The 300 Ramayanas and the District Mental Health Programme

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With the completion of the Eleventh Five-Year Plan, an appraisal of the mental health initiative in the space of state-sponsored health delivery seems appropriate and timely. Discourses in health delivery usually tend to implement similar sets of tools. This article argues that to achieve some form of clarity it may be appropriate to look at health delivery through the lenses of the social sciences. In this attempt, the article uses the metaphor of 300 Ramayanas and the tools of A K Ramanujan to review thinking about the District Mental Health Programme.

Both authors are members of the policy group set up by the Ministry of Health and Family Welfare, Government of India. The authors would however like to explicitly state that the views expressed here are personal. They would also like to acknowledge the contribution made to their understanding by all the other members of the policy group, and the Ministry of Health and Family Welfare, for setting up the group. The authors specifically like to thank Sushrut Jadhav of University College, London, and Perminder Sachdev of University of New South Wales, Sydney for their insightful comments and suggestions.

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In 2011 there was quite a furore over the withdrawal from the history curriculum of Delhi University of an essay by the noted scholar A K Ramanujan. This essay is titled "Three Hundred Ramayanas: Five Examples and Three Thoughts on Translation" (Ramanujan 1991). The point that the essayist makes is that there is no one "authentic version" of the Ramayana, that there are many different retellings of the same story and that with the same "anchor points" many different narratives can be constructed. The controversy has actually ensured that many beyond the confines of academy have actually read the essay, so, in a sense, it has served a larger purpose. As many commentators have noted, the diversity and variety of narrative is a testimony to the pluralism of tradition.[1]

To our minds, this remarkable essay actually makes three points: (a) There can be no one monolithic telling of a complex story, and that these stories are indeed open to many different tellings, (b) in the nature of narrative, there are interesting similarities and differences between the written and oral traditions, and (c) the interesting fact that the apparently different narratives actually relate to each other in many ways, and so, while there will be narratives and counter-narratives, all of these, will, in a sense, speak to each other. This is what has been called the "inter-textual" nature of the discourse.

Using the story of the seduction of Ahalya, wife of the sage Gautama by the god Indra, Ramanujan elegantly compares and contrasts the telling of it in Valmiki's *Ramayana* and the Kampan's *Irmavataram* (The Incarnation of Ram). As Ramanujan puts it "...the Ahalya, episode is essentially the same, but the weave, the texture, the colors are very different."

The Bare Bones of the DMHP

What we intend to do here is to use this essay and its tools to understand the complex realities of another story with interwoven threads, that is District Mental Health Programme (DMHP), and the story of community mental health in India. The post-Independence central planning for healthcare has relied heavily on the recommendations of the Bhore Committee suggestions,[2] which were made towards the end of direct British rule. These recommendations were largely influenced by the international advisers to the Bhore Committee, which the authors have commented on in another publication.[3] These were guided in part by disquiet about the status of healthcare (criticism had mounted in the 1930s) as well as the push in the UK (and the rest of British Empire and the Commonwealth) for the Beveridge inspired healthcare programme[4] (later the National Health Service). Universal healthcare was one of the major social reforms to arise out of the post-second world war political process. However, in India (and in much of the postcolonial world) sufficient resources or expertise was not available to evolve complex medical systems for healthcare delivery. A patchwork of top-down programmes that were targeted at specific diseases were often put into place (tuberculosis, malaria, diarrhoea, etc) (Park 2008), but a unified comprehensive healthcare service was conspicuous by its absence. Even the inclusion (or exclusion) of particular diseases was often guided by "expert opinions" and interventions, though it was often positioned as "community-oriented".

Mental healthcare was a relatively late entrant, as effective drug treatments became available only recently, and the "medicalisation" of distress was an even more recent development (though doubts are still raised about its validity). Initial community psychiatry services were theoretically inclusive and pluralistic, but given the ambiguities involved did not transfer themselves into the bulleted

action plans that were possible for other biomedical disease models. Focused attempts to simplify and codify interventions, with a large emphasis on drug treatments, were thus put to trial in certain areas, and the DMHP was gradually evolved to provide care to the poor.

The DMHP is the flagship mental health delivery programme of the Government of India. The DMHP is the district based, service delivery component of the larger National Mental Health Programme (the NMHP). It was launched in 1996 in four districts, one each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu. The spread of the DMHP was gradually increased to 27 districts in the Ninth Five-Year Plan (1996-97 to 2002) period, with a total budget allocation of Rs 28 crore (Isaac 2011).

The objectives of the centrally-funded DMHP scheme were as follows:

- Provide sustainable mental health services to the community, and to integrate these services with other services;
- Early detection and treatment of patients (of mental illness) within the community itself;
- See that patients and their relatives do not have to travel long distances to seek treatment;
- Take pressure off mental hospitals;
- Reduce the stigma attached to mental illness through change in public attitudes; and
- Treat and rehabilitate mentally ill patients discharged from the mental hospitals within the community.

With a budget of Rs 190 crore, the DMHP coverage was increased to 100 districts in the Tenth Five-Year Plan period (2002-07). This was also supported by other activities in the NMHP including upgradation of the departments of psychiatry in the medical colleges, modernisation of the mental hospitals, funding of information, education and communication (IEC) activities on mental health and support of research and training issues related to implementation of the NMHP.

In the Eleventh Five-Year Plan (2007-12), the total approved budget was Rs 408 crore, and the DMHP is supposed to be active in 123 districts over the country. Also 10 centres of excellence in the field of mental health have been funded in different parts of the country. Other planned activities have included upgradation of mental hospitals, strengthening of IEC activities, and research activities.

These are, then, the anchor points or the "bare bones" of the DMHP story, as it were. The question before us is whether the DMHP has been successful.

Critiquing the DMHP

Interestingly, there are as many answers to this as there are many Ramayanas. (Well, maybe not quite as many, but many "tellings" of the answer do emerge.) In fact, depending on whom one asks the question of, very different stories emerge.

There have been a number of appraisals of the current status of the delivery of mental health services in the country, and the effectiveness of the DMHP, and these have yielded interestingly different conclusions and pointers to the ways ahead.

Jacob (2011: 53: 195-98) in a recent guest editorial is quite categorical in the opinion that "Despite it's good intention, the programme failed to deliver", going on to say that

> The situation on the ground in most LMICs (low and middle income countries) has not changed. The national programs remain on paper while some smaller initiatives, after the initial fanfare, are dysfunctional.

Other attempts at appraisal offer different perspectives.

The World Health Organisation and World Organisation of Family Doctors (WHO/WONCA) joint report on "Integrating Mental Health into Primary Care – A Global Perspective"[5] in 2008 cites the Thiruvananthapuram district in Kerala as an example of success of the DMHP, quoting it for other low resource countries to follow.

An oft-repeated point has been that there has been no independent evaluation of the DMHP. Such an evaluation was conducted in 2009 by the Indian Council of Market Research, at the behest of the Ministry of Health and Family Welfare, Government of India.[6] Twenty districts from different zones and five non-DMHP districts were evaluated. Various parameters of efficacy of the programme were evaluated, including areas of capacity-building, awareness of mental illness in the community and the beneficiaries, the process of diagnosis, treatments offered, referral pathways, medication and personnel availability, and budget allocations and utilisation.

A wide variety of administrative, managerial and implementation problems were flagged by the evaluation, which included shortage of trained personnel, difficulties in retaining committed staff, delays in initiating programmes, low utilisation of funds, and difficulties in accessing the funds.

Intriguingly, however, among many other suggestions and recommendations, the Indian Council of Medical Research suggests the expansion of the programme to the other districts of the country.

In a clinical ethnographic exploration of the community mental health programme in the Kanpur DMHP district, Jain and Jadhav (2009: 60-85) opine:

> As the pill journeys from the Ministry of Health to the clinic, its symbolic meaning transforms from an emphasis on accessibility and participation to the administration of a discrete 'treatment.' Instead of embodying participation and access, the pill achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions for psychosocial problems. The symbolic inscription of NMHP policies on the pill fail because they are undercut by more powerful meanings generated from local cultural contexts. An understanding of this process is critical for the development of training and policy that can more effectively address local mental health concerns in rural India.

Isaac (2011), one of the architects of the current DMHP format, in a plea for reappraisal of the DMHP, asks a few pertinent questions:

- Is the main approach of the NMHP, namely, integration of mental health with primary care still the right approach?
- How effective is the implementation of the NMHP?
- Is there any evidence for the effectiveness of primary care of mental health?
- Has there been any independent evaluation of the DMHP?

He suggests a number of measures, which include looking at local modifications of the plan, strengthening of the sub-centres, capacity-building, and community participation. He also explores the possibility of integrating it with other governmental programmes like the National Rural Health Mission (NRHM), and strengthening partnerships with the non-governmental and private sectors.

Jacob (2011: 195-98), raising similar concerns, is of the opinion that the new community care initiatives, largely driven by World Health Organisation (WHO) ideology, are merely, a "slick repackaging" of older models, and so doomed to failure because they do not take into consideration the ground reality in the third world. They do not factor in poor infrastructure, overburdened systems, inappropriate training, professional apathy, problems with finance and delivery and a paucity of technical and advocacy inputs, and are therefore destined to the same dismal fate.

The Ministry of Health and Family Welfare in 2011 set up a policy group,[7] to help frame a national mental health policy, and in the process

> prepare a Situational Analysis for mental health care in the country and the current provision for mental health care in the country, including issues of human resources, essential drug procurement and distribution, advocacy, prevention of mental illness, rehabilitation and care and promotion of mental health.

Murthy (2011: 26-35), another architect of the DMHP, has, made an exhaustive review of community mental health initiatives in India, attempting to list its limitations, successes and problems. Describing both the strengths and weaknesses in the delivery of public mental health service, he writes about the developments in general hospital psychiatry, the benefits of family support, the space for traditional systems of healing, and the development of the private sector. He suggests that future planning should talk about prevention and promotion of mental health, the need for decentralisation, resource development, support of both the non-governmental organisations and the private sector, increasing awareness, research activity and governance. He says, that while there is actually a limited amount of published data evaluating the functioning of the DMHP, "published papers and (an) independent evaluation of the DMHP, indicate that the DMHP is, to a large extent, ineffective in practice".

The Impact of the DMHP

If we are to step outside the realm of the world of published data and try to see what actually happens on the ground, and see in what way the DMHP has made any difference to the lives of people living with mental illness, what emerges is not particularly positive.

In this process, the authors, as members of the policy group, have attended a number of the DMHP reviews conducted by the Ministry of Health and attended by the nodal officers of the DMHP. This was followed by a number of visits to various DMHP sites in an attempt to answer the basic question – Does the DMHP work and in what way does it need to be modified to make it more effective?

In a sense the answer to this vexed question lies with Ramanujan. All the "tellings" are true. In most of the districts where the DMHP is funded, not very much is actually happening. In some places human resources are not available, in most places medication is not. The difficulties with access to and availability of funding is an oft-repeated tale. The problems with implementation are many, the issues with governance are clear. Mentoring, monitoring and audits are woefully inadequate. Interestingly, the problem is not actually availability of finance. A rather large part of the allocated budget lies un-utilised, because the DMHP sites are either unwilling or unable to access them.

The basic ideology of the focus of integration with primary care and how specialist driven the service should be, are questions that get answered by ideology and rather fixed positions. This is not necessarily to suggest that the ideology is flawed, but rather that, like all ideology, much more needs to happen on the ground for it to be convincingly accepted.

This, however, should not distract from the fact that in many places sterling work is actually being done. With limited resource, and despite innumerable hurdles, in many districts, innovative and interesting strategies are adopted. In fact, the narrative that the DMHP is a failure, and does nothing, would, to our minds, be as invalid, as the one that whitewashes it with the false patina of unblemished success. In the course of visits across many DMHP sites, we found, among other things, the records instructive. In Hoshiarpur district in Punjab, the register maintained at the DMHP site was an endless series of undecipherable squiggles. In neighbouring Sangrur, the register quoted diagnoses of schizophrenia, bipolar disorder, delusional disorder, anxiety states, and trichotillomania (a syndrome where the patient plucks hair from the head and swallows it), reading very much like a compendium

of psychiatric diagnoses. In a sense, also, the moving away from the published literature to the stories on the ground, may, by moving from one form of narration to another helps us go beyond the projected fact and understand ground realities better.

What is also interesting is that the fidelity to the original DMHP model is actually quite variable and hence the degree and nature of integration of the service with primary care is very different. So Karnataka still follows the original Bellary model on which the DMHP is conceptualised, while in neighbouring Kerala the service tends to be more specialist-led. It is also instructive that Kerala is most often quoted as success of the DMHP model.

Ramanujan and the DMHP

So, depending on the perspective of the narrator, we could tell the DMHP story as a heroic struggle against overwhelming odds or as a case of abject failure. We could cast alternatively in the role of villain or hero the primary health centre doctor, the specialist, the state government administrator, the grand panjandrum in the central ministry. We could deify or demonise the ideological underpinnings of the model. Therefore, depending on the teller and the construction of the tale, the blame for non-performance can be laid squarely on the lack of implementation as a failure of governance and "hand holding" by the central ministry, a failure of dialogue within the ministry, and a communication wall between the directorates of health and medical education, a wall between state and centre, apathy in states, and the list essentially is endless. And each narrative would both be real and interconnected.

This is, as Ramanujan tells us, the intertextual nature of narrative.

> These various texts not only relate to prior texts directly, to borrow or refute, but they relate to each other through this common code or common pool. Every author, if one may hazard a metaphor, dips into it and brings out a unique crystallisation, a new text with a unique texture and a fresh context.

Where this takes us, inevitably, is to what the new, improved version of the DMHP should look like and what relationship this should have with its earlier avatar. To understand this better, we suggest that we turn again to Ramanjuan.

As Ramanujan says,

> Now, is there a common core to the Rama stories, except the most skeletal set of relations like that of Rama, his brother, his wife, and the antagonist Ravana who abducts her? Are the stories bound together only by certain family resemblances, as Wittgenstein might say? Or is it like Aristotle's jack knife? When the philosopher asked an old carpenter how long he had had his knife, the latter said, "Oh, I've had it for thirty years. I've changed the blade a few times and the handle a few times, but it's the same knife." Some shadow of a relational structure claims the name of Ramayana for all these tellings, but on closer look one is not necessarily all that like another.

So, as we prepare to change either the blade or the handle, it may be wise to remember the different telling of the tale and the nature of the intertextuality, which would be the nature of the conversations that both the narratives, and the narrators would have with each other. To carry the metaphors of the Ramayanas further, it may be a good idea to refer to Paula Richman (1991), who, in her introduction to this powerful essay, talks

about tellings as both "re-fashioning" and opposition, and as commentary and programmes for action. Quoting Thapar (1989), Richman is specific in warning us about monolithic state-sponsored versions of narrative. An obvious caveat to this would be that, looking at mental health delivery to the community as state responsibility, as we do, the contextuality of state-sponsored narrative is obviously difficult to not pay heed to.

The next logical step that this takes us to is that while the Ramayana is one telling of the life of Ram, Sita, Lakshman, and Ravan, other powerful and valid narratives exist. Similarly, the DMHP is one telling of the story of mental health delivery in a pluralistic reality. Other narratives, often counter to this narrative, do exist, and ignoring them is something we do at our peril. In another essay, Ramanujan (1989), exploring the nature of Indian thought, quotes a parable about the Buddha. He says:

> Once a man was drowning in a sudden flood. Just as he was about to drown, he found a raft. He clung to it, and it carried him safely to dry land. And he was so grateful to the raft that he carried it on his back for the rest of his life.

It could be posited that the DMHP is the raft that we are, as the Buddha ironically tells, carrying with us. If, for the purpose of argument, we were to accept this, then we may want to start thinking beyond the scope of the DMHP, in dimensions of both time and space. Essentially, a programme of the nature of the DMHP is conceptualised as a short-term initiative, which then is meant to seamlessly flow into a continuing care system, and this is something that has not really happened with the DMHP. This may be a good time to start thinking of these issues.

An Indian Way of Thinking

To extend the use of metaphor further, and paraphrase Ramanujan, in his second essay, we could ask –

- *Is* there a DMHP way of (mental) healthcare?
- Is there *a* DMHP way of healthcare?
- Is there a *DMHP* way of healthcare?
- Is there a DMHP way of *healthcare*?

To attempt an answer, psychiatric care in India has not developed a clear ideological position, and has largely relied on empiricism. Thus, the first query is not likely to be true, as the practice is not underwritten by any one ideological or scientific position.

There are, however attempts to codify or simplify procedures, so that a simulation of uniformity is produced and the answer to the second is a qualified yes.

The answers to the third and fourth are probably the more revealing. So, whether there is a DMHP way of thinking and healthcare, begs the question as to whether the programme becomes autonomous, or whether it is seen as a short-term enabler of healthcare delivery. This is particularly worrying, as there is no apparent planning for subsequent upgrading and evolution of services. The DMHP premise of a chronic shortage of well-trained professionals for the poorer sections of society sits uncomfortably with the burgeoning medical education, and private healthcare provision sector, which are seen as a successful business model. The relations between this de-professionalised service and the growing number of professionals, and the health industry have obviously been a source of tension, leading to questions being asked about the intent and nature of the DMHP. Visions of the DMHP thus tend to be viewed through preconceived notions about the nature of healthcare, and the role of the state and civil society in providing this. In the meantime, the number of mentally ill has continued to grow, the initial euphoria about the "success" of new psychiatric medications has been tempered, and planning for the future now has to be even more pragmatic. This two stream system will accentuate disparities, and authenticate, even validate, them.

Healthcare that is low cost, locally sensitive, respectful of diversity, and deliverable through minimal investments in skills has been attempted in many postcolonial countries. Austerity is criticised as a false remedy for the economic crisis of European Union and North America (with much dismay expressed about its impact on health and welfare services), while permanent austerity is portrayed as a virtue for the rest of the world.

In many ways, the answers will be myriad, and pluralistic, but, all, we think, are worthy of debate. We also need to realise that even if no concrete answers emerge at this stage, this debate and the recognition that the impact of a single monochromatic rendition would be limited is important. For effective intervention in both policy and planning, we will need to view healthcare in the wider social and political matrix of healthcare.

NOTES

1 Mahesh Rangarajan, *On Ramanujan's 300 Ramayanas and the Controversy,* http://radicalnotes.files.wordpress com/ 2008/ 10/ 4ramayanas.pdf
2 Bhore Committee report available at:http://nihfw.org/NDC/DocumentationServices/Reports/Bhore%20Committee%20Report%20-%20Vol%2011.pdf
3 See Murthy et al (2013).
4 The Beveridge report available at:http://www.sochealth.co.uk/history/beveridge.htm
5 "Integrating Mental Health into Primary Care: A Global Perspective". A WHO/WONCA publication 2008, http://www.who.int/mental_health/policy/ services/mentalhealthintoprimarycare/en/
6 Indian Council for Market Research (2009), "Evaluation of the District Mental Health Programme – Final Report", New Delhi.
7 Communication from the Ministry of Health and Family Welfare, Government of India, constituting a Policy Group to frame a Mental Health Policy for the country, available at http://mhpolicy.files.wordpress.com/2011/05/task-force-on-mh.pdf

REFERENCES

Isaac, Mohan (2011): *National Mental Health Programme: Time for Reappraisal*, Chapter from Kulhara P et al, "Themes and Issues in Contemporary Indian Psychiatry", Indian Psychiatric Society, New Delhi.

Jacob, K S (2011): "Repackaging Mental Health Programmes in Low and Middle Income Countries", *Indian Journal of Psychiatry.*

Jain, S and S Jadhav (2009): "Pills That Swallow Policy: Clinical Ethnography of a Community Mental Health Programme in Northern India", *Transcultural Psychiatry.*

Murthy, Pratima, Alok Sarin and Sanjeev Jain (2013): "International Advisers to the Bhore Committee: Perceptions and Visions for Healthcare", *Economic & Political Weekly*, 9 March, Vol XLVIII, No 10.

Murthy, Srinivasa R (2011): "Mental Health Initiatives in India (1947-2010)", *The National Medical Journal of India*, 24, 2.

Park, J E (2008): *Textbook of Preventive and Social Medicine: A Treatise on Community Health*, Banarsi Das Bhanot, July.

Ramanujan, A K (1989): "Is There an Indian Way of Thinking? An Informal Essay", *Contributions to Indian Sociology*; 23; 41, http://cis.sage.com

– (1991): "Three Hundred Ramayanas: Five Examples and Three Thoughts on Translation" in Paula Richman (ed.), *Many Ramayanas: The Diversity of a Narrative Tradition in South Asia* (Berkeley: University of California Press).

Richman, Paula (1991): "Introduction: The Diversity of the Ramayana Tradition" in Paula Richman (ed.), *Many Ramayanas: The Diversity of a Narrative Tradition in South Asia* (Berkeley: University of California Press).

Thapar, Romila (1989): "The Ramayana Syndrome", Seminar, No 353, January, 74.