

ARTICLE

Rural mental health in India

Kamlesh Kumar Sahu, Soma Sahu¹

Assistant Professor in Psychiatric Social Work, Department of Psychiatric Social Work, Institute of Psychiatry,

¹Lecturer, Department of Psychology, Bangabasi College, Kolkata, India

Abstract

The literature on differences in mental health between urban and rural settings is inconclusive. Rural and remote communities have been identified as population groups deprived for mental health care services. In India 68.84 per cent of population lives in rural areas, with only about 25 per cent of the health infrastructure, medical man power and other health resources. Against the huge need for mental health services in India there is scarcity of trained manpower. Origins of the rural mental health in India can be traced in way back and subsequently implementation of the National Mental Health Programme (NMHP) and the District Mental Health Programme (DMHP) aimed to enhance basic mental health care in rural areas, mental health care expanded steadily across the country. However published papers and independent evaluation of the DMHP indicates it is, ineffective in practice to a large extent. The limited success of the NMHP and the community mental health movement has to be recognised and accepted. Nongovernmental organisations, using a variety of community-oriented care programmes using various strategies that have been employed in community care have attempted to utilise existing community resources and demonstrated the feasibility and cost-effectiveness of the community outreach programs for persons with mental illness. It is also doubtful, whether the existing programme can take care of such a complex unmet rural mental health needs.

Sahu KK, Sahu S. Rural mental health in India. *Dysphrenia*. 2013;4(1):7-11.

Keywords: Primary health care. Mental disorders. Community mental health services.

Correspondence: withkamlesh@gmail.com

Received on 9 July 2012. Accepted on 9 November 2012.

Introduction

Yet there is no fixed criterion for defining ruralness. Consequently the term “rural” is often used loosely in both popular and scientific literature. This poses a problem for researchers seeking to make quantitative claims about rural effects related to mental disorders, its treatment, or outcomes. While there may be no harm in describing people and places as “rural” when the intent is to convey a general quality, more rigors is needed when the intent is to draw statistical inferences.[1] The literature on differences in mental health between urban and rural settings is inconclusive. Webb,[2] in a review of study, found little evidence that rates of psychiatric disorder were different in urban and rural areas in a number of countries. It has sometimes been assumed that rural life is low in physical as well as mental health problems compared with urban. However, rural settings may have considerable deprivation and inaccessibility of medical services.[3,4] Rural areas have unique characteristics that present barriers to mental health care. Accessibility and availability of mental health specialists, such as psychiatrists, psychologists, psychiatric nurses and social workers, are seriously lacking. Poverty, geographic isolation and cultural differences further hinder the amount and quality of mental health care available to

people in rural areas.[5] During the past three decades, after publication of the recommendations of the World Health Organization (WHO) expert committee and dissemination of the results of a WHO study of strategies for expanding mental health care,[6] several initiatives have been taken to improve mental health services in rural areas of low-income developing countries during the last two decades. They have included the formulation of national mental health programs and establishment of pilot programs for integration of mental health care with primary health care. India is one of the pioneers along with Iran, and other countries in Asia, Africa, and South America.[7,8] To fulfill the need of mental health services, mental health professionals has multiple roles to play in meeting the challenges of providing mental health care in rural areas in the country.

Burning need

Mental illness constitutes nearly one sixth of all health related disorders in the country.[9] With the population increase, changing values, life-style, frequent disruptions in income, crop failure,[10] natural calamity (drought and flood), economic crisis,[11] unemployment, lack of social support and increasing insecurity, it is fearfully expected that there would be a substantial increase[9,12] in the number of people suffering from

mental illness in rural areas. Severe mental disorders in India that include schizophrenia, bipolar disorder, organic psychosis and major depression affect nearly 20 per 1000 population.[13] This is a population that needs continuous treatment and regular follow-up attention. Close to ten million persons with severe mental illness are in our country without adequate treatment.[13] More than half remain without treatment. Lack of knowledge on the treatment availability and potential benefits of seeking treatment are important causes for the above. On one hand there is a large population in need for mental health services and very few psychiatrists being available on the other hand, less than one psychiatrist is available for every three lakhs population. In 68.84% of country's rural population psychiatrist/population ratio is one for every million.[13] Majority of rural areas are still underprivileged where availability and affordability of health services in general and mental health services in particular is very limited. Wainer and Chesters[14] has written in Australian context but it's quite true in India too, "Relative poverty, negative life experiences and a lack of control over work and life in general compromises mental health in rural places. Clearly, governmental or business (occupation) changes that reduce rural confidence and self-esteem will have negative effects on mental health. Globalisation, economic rationalism and the information and biotechnology revolutions are removing the locus of control from rural communities make the situation more worsted. Rural people and places are not homogeneous and there are some groups of people living in some rural places that experience more of the negative aspects of rural life than the rest of the population." In this context concern with mental health problems in rural areas has become more critical.

Service gap

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.[12] 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 persons with mental illness live in rural areas, far away from any modern mental health facilities.[15] The overall individual burden for rural areas cannot be estimated with the available studies. Nevertheless, considering the fact that 68.84% population of the country lives in rural areas, with only about 25 per cent of the health infrastructure, medical man power 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.[16] Against the huge need for mental health services in India there is scarcity of trained manpower. There are nearly

3500 psychiatrists, 1000 clinical psychologists, 1000 psychiatric social workers (PSWs) and 900 psychiatric nurses for 20-30 million people in need of them.[17,18] The mental health facilities available in the country are very meagre. There are around 20,000 psychiatric beds available in the mental hospitals of India. The number of psychiatric beds per 1000 population is less than one.[18] Though few non-governmental organisations (NGOs) play a pivotal role in filling the gap in the existing mental health services in India and the substantial need for these services[19] but with their limited resources it is not possible to scale up services. Whatever services are available is mostly centred in urban areas.

Development

Origins of the rural mental health in India can be traced to way back in 1967 when one of the earliest rural mental health clinics was started at Mandar near Ranchi by Central Institute of Psychiatry.[20] Later India has developed primarily rural mental health services.[21] Two projects that have influenced the development of India's mental health services are the Raipur Rani Project and the Bellary District Project. The Raipur Rani Project was part of the WHO collaborative study on strategies for extending mental health care.[6,21] Seven countries - Brazil, Colombia, Egypt, India, the Philippines, Senegal, and Sudan were involved in the seven-year study, from 1975 to 1981. In Raipur Rani Project, focus was evaluation of the integration of mental health care with general health services and the aim was to develop a model for rural psychiatric services.[22] The Bellary District Project, in Karnataka, was also a rural project which involved a unit of the health care infrastructure known as a district, which serves two million people.[7] The district project included decentralised training of primary health care personnel, provision of mental health care in all health facilities, involvement of all categories of health and welfare personnel, provision of essential psychotropic drugs, a simple record-keeping system, and a mechanism for monitoring the work of primary health care personnel in the provision of mental health care. The results showed that it is possible to provide basic mental health care as part of primary health care services. The results were especially noteworthy because the direct involvement of mental health professionals in planning and providing care was limited.[23] The results of the experiments in integrating mental health care with general health care were used in formulating the National Mental Health Program (NMHP), launched in 1982 and reviewed in 1995 as the District Mental Health Program (DMHP), sought to integrate mental health care with primary health centre (PHC).[24] This model has been implemented in all the states and currently there are 125 DMHP sites in India; majority of the sites in rural areas. The Ministry of Health, Government of India envisages extension of DMHP to all

the 625 districts in the country as part of the 11th and 12th five year plans. There is shortage of qualified mental health manpower for DMHP in particular and for the whole mental health sector in general. Recognising this key constraint, Government of India has formulated manpower development schemes under NMHP to address this issue. Under the scheme, 11 centres of excellence in mental health, 120 postgraduate (PG) departments in mental health specialties, upgradation of psychiatric wings of medical colleges, modernisation of state-run mental hospitals will be supported. The expected outcome of the manpower development schemes is 104 psychiatrists, 416 clinical psychologists, 416 PSWs and 820 psychiatric nurses annually once these institutes/departments are established, together with other components such as DMHP with added services, information, education and communication activities, NGO component, dedicated monitoring mechanism, research and training, this scheme has the potential to make a facelift of the mental health sector in the country which is essentially dependent on the availability and equitable distribution mental health manpower in the country obviously including rural areas.[25]

Objectives

Initially our NMHP and DMHP objectives were focused towards needs of mental health care in rural areas. NMHP was started with the following three objectives:

1. To ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population.
2. To encourage mental health knowledge and skills in general health care and social development.
3. To promote community participation in mental health service development and to stimulate self-help in the community.[15]

The main components of NMHP that have been proposed are as under:

- To establish centres of excellence in mental health by upgrading and strengthening of identified existing mental hospitals for addressing acute manpower shortage.
- To provide impetus for development of manpower in mental health, other training centres (government medical colleges/general hospitals etc.) would also be supported for starting PG courses in mental health or increasing intake capacity.
- Spill over of 10th Plan schemes for modernisation of state run mental hospitals and upgradation of psychiatric wings of medical colleges/general hospitals.
- DMHP with added components of life skills training and counselling in schools, counselling service in colleges,

work place stress management and suicide prevention services.

- Research: There is huge gap in research in mental health which needs to be addressed.
- Information, education and communication (IEC): A lot of stigma is attached to mental illnesses. It needs to be stressed that the mental illness is treatable. An intensive media campaign is planned for 11th Plan duration.
- NGOs and public private partnership for implementation of the Programme: This would increase the outreach of community mental health initiatives under DMHP.
- Monitoring implementation and evaluation: Effective monitoring at central/state/district level will facilitate implementation of various components of NMHP.[13]

The objectives of the DMHP are:

1. To provide sustainable basic mental health services to the community and to integrate these services with other health services.
2. Early detection and treatment of patients within the community itself.
3. To ensure that persons with mental illness and their relatives do not have to travel long distances to go to hospitals or nursing home in cities.
4. To take the pressure off from mental hospitals.
5. To reduce the stigma attached towards mental illness through change of attitude and public education.
6. To treat and rehabilitate persons with mental illness discharged from the mental hospital within the community.[26]

Results

As the implementation of NMHP, particularly the DMHP, community mental health programme aimed at enhancing access to basic mental health care in rural areas, expanded steadily across the country.[27] However published papers and independent evaluation of the DMHP indicate that the DMHP is, to a large extent, ineffective in practice.[26] The limited success of the NMHP and the community mental health movement has to be recognised and accepted.[28] On the other hand NGOs, using a variety of community-oriented care programmes and various strategies that have been employed in community care, have attempted to utilise existing community resources and demonstrated the feasibility and cost-effectiveness of the community outreach programs for persons with mental illness.[23] It has had mixed success in achieving this goal and 90% of the rural population remain without access to mental health services.[24,29,30] In the past, besides the various steps taken by the government, NGOs and other agencies

to improve mental health services, but mental health did not find its appropriate place in the national and state health planning.[31] National Rural Health Mission (NRHM) is being implemented since 1982 but silence on mental health services in rural India[32] is a serious matter of concern. The omission of mental health in the NRHM document becomes even more serious in the backdrop of the uneven performance of the NMHP.[15] Outcome of initiatives under 11th five year plan is yet to be evaluated.

Conclusion

Rural and remote communities have been identified as population groups deprived for mental health care services. As mental health researchers and educationalists, we should think about the relationship between unmet mental health needs and the rural environment and make better promotion and intervention programmes. We should be interested in what it is about rural people, rural lifestyles and rural places that enhance mental health, predispose people to mental health problems or support resilience and recovery. Findings reveal that negative attitudes towards persons with mental illness are widespread and may impair their social reintegration in to the community.[33] Hence, there is an urgent need to develop strategies to enlighten the public regarding nature of mental illness to foster acceptance of people with mental illness by the rural community.[33]

Community mental health services have to be different in rural and in urban areas, since it is certain: local needs need local solutions. Various issues are crucial with implications for rural mental health. The most notable are poverty, low level of literacy, alcoholism, rapid urbanisation, unemployment, migration and refugees, stress related to work, violence in society, the growing population of elderly persons, mental health issues of women, children and adolescents and disasters. These problems pose serious challenges to existing mental health services and infrastructure particularly in rural areas. It is also doubtful, whether the existing programme can take care of such a complex unmet rural mental health needs.

References

1. Dembling B. Measuring rurality: applying the rural-urban continuum. Southeastern Rural Mental Health Research Centre.
2. Webb SD. Rural-urban differences in mental health. In: Freeman HI, editor. Mental health and the environment. Edinburgh: Churchill Livingstone; 1984.
3. Bentham G, Haynes R. A raw deal in remoter rural areas? Family Practitioner Services. 1986;13:84-7.
4. Shucksmith M, Roberts D, Scott D, Chapman P, Conway E. Disadvantage in rural areas. London: Rural Development Commission; 1996.
5. National Institute of Mental Health (NIMH). Rural Mental Health Research; 2000.
6. 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.
7. Murthy RS. Economics of mental health care in developing countries. In: Lieh Mak F, Nadelson CC, editors. International Review of Psychiatry, vol 2. Washington, DC: American Psychiatric Press; 1996.
8. Wig NN. Rational treatment in psychiatry: perspectives on psychiatry treatment by level of care. In: Sartorius N, De Girolamo G, Andrews G, German A, Eisenberg L, editors. Treatment of mental disorders: a review of effectiveness. Washington, DC: World Health Organization and American Psychiatric Press; 1993.
9. Pathare S. Less than 1% of our health budget is spent on mental health [Internet]. InfoChange News & Features; 2005 June [cited 2012 Nov 8]. Available from: <http://infochangeindia.org/agenda/access-denied/less-than-1-of-our-health-budget-is-spent-on-mental-health.html>
10. National Commission on Farmers. Serving farmers and saving farmers, fifth and final report. New Delhi: Ministry of Agriculture, Government of India; 2006.
11. Chatterjee P. Economic crisis highlights mental health issues in India. Lancet. 2009;373:1160-1.
12. National Commission on Macroeconomics and Health. Background papers: Burden of disease in India [Internet]. New Delhi: Ministry of Health & Family Welfare; 2005 [cited 2012 Nov 8]. Available from: [http://www.who.int/macrohealth/action/NCMH_Burden%20of%20disease_\(29%20Sep%202005\).pdf](http://www.who.int/macrohealth/action/NCMH_Burden%20of%20disease_(29%20Sep%202005).pdf)
13. National Portal Content Management Team. Mental health programme [Internet]. National Informatics Centre, Government of India; 2011 Feb 10 [cited 2012 Nov 8]. Available from: http://india.gov.in/sectors/health_family/index.php?id=13#maincontent
14. Wainer J, Chesters J. Rural mental health: neither romanticism nor despair. Aust J Rural Health. 2000;8:141-7.
15. National Mental Health Programme for India. New Delhi: Ministry of Health and Family Welfare; 1982.
16. Gururaj G, Girish N, Isaac MK. Mental, neurological and substance abuse disorders: strategies towards a systems approach. In: National Commission on Macroeconomics and Health (NCMH) background papers: Burden of disease in India. New Delhi: Ministry of Health & Family Welfare; 2005. p. 226-50.
17. National Human Rights Commission. Quality assurance in mental health. New Delhi: National Human Right Commission, Government of India; 1999.
18. World Health Organization. The world health report: mental health: new understanding, new hope. Geneva: World Health Organization; 2001.
19. Padmavati R. Community mental health care in India. Int Rev Psychiatry. 2005;17:103-7.
20. Nizamie SH, Goyal N, Haq MZ, Akhtar S. Central Institute of Psychiatry: A tradition in excellence. Indian J Psychiatry. 2008;50:144-8.

21. Wig NN, Murthy RS, Harding TW. A model for rural psychiatric services-Raipur Rani experience. *Indian J Psychiatry*. 1981;23:275-90.
22. Murthy RS. Mental health care by health workers. In: Murthy RS, editor. *Mental health by the people*. Bangalore: People's Action for Mental Health; 2006.
23. Murthy RS. Rural psychiatry in developing countries. *Psychiatr Serv*. 1998;49:967-9.
24. Khandelwal SK, Jhingan HP, Ramesh S, Gupta RK, Srivastava VK. India mental health country profile. *Int Rev Psychiatry*. 2004;16:126-41.
25. Sinha SK, Kaur J. National mental health programme: manpower development scheme of eleventh five-year plan. *Indian J Psychiatry*. 2011;53:261-5.
26. Murthy RS. Mental health initiatives in India (1947-2010). *Natl Med J India*. 2011;24:98-107.
27. Isaac M. National Mental Health Programme: time for reappraisal. In: Kulhara P et al., editors. *Themes and issues in contemporary Indian psychiatry*. New Delhi: Indian Psychiatric Society; 2011.
28. Desai NG. Public mental health: an evolving imperative. *Indian J Psychiatry*. 2006;48:135-7.
29. Thara R, Padmavati R, Srinivasan TN. Focus on psychiatry in India. *Br J Psychiatry*. 2004;184:366-73.
30. Weiss MG, Isaac M, Parkar SR, Chowdhury AN, Raguram R. Global, national, and local approaches to mental health: examples from India. *Trop Med Int Health*. 2001;6:4-23.
31. Kumar A. District Mental Health Programme in India: a case study. *Journal of Health & Development*. 2005;1:24-35.
32. Kumar A. National Rural Health Mission and mental health. *HealthAction*. 2005;18.
33. Vijayalakshmi P, Ramachandra, Nagarajaiah, Reddemma K, Math SB. Attitude and response of a rural population regarding person with mental illness. *Dysphrenia*. 2013;4:42-8.