 2005. World Health Organization.

try. Interestingly, the number of availability of psychiatrist has gone down during 2001 and 2005. To make the resources equitable, India needs about 140,000 psychiatrists whereas we have about 3000 psychiatrists and 75% of them are working in urban areas where less than 28% of the population lives. The government expenditure on mental health is another concern where it spends just 0.83 percent of its total health budget on mental health [35].

7. INNOVATIONS ATTEMPTED SO FAR

NGOs and civil society groups are involved in providing mental health service delivery and community mental health and have done commendable job [36]. Many of them have set up day care centres, half-way homes, long-stay homes, counselling centres, suicide prevention centres, school mental health programmes, disaster mental health care, and community based programmes for the mentally ill. Nevertheless, most of their services are "extension clinics" concentrated in urban areas with little attention on rural areas. Some of NGOs who are doing commendable jobs are Medico-Pastoral Association, Bangalore; Paripurnata, Kolkata; SCARF and The Banyan, Chennai; Richmond Fellowship Society (Bangalore, Lucknow, and Delhi); Cadabams, Bangalore; and Ashadeep in Guwahati. Interestingly most of these efforts are concentrated in Southern states and in urban areas. Nav Bharat Jagriti Kendra (NBJK), Hazaribagh is one of few organizations working in rural areas in partnership with 23 NGOs in 14 districts of Bihar and Jharkhand [37]. Some of other organisations working on mental health in rural areas are Shant Manas Trust in Madurai [38], and the Richmond Fellowship Society in Bangalore [39].

Though various NGOs are doing commendable job in their areas, their geographical and service reach is very limited and dependent on donor support. Secondly, their initiatives have been isolated to pockets with limited funds and have not been supported by the government, both at the Centre and state level [40]. Thirdly, the continuance and the quality of services is a serious concern where the staffs lack professional training and skills. Fourthly, we have failed to recognize, learn from their experiences and extend these efforts in rural areas. It emerges that these NGOs can supplement in providing mental health services but they cannot be an alternative to provide mental health care services in rural areas considering the need and treatment gap.

8. FUTURE PROSPECTS

Proposed decentralization and synchronization of National Mental Health Programme (under 11th Five Year Plan, 2007-2012) with National Rural Health Mission is a good opportunity and has a wider prospect [41]. We can hope that this will ensure Primary Health Centre (PHC) based mental health services to the rural population. Involving and training village level Accredited Social Health Activists (ASHA) is another opportunity. Adding a module on community mental health and training ASHAs will definitely help in early detection, treatment, and rehabilitation of patients in the community in the rural areas. Presently, most of the rural people approach traditional healers (religious saints, tantriks (black magicians), unregistered medical practitioners, and quacks) for treating mental health problems. Considering people's faith in them and lack of trained professional, training these traditional healers could help in alleviating mental illness in rural areas. Developing short-term special curriculum based training for medical officers is another prospect which will help in providing clinical services at block level.

9. SUGGESTIONS

Presently, the Government of India is providing mental health services in 125 districts through District Mental Health Programme under NMHP. There is need to integrate NMHP and DMHP with NRHM Programme to provide mental health care, services and support to each and every individual in rural areas.

The **Table 3** suggests a model to provide mental health services in rural areas. Some of the suggestions through

Table 3. Model of mental health care and service in rural areas.

Institution	Personnel	Level	Role
Mental Health Institution	Specialist institutional care and services	State level	Treatment of severe mental health disorders
District Health Society	Civil surgeon	District level	Planning, implementation, and service delivery
Community Health Centre	Psychiatrist	On one lakh population	Treatment for common mental health disorder
Primary Health Centre	Medical officer in charge	Block (on 30,000 population)	Counselling/identification/ referral
Community Care	ASHA	Village/Community	Care, support, education, acceptance, and in addressing stigma and discrimination
Self Care/Family Care	Family/Community members	Family	Care

which mental health care and services can be strengthened in rural areas are increasing the availability of resources, improving equity in their distribution, and enhancing efficiency in their utilization. Besides, there is also a need to emphasize the role of specialists in filling the treatment gap. Building capacity of other health workers, particularly ASHA under the NRHM programme may help in demand generation as well as referral. Following suggestions or strategies in combination can be used for strengthening the rural mental health care services:

1) Convergence of National Mental Health Programme/ District Mental Health Programme under National Rural Health Mission Programme and using existing PHCs and sub centres to provide mental health services;

2) Capacity building of Rural/registered Medical Practitioners/Primary Health care doctors/ASHA workers/ teachers/Aanganwadi workers on tailor made modules;

3) Advocacy through community, social and other bodies and involvement of religious leaders, teachers, local community leaders with key stakeholders;

4) Targeted awareness programme using available rural media;

5) Provisioning social security to the mentally ill patients; and

6) Training for caregivers and relatives.

10. CONCLUSIONS

The rural mental health services are neglected area which needs immediate attention considering the burden of disease and treatment gap. District Mental Health Programme needs restructuring and convergence within the NRHM. The "extension clinic" approach needs to be replaced with integration of mental health services with general health services, particularly under NRHM. Involving ASHAs under NRHM is an opportunity to provide mental health services at door steps in rural areas. Lastly, ensuring bottom up approach and community ownership are must to achieve universal mental health services, care and support in rural areas.

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