

Review Article

National mental health program of India: a review of the history and the current scenario

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ABSTRACT

Mental health is an important and essential component of Health. India was one of the first few countries in the developing world to formulate a National Mental Health program (NMHP). NMHP was launched in 1982 with very comprehensive objectives. The basic strategy of NMHP was to integrate the basic mental health care with general health services. At the end of five years of initial implementation of NMHP it was observed that although there were some developments but the financial constraints limited its success. The concept of DMHP was introduced in 1996 and various changes were made in the consecutive five year plans. In the XIth plan there was an effort to address the main barrier in the mental health service provisions i.e. the shortage of manpower. The NMHP in the XIIth plan has a focus on psychiatric problems specific to vulnerable sections of the population. The program has had various modifications since the time of its inception and now that the time is approaching for the XIIth plan to conclude it would be an opportunity to have deliberations over the success and the failures of the program and to take the program to the next level.

Keywords: NMHP, DMHP, Mental health, Community psychiatry

INTRODUCTION

Mental health is an integral and essential component of health. World health organization defines the mental health as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stressors of life and can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of the community. Globally the mental health problems are rising and the burden of illness resulting from the psychiatric and behavioural disorders is enormous.¹

This review paper will examine the burden of mental health problems globally and in India; the history of mental health services and initiatives and the evolution of National Mental health program (NMHP).

BURDEN OF MENTAL HEALTH PROBLEMS

International scenario

The prevalence of mental disorders as per World Health Report is around 10% and it is predicted that burden of disorders is likely to increase to 15% by 2020.²

The mental, neurological and substance use disorders account for 13% of the total global burden of disease in the year 2004.

Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women.

The gap between the need for treatment and its provision is large all over the world. WHO Mental Health Atlas 2011 provides data that demonstrate the scarcity of resources within countries to meet mental health needs.³

The Director General, World Health Organization launched the Mental Health Action Plan 2013- 2020 on 7th October 2013. The Action plan recognizes the essential role of mental health in achieving health for all people. It aims to achieve equity through universal health coverage and stresses the importance of prevention in mental health.

The objectives of World Health Organization Mental Health action plan 2013-2020 are;

- More effective leadership and governance for mental health,
- The provision of comprehensive, integrated mental health and social care services in community-based settings,
- Implementation of strategies for promotion and prevention,
- Strengthened information systems, evidence and research for mental health.³

Indian scenario

According to various community based surveys, prevalence of mental disorders in India is 6-7% for common mental disorders and 1-2% for severe mental disorders.

In India the rate of psychiatric disorders in children aged between 4 to 16 years is about 12% and nearly one-third of the population is less than 14 years of age.

With such a magnitude of mental disorders it becomes necessary to promote mental health services for the wellbeing of general population, in addition to provide treatment for mental illnesses.

Treatment gap for severe mental disorders is approximately 50% and in case of Common Mental Disorders it is over 90%.³

Status of manpower in mental health

As per the National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Ministry of Health and Family Welfare during May and

July 2002, the ideal required number of mental health professionals has been calculated and the details of present requirement and availability of mental health professional in the country is:

1. *Psychiatrists*: 1.0 per 1,00,000 population
2. *Clinical psychologist*: 1.5 per 1,00,000 population
3. *Psychiatric social workers*: 2.0 per 1,00,000 population
4. *Psychiatric nurses*: 1.0 per 10 psychiatric beds

The details of requirement and availability of mental health professionals in the country is represented in Table 1.

Table 1: Details of requirement and the availability of mental health professionals in India.

Manpower	Requirement	Availability
Psychiatrists	11500	3800
Clinical psychologist	17250	898
Psychiatric social workers	23000	850
Psychiatric nurses	3000	1500

The above mentioned estimated numbers is calculated using a norm of 1 psychiatrist per 100,000 populations, 1.5 clinical psychologists per 100,000 population, and two psychiatric social workers per 100,000 populations and one psychiatric nurse per 10 psychiatric beds.⁵

HISTORY OF MENTAL HEALTH SERVICES AND INITIATIVES

Bhore committee

The Bhore committee report in 1946 stated that the prevalence of mental illness during that period was estimated to be 2/1000 general population and India had only 10,000 psychiatric beds and 30 institutions for a population of over 400 million. The committee recommended that;

1. The hospital beds for mental diseases should be increased.
2. Mental health organization should be created at centre as well as under DGHS in all the states.
3. The training in mental health for all medical and ancillary personnel in India and abroad.
4. Creation of a department of mental health in the proposed All India Institute of Mental Health.⁷

Mudaliar committee

The Government of India appointed Health Survey and Planning Committee in 1959, chaired by Dr Mudaliar to assess the state of health care and review the progress after the implementation of Bhore committee's recommendation. Committee submitted their report in 1962 and identified that;

- Reliable statistics were not available regarding the burden of mental health problems/morbidity in India.
- There must be a huge number of patients requiring assistance and treatment.
- The provision for treatment of psychosomatic diseases was limited.
- There were no avenues for education of mentally sick.

The committee recommended;

1. The setting up of in-patient and outpatient departments at hospitals.
2. Setting up of Independent Psychiatric and Mental health clinics and Institutions for mentally sick.
3. To develop the Psychiatric clinics with 5-10 beds in each district.⁶

Srivastava committee

The Srivastava Committee recommended that Community health volunteer (CHV) scheme. CHV were supposed to provide their services to a population of 1000. The Committee recommended that the training of Community health volunteers should have a component on mental health. They also recommended that one of the manuals of these workers should deal with identifying and managing mental health emergencies and problems.⁸

Various milestones leading to development of NMHP

In the post independence time, the initial two decades were focused on increasing the number of beds for mental hospitals.⁹ Some new mental hospitals were started and All India Institute Mental Health was setup in 1954 which later became NIMHANS in 1974.

The concept of community psychiatry was initiated by CIP Ranchi by starting a rural mental health clinic in 1967 at Mandar. Major community mental health initiatives were taken at NIMHANS Bangalore and PGIMER Chandigarh during 1970's. Community Psychiatry unit was established by NIMHANS.

The National Mental health Program has developed gradually. India is one of the first few countries in the developing world to formulate the NMHP. There are 5 important factors which contributed to the drafting of the National mental health program;¹⁰

- a) *A set of recommendation by an Expert Committee of WHO:* 'The organization of mental health services in developing countries: The expert committee had endorsed the strategy of integrating the mental health services into the primary care services.
- b) *Starting of "Community Mental Health Unit" at National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore:* In 1975. Sakalwara Project.

Community Mental Health Unit at NIMHANS carried out the mental health need assessment and situation analysis in nearly 200 villages around the Sakalwara rural mental health centre, covering a population of 100,000. Simple ways of identifying and managing persons with mental illness, epilepsy mental retardation were developed. The Mental Health education material was developed which could be used by the MPW in rural areas. Manuals for PHC personnel were developed and it was also decided that how the training's provided to the PHC personnel can be evaluated.

The overall experience of Sakalwara Project led to development of strategy for provision of Mental Health care to the rural areas through the existing primary health care network.

- c) *Multi:* Country Project WHO, "Strategies for extending Mental Health Services into the Community (1976-1981).

This model of care proposed the integration of mental health with general health services and provision of basic mental health care by trained health workers and doctors. This was executed as a multicounty project in 7 developing countries. The department of Psychiatry at PGIMER Chandigarh was the centre in India and the model was developed in Raipur Rani Block of Haryana.

- d) The "Declaration of Alma Ata" to achieve "Health for all by 2000" (1978).

The increasing awareness regarding the mental health problems and the Alma-Ata Declaration in 1970, which emphasizes on the health for all by 2000 led to the launching of NMHP by Govt. of India in 1982.

- e) ICMR-DST Collaborative Project on "Severe Mental Morbidity".

In late 70's and early 80's this project was done to evaluate the feasibility of training of PHC staff to provide mental health care as part of their routine work.

In 1982, the highest policy making body in the field of health in the country, the Central Council of Health in the country, the Central Council of Health and Family Welfare (CCHFV) adopted as well as recommended the implementation of NMHP in India. NMHP was launched in 1982 with very comprehensive objectives which stand true even today.

NATIONAL MENTAL HEALTH PROGRAM (NMHP)

Objectives

- To ensure the availability and accessibility of mental healthcare for all in the foreseeable future,

particularly to the most vulnerable and most underprivileged sections of the population.

- Encourage application of mental health knowledge in general health care and social development.
- Promote community participation in mental health services development and stimulate efforts towards self-help in community.

Strategies

- Integration of mental health with primary health care through the NMHP
- Provision of tertiary care institutions for treatment of mental disorders.
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority (CMHA) and State Mental Health Authority (SMHA).

Specific approaches

- Diffusion of mental health skills to the periphery of health services
- Appropriate appointment of tasks
- Equitable and balanced distribution of resources.
- Integration of basic mental health care with general health services
- Linkage with community development¹²

Service component

The service component comprised of Treatment, Rehabilitation and Prevention.¹³

Treatment

The treatment component was planned to be provided at various levels,

1. *Village and sub-centre level*: Multipurpose workers (MPW) and health supervisors (HS) under the supervision of Medical doctors (MO) were trained for:
 - a. Management of psychiatric emergencies.
 - b. Administration and supervision of maintenance treatment for chronic psychiatric disorders.
 - c. Diagnosis and management of Grand mal epilepsy.
 - d. Liaison with local school teacher and parents regarding mental retardation and behavior problems in children.
 - e. Counselling in problems related to alcohol and drug abuse.
2. *Primary health centre (PHC)*: MO aided by health supervisor were trained for:
 - a. Supervision of MPW's performance.
 - b. Elementary diagnosis.
 - c. Treatment of functional psychosis.

- d. Treatment of uncomplicated cases of psychiatric disorders associated with physical diseases.
- e. Management of uncomplicated psychosocial problems.
- f. Epidemiological surveillance of mental morbidity.

3. *District hospital*: The district hospital to have 30-50 psychiatric beds and least 1 psychiatrist attached to every district hospital. The psychiatrist was entrusted with the responsibility of clinical care of patients and training and supervision of non-specialist health workers.

4. *Teaching psychiatric units and mental hospitals*: Their desired role was:

- a. Providing help for difficult cases.
- b. Teaching.
- c. Specialized facilities such as occupational therapy units, psychotherapy, counselling and behaviour therapy.¹³

Rehabilitation

The subcomponents of rehabilitation include maintenance treatment of epileptics and psychotics at the community levels and development of rehabilitation centers at both the district level and the higher referral centers.¹³

Prevention

This component was community based, with the initial focus on the prevention and control of alcohol related problems and later on other issues like addictions, juvenile delinquency and suicides.¹³

Features of the NMHP

Decentralized and phased training courses were conducted for all the health personnel of the district so that they would deliver basic mental healthcare services to the needy.

- The services covered a population of 1.5 million distributed in seven talukas.
- A program officer for mental health was appointed in the district health and family welfare office, WHO organized a mental health clinic in the premises and also toured the entire district in the premises to monitor the program.
- A simple recording and reporting system was developed. The district health officer monitored the progress every month during the monthly review meetings along with other health programs.
- Five essential drugs were made available for distribution in all the health centers in the district.
- During the first three years of the project (1985-88), 1200 patients with psychosis, 3525 patients with epilepsy, 750 patients with neurosis and 380 mentally retarded (learning disabled) persons were registered. Forty-two percent of patients with

psychosis and 53% of those with epilepsy took treatment regularly and showed improvement. Seventy percent of patients came from places within a five-kilometre range of the health center. Thus, distance and availability of free care facilities appear to be important factors in good compliance.

- Good performers in the mental health care program of the system were good in all other health programs. Poor performers appeared to have had many personal and psychosocial problems which came in the way of their performance.
- As the mental health services became popular, patients reached the centers within a few days/ weeks of the onset of the illness and took a short and straight path instead of taking a long path by visiting various faith healers and other agencies.
- The district program gave professionals an idea as to how to organize services in a cost effective manner and maintain a reasonable quality.

The main strength of NMHP document drafted in 1982 was that it envisaged the integration of mental healthcare with the general primary healthcare.

On the other hand there was some inherent weakness of this model of care:

- The program emphasized more on curative components rather than the preventive and promotive components;
- Role of support of families in the treatment of the patient was not given due importance;
- Short term goals were given priority over the long term planning;
- The administrative structure of the program was not clearly outlined;
- No estimates of budgetary support were made.¹³

After reviewing the progress made during 1982-88, it was concluded that although the developments in this area raised the hopes for beginning a big program in the country, the financial constraints somehow restricted it. In the IX five year plan Rs 28 crores were allocated to NMHP. In depth analysis and consultation with the stakeholders led to a major change in NMHP and was launched with certain changes in 2003.¹⁴

NMHP Xth five year plan was launched, with a plan to extend the DMHP to 100 districts. In the Xth plan allocated Rs 139 crores to NMHP and emphasized:

- The need to broaden the scope of existing curriculum for undergraduate training in psychiatry and to give more exposure to psychiatry in undergraduate years and internship.
- Need for DMHP to be spread to the entire country in a more effective manner.
- Streamlining /modernization of mental hospitals to overcome their custodial role.

- Strengthening the Central and State mental health authorities with a permanent secretariat.
- Appointment of MO at state headquarters.
- Research and training in the field of community mental health, substance abuse and child/adolescent psychiatric clinics.¹⁵

During the XIth Five year plan in NMHP the focus was on establishing centers of excellence in mental health, increasing intake capacity and starting postgraduate courses in psychiatry, modernization of mental hospitals and up-gradation of medical college psychiatry departments, focus on non-government organizations (NGOs) and public sector partnerships, media campaign to address stigma, a focus on research and several other measures.¹³

The emphasis of NMHP-1982 was primarily on the rural sector. It is being realized that the urban mental health needs also need to be addressed under the ambit of NMHP.

DISTRICT MENTAL HEALTH PROGRAM (DMHP)

NIMHANS developed a program to operationalize and implement the NMHP in a district. DMHP was launched in 1996 with an aim to achieve the objectives of NMHP.

Pilot of District mental health program was done at Bellary district in Karnataka. Bellary is located about 350 kms away from Bangalore and the total population of Bellary was about 20 lakhs at that time.

The main components of the DMHP at Bellary were:

- Training for all primary care staff.
- Provision of 6 essential psychotropic and antiepileptic drugs (Chlorpromazine, amitryptaline, trihexphenldyl, Injection fluphenazine deaconate, phenobarbitone and diphenylhydantoin) at all PHCs and sub centres.
- A system of simple mental health case records.
- A system of monthly reporting.
- Regular monitoring and feedback from the district level mental health team.

The main objectives of DMHP were;

- To provide sustainable basic mental health services in community and integration of these with other services.
- Early detection and treatment in community itself to ensure ease of care givers.
- To take pressure off mental hospitals.
- To reduce stigma, to rehabilitate patients within the community.
- To detect as well as manage and refer cases of epilepsy.

The main approaches of DMHP were training of medical, paramedical personnel and community leaders, Community Mental Health care through existing infrastructure of the health services and the most important component being the Information, Education and Communication (IEC) activities.

Initially the community based mental health care at district level was initiated in four districts in 1996. It was extended to 27 districts across 22 states/UTs in the IXth 5-year plan.

NMHP was re-strategized during the Xth 5 year plan, DMHP was expanded and more components were added to make it more comprehensive.

There was expansion of DMHP to 100 districts all over the country, modernization of state-run mental hospitals, up-gradation of Psychiatry wings in the Government medical colleges/general hospitals, IEC activities, research and training in mental health for improving service delivery.

At the end of the Xth 5 year plan, DMHP was extended to 110 districts, up-gradation of psychiatric wings of 71 medical colleges. Modernization of 23 mental hospitals and general hospitals was funded.

In the XIth five year plans DMHP was spread to 123 districts in 30 states /UTs.¹⁶

The team of workers at the district under the program consists of a Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatry/Community Nurse, a Program Manager, a Program/Case Registry Assistant and a Record Keeper.

Based on the evaluation conducted by Indian Council of Marketing Research (ICMR) in 2008 and feedback received from a series of consultations DMHP has now incorporated promotive and preventive activities for positive mental health which includes:¹⁷

- *School mental health services*: life skill education in schools, counselling.
- *College counselling services*: Through trained teachers/ counsellors.
- *Work place stress management*: Formal and informal sector, including farmers, women etc.
- *Suicide prevention services*: Counselling centre at district level, sensitization workshops, IEC, helpline

MANPOWER DEVELOPMENT SCHEME

In the XIth plan there was an effort to address the main barrier in the mental health service provisions i.e. the shortage of manpower. A component of manpower development scheme was developed;

- To improve the training infrastructure in mental health, Government of India had approved the Manpower Development Components of NMHP for XIth five year plan.
- It has two schemes:
 - a. Centers of excellence (Scheme - A)
 - b. Setting UP/ Strengthening PG Training Department of Mental Health Specialties (Scheme - B).

Centers of excellence (Scheme – A)

Under Scheme - A, at least 11 Centers of Excellence in Mental health were to be established by upgrading existing mental health institutions/ hospitals. A grant of Rs. 30 crores for each centre (total 338 crores) was made available for undertaking the capital work, equipment, library, faculty induction and retention.

At present the academic sessions have already started in 8 out of 11 centers and the process in the rest have been initiated.

Setting up/strengthening PG training department of mental health specialties (Scheme - B)

Under Scheme - B, the Government Medical College/Hospitals were supported to start PG Courses in Mental Health or to increase the intake capacity for PG training in Mental Health. The Support also involved Establishing/improving mental health departments (30 departments of Psychiatry, 30 departments of Clinical Psychology, 30 departments of Psychiatric Social work, and 30 departments of Psychiatric Nursing); equipment tools and basic infrastructure; support for engaging required/ deficient faculty for starting/enhancing the PG Courses. The support of up of Rs. 51 lakhs to Rs. 1 crore per PG Department was made available. As of now the 27 PG departments in 11 institutes have been taken up.

The manpower development and the expansion of DMHP services will gradually lead to increase in number of mental health professionals in the districts and in the Institutions which have been given grant for manpower development schemes.

IEC ACTIVITIES

The awareness regarding mental illness, availability of treatment and provisions of Mental Health Act, 1987 is very low among the masses. NMHP has got sufficient funds for IEC activities for the purpose of increasing awareness and removal of stigma for mental illness by mass media campaigns through audio-video and print media. The funds are allocated at central and state levels for IEC activities. At the district level the IEC activities are conducted under the District mental health program.

RESEARCH AND TRAINING

There is a paucity of research in the field of mental health in our country. Under this component of NMHP, the support would be provided to various institutes and organizations for carrying out basic, applied and operational research in the field of mental health. As it has been obvious in various evaluations of the program that one of the main problem is the shortage of skilled mental health manpower therefore in order to overcome this problem short term skill based training will be given to the DMHP teams at some identified institutes. Financial support would also be provided for Standard treatment guidelines, training modules, CME, distance learning courses in mental health, surveys etc.

SUPPORT FOR CENTRAL AND STATE MENTAL HEALTH AUTHORITIES

According to Mental Health Act 1987, there is a provision for constitution of Central Mental Health Authority (CMHA) at the central level and State Mental Health Authority (SMHA) at the state level. They have been assigned the responsibility of development, regulation and coordination of mental health services in a State/UT and also the implementation of Mental Health Act 1987 and the operationalization of mental health activities.

MONITORING AND EVALUATION

There is a financial support under NMHP for strengthening the component of monitoring and evaluation. National level institutions are entrusted with the responsibility to evaluate the models of care, training of different categories of personnel and monitoring the mental health programs. A survey was conducted by NIMHANS, Bangalore to ascertain the number of mentally ill patients and availability of mental health resources in the country.

MAINSTREAMING NMHP INTO NHRM AND NUHM

There has been an intensified effort to mainstream the components of NMHP under the National health mission so as to enable the states to plan requirements concerning mental health services for their specific areas. The existing district where the DMHP is presently under implementation continues to be supported under the NHRM on the existing norms.

The advantages of mainstreaming the NMHP through NHRM are:

- Optimal use of existing infrastructure at various levels of the health care delivery system.
- Use of the NHRM platform for transfer /flow of funds to the states/UTs for better accountability and flexibility in implementation of program

- Integrated IEC activity under NHRM
- Involvement of NHRM infrastructure for training related to the mental health in the district
- Use of NHRM machinery for procurement of drugs for NMHP
- Using improved linkages /communication under the NHRM for MIS (Management Information System) in NMHP
- Sustaining DMHP after the expiry of the period of central assistance in the district by its integration in the district health system.

NUHM would ensure:

- Resources for addressing the health problems in the urban areas
- Partnership with the community for a proactive involvement in planning, implementation and monitoring of health activities

ROLE OF NGO IN NMHP

There is an immense role of NGO's in the mental health program. They can contribute in IEC Activities; Support for health promotion using life skill approach; Support for follow up of severely mentally ill persons in community; Support for mentally retarded children and their families.; Organization of mental health camps; Networking with primary health care team; Facilitation of disability welfare benefits for the mentally ill and mentally challenged and also for Home care of severely mentally ill person.

NATIONAL MENTAL HEALTH PROGRAM IN THE XIITH PLAN

The National Mental Health Program in the XIIth plan will focus special attention on psychiatric problems specific to certain vulnerable sections of the population who are often marginalized and neglected owing to lack of effective advocacy.

Special issues

- Senior citizens suffering from severely disabling diseases such as depressions of late onset and other psycho geriatric disorders.
- Victims of child sexual abuse, marital/ domestic violence and dowry related ill-treatment, rape and incest.
- Children and adolescents affected by problems of maladjustment of other scholastic problems, depressions, psychosis of early onset, attention deficit hyperactivity disorders and suicidal behavior resulting from failure in examination or other environmental stressors.
- Victims of poverty, destitution and abandonment such women thrown out of the marital home or old and infirm parents left to fend for themselves.

- Victims of natural or man-made disasters such as cyclones, earthquakes, famines, war, terrorism and communal/ ethnic strife, with special attention to the specific needs of children orphaned by such disasters.

DMHP IN XIITH FIVE YEAR PLAN

Goal

The goal of DMHP is to improve the health and social outcomes related to mental illness.

The key principles of DMHP in XIIth plan are;

- A life course perspective with attention to the children, adolescents and adults.
- A recovery perspective through continuous care provision and empowerment of people with mental illness and also their care givers.
- An equity perspective which includes specific attention to vulnerable groups and ensuring the geographical access to mental health services.
- An evidence based perspective by following the established guidelines for treatment and delivery model.
- A health system perspective defining clear roles and responsibilities for each level.
- A right based perspectives to ensure the protection of rights of persons with mental illness.

Primary objective

- To reduce the distress, disability and premature mortality related to mental illness and enhance recovery from mental illness by ensuring the availability and accessibility to mental health care for all, particularly the most vulnerable and underprivileged sections of the population.

Secondary objectives

- To reduce stigma towards mental illness.
- To promote community participation in the mental health service development and to stimulate efforts towards self help in the community.
- To increase access to preventive services to the population at risk, in particular, addressing the risk of suicide and attempted suicide.
- To inform the persons with mental illness, their caregivers, professionals and other stakeholders of the rights of persons with mental illness and ensure that rights are respected during the provision of care and services.
- To broad base mental health into other related programs such as RCH, SSA, work place intervention and similar.

- To ensure a motivating and empowering work place for staff by allowing an opportunity to improve their skills and recognition of their work.
- To generate knowledge and evidence related to delivery of mental health care and services.
- To establish governance, administrative and accountability mechanisms to realize the above objectives.

During the XIIth five year plans:

- DMHP will be extended to the remaining 161-districts and the gains made in the previous plans will be consolidated.
- Up gradation of the remaining 39-Medical College Psychiatry Departments will be undertaken and 20-Mental Hospitals will be taken up for disinvestments/reconstruction.
- Central and state mental health authorities will be further reinforced and long term research projects will be initiated in selected institutions along with continuing support to community based research.
- Augmentation of IEC activities to cover all sections of the population covering entire country.
- Comprehensive assessment and performance appraisal would be done at the national and state level by independent agencies.

CONCLUSION

NMHP was launched in 1982 with very comprehensive objectives and had lots of strengths but on the other hand had some inherent weaknesses, the foremost being no budgetary estimates made for the program implementation. There were no obvious guidelines that the funding would be provided by the Central or state governmental funds. In the IXth five year plans, NMHP got specific budgetary allocation of 28 crores and the major focus during these five years was on DMHP. The Xth five year plans were introduced in 2003 after In-depth analysis and consultations with the stakeholders. There was several folds increase in the budgetary allocation for the program. XIth five year plan focused on centers of excellence in mental health and the manpower development in the field of mental health. Over the years it has been observed that the focus on community mental health is of utmost importance and DMHP needs to be strengthened in view of its coverage and utilization of its service components. Public awareness and IEC programs need to be the most important components for a change to happen at the community level as is true for many other public health programs. Further NMHP had major focus in rural sector but the urban mental health needs to be addressed equally hence NMHP has been gradually been mainstreamed into National health mission (NRHM and NUHM-NHM). The NMHP in the XIIth plan will have expansion of all existing components and additionally has a special focus on the vulnerable and marginalized sections of the society. The monitoring and evaluation component is inbuilt in the program and the outcomes of

the NMPH at the end of the XIIth plan will set the ball rolling for brainstorming over the success and the failures of the program

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