REPORT OF EVALUATION OF DISTRICT MENTAL HEALTH PROGRAMS TAMIL NADU, KARNATAKA, ANDHRA PRADESH AND MAHARASHTRA PREPARED BY

DEPARTMENT OF PSYCHIATRY

NATIONAL INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES, BANGALORE

Introduction

Mental, physical and social health is vital strands for the individuals. These elements are interwoven and deeply interdependent. As the understanding of this relationship grows, it becomes clear that mental health is crucial to the overall well being of the individuals, communities and societies (World Health Report, WHR 2001). Mental health is as important as physical health. Yet there is wide gap between what scientists know and what actually reaches the general public. For example, merely a fraction of the millions of people suffering from mental or behavioral disorders are receiving treatment. Advances in neuroscience and behavioral medicine have shown that, like many physical illnesses, mental and behavioral disorders are the result of a complex interaction between biological, psychological and social factors. However, most health problems are seen as only either physical or mental disorders. While there is still much to be learned, we already have the knowledge and power to reduce the burden of mental and behavioral disorders and promote the mental health of individuals (WHR 2001).

The mental health care program has evolved from bottom to top over the last three and half decades. This has been possible because of commitment of the Government, mental health professionals, health administrators, policy makers and the community. The initial work demonstrated that mental illness is uniformly distributed in rural and urban areas, and that very wide treatment gaps exist in the community due to lack of mental health services, poor awareness about mental disorders on the part the community (Chandrashekhar et al 1981). In addition, poverty and its consequences contribute and complicate the situation in the family. The above scenario results in significant disability and chronicity of the illness in the person and burden on the family thereof. It was recognized that mental health professional resources available were too inadequate to meet the needs of the ill population in the community.

Decentralizing mental health care by involving other health professional like general medical doctors, primary care doctors, health workers, and other paramedical personnel was recognized as a practical and feasible alternative to meet the urgent mental health care needs of the community covering rural, urban and tribal population of the country. This approach was also advocated as being important and a practical alternative to respond to the mental health needs of the community and more so in developing countries (WHO-TRS 564 (1975). It is interesting to note that this involvement of general practitioners, nurses, health workers and other paramedical workers has become an

universally accepted approach to address the great challenge of mental health care all over the world both in the context of developing and developed nations. Therefore, decentralized mental health care using the existing resources is a not a cheap alternative to lack of mental health professional resource but a scientifically- tested, pragmatic, community -based, economically viable and accessible care.

In India, mental health services were characterized by paucity rather than adequacy since time immemorial. Because of lack of services for the mentally ill, poor awareness about mental disorders, most people used whatever services were available such as those of faith healers, traditional healers, and religious and magical healing practices. Need to develop mental health services were never due to the fact that institutions were less useful. In fact at the time of independence, India had only 17 mental hospitals and the number at the present time is only 42. Community based services were developed based on the demonstration of large unmet need with respect to mental services and the feasibility on such services using non mental health professionals in the community. A district model of mental health program was implemented in the District of Bellary in Karnataka State and it was demonstrated that mental health care could be integrated as part of primary health care. Further, it was demonstrated that it was possible to build capacity of the primary care personnel within the district, provide logistic support, provide supervision and also coverage to large population needing mental health care. Based on the usefulness of this model, districts were taken up for implementation of DMHP in an incremental manner. Currently, there are 125 districts implementing DMHP in India covering all the states and union territories.

District Mental Health Programme:

The District mental health program was funded by the Ministry of Health and Family Welfare Government of India to kick start mental health care activities in various States. The objectives were as follows

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 see those patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities;
4. To take pressure off the mental hospitals;
5. To reduce the stigma attached towards mental illness through change of attitude and public education;
6. To treat and rehabilitate mental patients discharged from the mental hospitals within the community

Findings of the earlier review by the Ministry of Health and family welfare Government of India

A systematic evaluation was carried out by the Ministry of H&FW Govt of India and following are the findings.

Findings of independent evaluation initiated by the ministry in 2008

- One third of the Districts under the 9th plan have utilized over 99%, one third has utilized 63-91%, and rests have utilized 37-47% of the total amount they have received. This is mainly due to administrative delay, difficulty in recruiting and retaining qualified mental health professional, low utilization in training and IEC components.

- In Case of the 10th plan districts, most of the districts had received only the 1st installment under DMHP. Of the grant received one third have utilized more than 90%, half of the districts spent 51-87% and rests of the districts the programme has recently started. This again is due to above-mentioned reasons.

- Most of the Districts had not utilized the full amount for training due to delay in implementation. Only 10% of the districts, utilized funds allocated for IEC activities. 20% of the districts did not utilize funds under IEC and rest 70% district had partially utilized.

- Overall, 55% of the health personnel confirmed that they had received training. Regarding the satisfaction with the training program, more than half of the health personnel (54.7%) trained were satisfied with the training program. However, rest of the personnel suggested training in the simple language and making the content simple by using case studies, increase training frequency and refresher training.

- The expenditure on above two components i.e. training and IEC components which requires a lot of groundwork, coordination and networking in the community is below par in most of the districts. **This is mainly due to lack of organizational skills in the DMHP** team, low community participation in the programme and lack of coordination with the district health system which comes under a different department.

- About 85% of the health personnel stated that Spreading Awareness is the main purpose of DMHP, followed by Integrating mental health and general health services is the second most important purpose (69.9%). However, designation wise analysis showed that Psychiatrists and Clinical Psychologists stated the main purpose of DMHP is Capacity building of the health system for mental health service delivery.

- Regarding availability of drugs, 25% of the districts reported that there has been a regular inflow of drugs. Rest of the districts faced difficulties in maintaining regular availability. This is because of lack of dedicated drug procuring mechanism for DMHP and financial authority to the nodal centre. Though 80%

beneficiaries across all the districts also indicated having received at least some medicines from the health centre.

- About 61% of the beneficiaries accessed the district hospital as their first point of contact. The percentage of patients accessing CHCs (12.7%) and PHCs (11.5%) were found to be low. Again 18% of the total respondents confirmed that they were referred to district level for treatment.

- Regarding diagnosis 90% of the patients were of the opinion that diagnosis was explained to them. Rest 10% of the patients or their family members reported that the diagnosis was not al all explained to them. About 61% of the beneficiaries confirmed that the possible side effects of the medicines were explained to them.

- Overall, 75.7% of the patients also reported that they were treated with respect and dignity. With respect to trust and confidence, overall 72.8% reported that they had full trust and confidence with the medical personnel who treated and another 25.3% stated that they had trust and confidence to some extent.

- One fourth of the beneficiaries contacted also indicated having received counseling services under DMHP.

- Comparative analysis of satisfaction with quality of service provided under DMHP revealed that on a 1 to 10 scale, District Madurai in Tamil Nadu attained the highest score at 9.6. The other districts, which are rated higher than the average of 7.3, are Raigarh in Maharashtra, Tinsukia in Assam, Navsari in Gujarat, Delhi, Nagaon in Assam and Buldana in Maharashtra.

- In DMHP districts, 86.9% of the community members contacted knew about mental illness, which is higher than non-DMHP districts (74.7%).

- Nearly half of the respondents (48%) had reported sadness and depression as the symptoms of mental illness, followed by fear and nervousness (42%), lack of sleep (41.6%) and over excitement and mood swings (41.4%) in DMHP districts. On the contrary in Non-DMHP districts, gross behavioral symptoms like Hallucinations (36%), Fits (45%) and Fear and nervousness (44%), which are easy to recognize, were found to be higher.

- Awareness about the types of mental illness namely psychosis, neurosis, epilepsy etc. were found to be significantly higher in DMHP districts as compared to non-DMHP districts.

- More than half of the respondents from the DMHP districts agreed that proper medications and counseling can help in the treatment of mentally ill people against only 30% in Non DMHP districts. 70% of the respondents in DMHP districts also recommended cure at a hospital.

- The difference in approach of respondents of DMHP and non-DMHP districts is clearly evident as far as conservative methods and beliefs are concerned. For example consulting occult practitioners was suggested by only 47.3% of respondents from DMHP districts as against over 70% of Non DMHP respondents. The lower responses from the DMHP districts, in comparison to the non DMHP districts, on Mental illness is due to evil spirit, black magic, Mentally ill people are harmful and should be avoided and Mentally ill people can not be taken care at home clearly indicates that DMHP has been able to spread awareness in the districts where it was being implemented.

All districts with a DMHP in the states of Karnataka, Tamilnadu, Andhra Pradesh & Maharashtra were evaluated using structured proformas sent by the ministry of health Government of India. In addition to the above, a proforma was developed by the department of psychiatry NIMHANS to generate additional information so as to understand the effectiveness, approach to care and coverage for mental health problems as part of DMHP. This included collecting qualitative information and experiences of the doctors as well as users.

The following are some of the key observation made during the visits to the DMHP districts.

Methodology of Monitoring and Review

The faculty, Senior and junior residents of the department of psychiatry, NIMHANS undertook field trips to the DMHP sites. The review of the DMHPs involved focus group discussion with medical officers, multiple purpose workers and other functionaries associated with the primary care system to understand the problems encountered during implementation of DMHP. Focus group interviews were conducted with the program officers, psychiatrist and the officials in the district administration. Further, primary care institutions were visited to understand the ground reality such as availability of drugs, training of staff, documentation of mental health problems and status of persons using the mental health services – a random sample (three – five families). Proforma sent by the ministry of health Government of India and additional proforma was specifically designed for this purpose. All the relevant information was obtained to complete the proforma from the district psychiatrist and his team. The State nodal officer for mental health were also involved in the evaluation process. This exercise was followed by summarizing the observations and writing a brief report for the ministry. .

Findings of the present evaluation- Tamil Nadu

Based on the instructions of the ministry of Health and Family welfare Government of India, an evaluation of 23 DMHPs covering the States of Karnataka, Tamil Nadu and Andhra Pradesh was carried out by the faculty and trainees of the department of

psychiatry NIMHANS. The senior and junior residents were involved in this exercise to facilitate an understanding about the community based mental health programs and issues that are relevant to the implementation of such programs in the country. The following are the key findings of the evaluation

Mental health services - Approach to care.

It was interesting to note that a large number of patients have received care as part of the DMHP.

The approach used to deliver mental health care has been one of establishing psychiatric services in taluk and district centers one a week.

The DMHP team comprised of psychiatrist, social workers, psychologist and a nurse.

All patients who attended these facilities were evaluated and initiated on treatment. Each of these patients was issued free drugs for two weeks and they had to return to these clinics to collect medicines. A small proportion of patients from these out reach clinics were referred to primary health centers so that they could follow up with their primary care doctor. **This was not uniformly seen across the DMHP's in Tamil Nadu**

Patients evaluated in these clinics were given a small booklet, which contained some details about their illness, diagnosis, dose of medication. Information about the users was recorded in a central register and each of these patients was given registration number.

Simple mental health record was kept only in one centre (Trichy) while other centers did not maintain any records at all. The patients who visited the out reach clinics received care while there was no mechanism in place to reach out to people who did not turn up to the clinic for one or the other reason.

- All the patients who were admitted for acute care were evaluated using a fairly detailed mental health record and these were stored with the records clerk of the district hospital. The average duration of admission ranged from two to three weeks.
- Patients who returned for follow up after discharge was seen using the booklet issued to him/her and information about the progress such as, current symptoms and level of functioning is recorded in that booklet itself.
- **Three DMHP sites** did not have inpatients beds at present. In perambalur 30 beds in patient facility is being developed and will soon be commissioned. There are no facilities like toilets, bathrooms, nursing This initiative will require additional funds from the government to put up facilities to make the ward usable. Patients from these centers have not been able to access any acute care so far.
- All the DMHP sites conducted mental health camps in the district in collaboration with department of rehabilitation and the district rehabilitation officer at the. district headquarters periodically. It is very difficult to ascertain how of these individuals who received disability identification cards were accessing disability benefits.
- None of the DMHP sites involves public health system **(Medical officers and paramedical staff)** to deliver mental health care. The responsibility of delivery of mental health services is with the department of health services and all the service

delivery point has been taluk and the district hospitals. These clinics are conducted once a week for about three hours.

- In Three DMHP sites (Theni, Ramanathapuram and Trichy) the psychiatrist and his team visit the primary health centers once a week to evaluate mental health problems identified by the primary care team and initiate them on treatment.

Operational guidelines

- None of the DMHP members were aware of the operational guidelines with respect to implementation of DMHP program in the district.
- They were provided information about mental health services in the state level meeting / district level meetings.
- Only two DMHP psychiatrists were trained in operational aspects of DMHP so far.

Logistic difficulties.

- The mental health program is specialist driven rather than being based in primary care settings**.**
- The DMHP team had to travel to taluk and district head quarters every week to deliver mental health care.
- The fuel available for the travel was too little and often insufficient to complete **one** round of travel to conduct the clinics

Clarity of role and tasks for the DMHP personnel

- The DMHP consists of psychiatrist, psychologist, social workers, nurse and support staff.
- The psychiatrist is involved in diagnosis and initiation of treatment for mental health problems and the nurse is associated with assisting the psychiatrist in administration of medication and in inpatient care.
- The psychologist and social workers are trained in mental health but they are not involved in any tasks they are expected to perform. They are currently working as assistants to the psychiatrist. Often they are engaged in follow of and repeating drug prescription for patients with epilepsy, psychosis and other mental health problems which they are not supposed to do.
- Lack of clarity as to what their role and task is a source of major concern and also an area of intense conflict in the DMHP team. In many of the sites the team members are not united and they frustrated.
- Tamil Nadu is one of the states which has tried to fill the gap of lack of mental health resource to strengthen the DMHP team by appointing MA psychology and MSW social work post graduates to work in the DMHP after three months training in NIMHANS. It is very unfortunate to see that none of these personnel are used to deliver mental health care. The psychology post graduates are not allowed to carry out IQ testing even though each of the sites have testing material.

Unfilled vacancies

- Many posted are unfilled and lying vacant in the DMHP program. Each DMHP should have a multidisciplinary team with specific roles and responsibilities.
- Many the vacancies remain unfilled because of poor salary and lack of job description and consequent poor job satisfaction.
- Many vacancies, large number of patients to be seen in short period of time results in poor quality of care. It was surprising to see psychologists and social workers repeating prescription, which is a reflecting of duress of the DMHP team.

Impact of DMHP

- Based on the data it was evident that large number of patients have come in contact with the DMHP team. The total number of new patients registered in the 9 DMHP sites in Tamilnadu alone is about **34152 from the year 2000.** It is very difficult to decipher what has happened to patients with treatment. There is no data as to how many are regular, irregular, dropouts, migrated, died, recovered or remaining unwell. Similarly, **815801 follow visits were reported across all the DMHP's** and **3199 patients received in-patient c**are over the 10-12 years. With out a mechanism for follow of treated patients the utility value of the program is extremely difficult to infer.
- However, from a situation of no care to some care in Tamil Nadu is a positive aspect of the DMHP. But in terms of efficiency, reaching the unreached, providing care closer to where patients live and integration of mental health with general health services was not achieved at all. The mental health care being available once a week in Taluk and District headquarters' hospitals will not be able to cater to the needs of the people living in rural areas and the purpose for the DMHP was meant is therefore defeated.

Capacity building for public health personnel.

District mental health program has been implemented in Tamil Nadu for the last one and half decades. Integration of mental health into general health services is one of the important objectives of the DMHP program. Table 5 shows the number of personnel trained as part of the DMHP. It was surprising to note that these personnel were trained only once and there was no follow up support or supervision. Further, they were expected only to identify and refer cases to the Taluk and the District clinic.

Support and Supervision

- The nodal officer for the State of Tamil Nadu has been extending all the support- technical and timely help to sort out administrative issues from time to time.

- Despite this there are issues of lack of coordination between the Department of Health services, Department of Public health and the department of medical education.
- Lack of communication to him about the relevant orders both from the Ministry and the local Government results in poor clarity about the implementation of the program- for example none of the DMHP sites had a copy of guidelines for implementation of DMHP. There is likely to be confusion about various elements of the program.
- The funds for the DMHP comes directly form the secretariat to the respective DMHP's rather than through the nodal officer. The funds are handled by all the three Departments – Health services, Public health and the Medical education and coordination becomes very difficult with this kind of arrangements.

Table: 1 Staff strength in the DMHP

SL NO	Name of the DMHP site	Vacancies	Number of personnel managing the DMHP at present
1	Madurai	Social worker, clerk and nursing orderly	6- psychiatrist, psychologist and 4 general nurses
2	Virudhunagar	Nurse, clerk and nursing orderly	3- psychiatrist, social worker and the psychologist
3	Theni	Psychologist, social workers, clerk and nursing orderly	2 – psychiatrist and nurse
4	Ramanathapuram	Social worker, clerk and nursing orderly	3–psychiatrist, psychologist and nurse
5	Perambalur	Nurse, clerk and the nursing orderly	3 – psychiatrist, social worker and the psychologist
6	Trichy	Psychologist, social workers, clerk and nursing orderly	5 – Psychiatrist and four nurses
7	Thiruvarur	Social worker, nurse, clerk and nursing orderly.	2 – psychiatrist and the psychologist
8	Kanyakumari	Psychologist, clerk and nursing orderly	3- psychiatrist, social worker and the nurse
9	Nagapattinum	Social worker, nurse, clerk and nursing orderly	3 – **2 psychiatrist** and psychologist

**Details of Nammakal, Dhamapuri and Erode not included*

Number of beneficiaries from the DMHP

Table : 2- Total number of patients seen so far as part of DMHP

SL NO	Name of the DMHP site	Years since inception of DMHP	Total number of new patients	Total number of old patients-follow up visits	Total number of inpatients	Total
1	Madurai	10 years	6327	135461	1195	142983
2	Virudhunagar	3 years	2833	4511	178	7522
3	Theni	5 years	4440	80998	535	85963
4	Ramanathapuram	7 years	3788	1,48.473	1235	153496
5	Perambalur	3 years	1538	20324	Nil	21862
6	Trichy	10 years	7676	346146	3**	353822
7	Thiruvarur	3 years	2494	19474	Nil	21968
8	Kanyakumari	2 years	919	3848	21*	4788
9	Nagapattinum	3 years	4137	56576	32	60745
	Total		**34152**	**815801**	**3199**	**853125**

Patients are provided in-patient care using the facilities in general medical ward. There is no specific inpatients facility exclusively for psychiatric patients

***** Inpatient facility was set up recently in Manaprai General hospital.***

**Details of Nammakal, Dhamapuri and Erode not included*

Training for primary health care personnel to facilitate integration of mental health in general health care

Table: 3- Capacity building for primary care staff to integrate mental health into primary care

SL NO	Name of the DMHP site	No of medical officers train	No of Paramedical workers trained	No of teachers, panchay	Total.

		ed		at offic ials trai ned	
1	Madurai	150	200	0	350
2	Virudhunagar	52	100	540	692
3	Theni	40	93	250	383
4	Ramanathapuram	50	196	540	786
5	Perambalur	20	0	0	20
6	Trichy	131	1316	0	1447
7	Thiruvarur	58	80	250	388
8	Kanyakumari	48	85	0	133
9	Nagapattinum	56	0	0	56
	Total	**605**	**2070**	**1580**	**4255**

**Details of Nammakal, Dhamapuri and Erode not included*

Admission facility for persons with mental health problems in the District Hospital

Table:4; In patient beds

SL NO	Name of the DMHP site	Number of inpatient beds
1	Madurai	10 beds
2	Virudhunagar	10 beds
3	Theni	10 beds
4	Ramanathapuram	10 beds
5	Perambalur	30 beds- not yet commissioned
6	Trichy	8 beds in Manaparai
7	Thiruvarur	Nil
8	Kanyakumari	Nil
9	Nagapattinum	10 beds

****Details of Nammakal, Dhamapuri and Erode not included***

Disability benefits for persons with mental health problems

Table : 5- Patients who were issued disability ID cards

SL NO	Name of the DMHP site	Mental retarda tion	Mental illness	Total
1	Madurai	840	88	928
2	Virudhunagar	1513	30	1543
3	Theni	1200	100	1300
4	Ramanathapuram	4331	181	12
5	Perambalur	600	0	600

6	Trichy	821	53	873
7	Thiruvarur	500	200	700
8	Kanyakumari	500	75	575
9	Nagapattinum	3244	482	3726
	Total	**13549**	**1209**	**14758**

Details of Nammakal, Dhamapuri and Erode not included

Evaluation of DMHPs – Karnataka

The state of Karnataka has four DMHPs – Shimoga, Chamarajnagar, Karwar and Gulbarga. The following table shows the nodal institution associated with the implementation of DMHP

SL NO	**Name of the District**	**Year of Initiation**	**Nodal Institutions**
	Chamarajnagar	**2007**	District Hospital Chamarajnagar
	Gulbarga	**2006**	District Hospital, Gulbarga
	Karwar	2008	Karantaka Institute of Medical sciences-Hubli
	Shimoga	2007	District Hospital Shimoga

The State of Karnataka has a nodal officer who is a psychiatrist. This is very positive development like in most states. However, the nodal officer is over burdened with supervision and monitoring responsibilities of many other programs. Multiple responsibilities of the nodal officer has become a barrier for very effective implementation of the DMHP. The most important aspect of the DMHP in the State of Karnataka is that the program is public health enabled and driven by the primary care physicians. The program officer who is trained in mental health provides supervision and support for the primary care personnel in an ongoing manner.

It is interesting to note that psychiatrists are not posted in the Districts of Karnataka where the DMHP is in operation unlike in the State of Tamil Nadu. The three out of the four districts have psychiatrist working in the district head quarters but they are not involved in the District mental health program. The DMHP program is managed by a trained program officer who coordinates

the overall implementation of the program. It is note worthy that these program officers are able to take the program forward with support from certain institution like NIMHANS, Karnataka Institute of Medical Sciences, Hubli and the State Nodal Officer. However, the fact remains that the said program officers was not able to continuously conduct field trips to the primary health centers to support the medical officers, which was a serious limitation. Because of lack of support from the program officers on a regular basis, the primary health care team could not be motivated to carry on mental health work to great extent. Adding fuel the fire was limited time given by the Taluk medical officer and the district health officers during their monthly review. In some instances the medical officers got frustrated because of lack of support from the larger system like making psychotropic drugs and other logistic supports like records were not available to carry routine program.

Table showing the Staff Situation in four DMHPs of Karnataka

SL No	Name of the DMHP site	Number of vacancies	Number of personnel managing the DMHP
1	**Karwar**	**Nil**	**6 –** (psychologist, 1 social workers, one nurse, one clerk and orderly.) The post of psychiatrist is filled by the program officers deputed from the State
2	**Gulbarga**	**Nil**	**6 –** (psychologist, 1 social workers, one nurse, one clerk and orderly.) The post of psychiatrist is filled by the program officers deputed from the State
3	**Shimoga**	**Nursing orderly and one clerks post is vacant**	**5 –** (psychologist, 1 social workers, one nurse,) The post of psychiatrist is filled by the program officers deputed from the State
4	**Chamarajnagar**	**Nursing orderly and the psychologist post is vacant**	**5 –** (1 social workers, one nurse, one clerk and orderly.) The post of psychiatrist is filled by the program officers deputed from the State

Table showing the impact of the DMHP in terms of service provision

SL NO	Name of the DMHP site	Years since inception of DMHP	Total number of new patients	Total number of old patients-follow up visits	Total number of inpatients	Total
1	Karwar	4 years	5813	15824	No data is available	21637
2	Gulbarga	5 years	10018	138939	Nil	148957
3	Shimoga	4 years	13631	28832	1040	43603
4	Chamarajnagar	4 years	3493	32044	No data is available	35537
	Total		**32955**	**215639**	**1040**	**249634**

Inpatients facilities in DMHP sites

SL NO	Name of the DMHP site	Number of inpatient beds
1	Karwar	10 beds - recently started after posting a psychiatrist
2	Gulbarga	Nil – no psychiatrist posted
3	Shimoga	10 beds
4	Chamarajnagar	10 beds – recently started after posting a psychiatrist
5	Total	30 beds

Disability certification to facilitate welfare benefits

SL NO	Name of the DMHP site	Mental retardation	Mental illness	Total
1	Karwar	Data not available	Data not available	Data not available
2	Gulbarga	Data not available	Data not available	Data not available
3	Shimoga	Data not available	Data not available	Data not available
4	Chamarajnagar	Data not available	Data not available	Data not available
	Total	Data not available	Data not available	Data not available

Capacities building of primary care personnel.

SL NO	Name of the DMHP site	Number of medical officers trained	Number of paramedical staff trained	Total number of non medical personnel	Total
1	Karwar	98	1740	2455	4293
2	Gulbarga	230	1812	0	2042
3	Shimoga	136	558	178	869
4	Chamarajnagar	89	329	0	418
	Total	553	4439	2633	7625

The following are the high lights of the DMHP evaluation in Karnataka.

Training of primary health care personnel.

- The training was conducted for three days for medical officers at the District headquarters and the coverage was nearly 80% in so far as the capacity building was concerned. The training for health workers was one day and capacity building was done at taluk level.
- Training was done using audio visual aids and real cases were used to build skills in the training using the computer based interactive learning modules. Availability of this material has made training very meaningful activity and the task of the getting across the issues of mental health to the trainees an easy one.
- Most of the primary health care personnel were trained in the district at least once in all the four districts. The lack of funds and coordination between the trainers, program officers and resource person were barriers in completing the training program.
- Mental health care getting least priority in comparison to other programs is another reason why training could not be done.
- While District level training was done quite well, follow up that was required to kick start the program was either delayed or poor because the program officers had to take care of other programs and hence mental health care took the back seat.
- Following the training there was significant change in attitude towards mental health problems and also knowledge and skills with respect to mental disorders. Unfortunately, the gains made following the training program was not sustained

over a period of time by regular handholding and on job training by either program officer of the psychiatrist. Often this link is critical to keep the mental health care deliver loop intact. If for some reason there is no sustained effort to foster this link, interest in mental health care come down and delivery of mental health services becomes very slow.

- Trained medical officers were either transferred outside the district or they were deputed for postgraduate studies. This is a major barrier for effective implementation of the program.
- Though the Ayush doctors were included in the training to implement mental health program in primary care settings, they were not supposed to prescribe psychotropic medication. If they have to prescribe, they had to discuss with allopathic doctors before they initiated treatment. This was often cumbersome and conflict producing in nature. The Ayush doctors chose not to prescribe mental health drugs.

Mental health services

- Following training primary care personnel were able to initiate mental health care in their primary health centers.
- The approach to deliver mental health care was by integrating mental health into general health services.
- Details of the patients seen were documented in the primary mental health care record, which is a set of checklist to document symptoms pertaining to priority mental disorders. Nearly a third of the primary health centers had primary mental health care records and there were issues of quality and completeness of these records.
- In at least a third of the primary health centers, mental health records were maintained and it was retrieved every time the patient came for follow up. The notes written was however, very minimal. It was found that medical officers did not fill in information in the case records as and when patients came for follow up.
- Mental health problems like psychosis, depression, mental retardation and neurotic illness were the broad diagnostic groups seen and overall the coverage was less than 15% of the expected cases. The number of epileptics registered in primary care clinics was in equal proportion to mental health problems.

IEC activities

- Information, education and communication activities were done all over the district using ten features of mental disorders developed by NIMHANS.
- All the districts had spent some of the IEC funds for wall writings and street plays but no sustained effort was made to educate the public about mental health problems.
- Mental health component was included in other IEC activities in the district.

- The local psychiatrist and the program officer did deliver radio talks and also publish mental health material in the lay press but not on a regular basis.

In patients services

- In-patient services were located in the district hospital premises and the DMHP services used these facilities as referral services for their patients. It is note worthy that this facility was not used by the primary care doctors very efficiently because they did not encounter acute problems as part of their work since such patients reached the district hospital directly or went to seek help from other service providers either in local area or some other centre.
- All the four DMHP sites had ten beds each in the District hospitals and these beds were regularly used in three centers. One DMHP site for Karwar, in-patient beds was not used for a long time since the psychiatrist post was vacant for along time.
- The District psychiatric service had its own team of one psychiatrist, social worker, nurse and the psychologist specifically appointed for that purpose. However, in Gulbarga all the posts in the District hospital remained vacant even till date. Many efforts were made to post mental health team to Gulbarga and professional were not willing to work there.

Support and supervision

- Support and supervision for the trained primary health care personnel was done by the program officer mental health.
- These hand holding visits were not done regularly by the program officer because of other commitments like implementation of other programs.
- In the District of Karwar, the program officer for mental health had to monitor many programs and he did not have time to supervise the trained medical officers regularly.
- Program officer was handling many programs simultaneously was a common feature in Karnataka.

Utilization of funds

- Funds allocated for the DMHP was spent appropriately in three districts under all the heads while funds were under utilized in one district because of lack of program officer.
- The program officers and the District Health Officer held the funds using a joint account. This is a very positive development in so far as de-centralization of the program.
- Even though the utilization certificates were submitted in time, the program officer did not receive any acknowledgement to that effect and often the UCs were submitted many times.

Monitoring

- Monitoring of the mental health program did not occur using any targets.
- No objective data based on the number of persons registered, number of person using the services regularly, number of people who have dropped out of the program was used as evidence to monitor the program. This is a major limitation even though mental health records were available to some extent.
- No effort was made at the primary health centre level to understand utilization of mental health services sub centre wise so that the entire process could become very easy.

Involvement of the district administration and district health officials in the DMHP

- Involvement of the district administration in implementation of mental health program was very minimal in Karnataka in comparison to States like Tamil Nadu
- The District health officers did not emphasize on integration of mental health into general health services in all the review meetings.
- De-linking monitoring to the taluk level seemed a great disadvantage because the Taluk medical officer did not take the program seriously and he does not posses the required skills to monitor the mental health program implementation.

Role of the State Nodal officer

- The State nodal officer was a psychiatrist and did play an active role in the implementation of the mental health program.
- Even though he was designated nodal officer for mental health, in reality he was given the responsibility of several other program like immunization, RCH, School Health and so on.

Barriers to integrate mental health into general health services

- Lack of guidelines for implementation of the mental health program was a major barrier.
- Lack of training in the implementation of the DMHP is another barrier.
- Multiple roles of the program officer is a major limitation in implementation of DMHP.
- Lack of demand for services from the community.
- The users did not take up the issue of lack of services with appropriate authorities from time to time.
- Lack of monitoring and supervision from the ministry of health and family welfare periodically.
- Lack of data about mental health problems from the all the districts every month and trouble shooting by a responsible officer from the MOHFW based on an objective evidence as to why coverage is poor could have made the mental health program much better.

- Lack of district level monitoring committee is an other factors for delays and poor implementation.

Evaluation of DMHP in the State of Andhra Pradesh

Andhra Pradesh

SL No	Name of the DMHP site	Number of vacancies	Number of personnel managing the DMHP
1	**Vizianagaram**	**Nil**	**10 –** (psychiatrist psychologist, social workers, one nurse, one clerk and orderly.) The program was stopped in Jan 2009 since funds were not released based on the instructions from the collector
2	**Mahaboobnagar**	**All the posts are vacant**	Nil the program has not started
3	**Cuddapah**		
4	**Prakasham**		

Impact of DMHP – Services provided

SL NO	Name of the DMHP site	Years since inception of DMHP	Total number of new patients	Total number of old patients-follow up visits	Total number of inpatients	Total
1	**Vizianagaram**	2005	8419	33276	No data	
2	**Mahabobnagar**	2009	0	0	0	0
3	Cuddapah	2004	7421	12135	No data	

4	Prakasham	2005	6512	9356	No data	
	Total					

Information will be updated later in the final report

In patients facilities in the Districts

SL NO	**Name of the DMHP site**	**Number of inpatient beds**
1	**Vizianagaram**	Mental hospital
2	**Mahabobnagar**	Nil
3	**Cuddapah**	
4	**Prakasham**	
5	Total	

Disability certification for welfare benefits

SL NO	Name of the DMHP site	Mental retardation	Mental illness	Total
1	**Vizianagaram**	Data not available	Data not available	Data not available
2	**Mahabobnagar**	Data not available	Data not available	Data not available
3	**Cuddapah**	Data not available	Data not available	Data not available
4	**Prakasham**	Data not available	Data not available	Data not available
	Total	Data not available	Data not available	Data not available

Information will be updated later in the final report.

Capacity building for primary care personnel in the District

SL NO	Name of the DMHP site	Number of medical officers trained	Number of paramedical staff trained	Total number of non medical personnel	Total
1	**Vizianagaram**	54	16	26	0
2	**Mahabobnagar**	0	0	0	0
3	**Cuddapah**	39	15	20	74
4	**Prakasham**	67	50	35	152
	Total	160	81	81	226

Information will be updated later in the final report.

There are four district mental health programs in the State of Andhra Pradesh located in Vizianagaram, Cuddapah, Prakasam and Mahaboobnagar. The DMHP program in Andhra Pradesh like in Tamil Nadu and Maharashtra is a specialist driven program. Psychiatrists working in the State are appointed to work in the DMHP and they involved in delivery mental health care by organizing out reach services in Taluk headquarters and the in the District Hospital. Mental health clinics are conducted in these locations once a week. A team consisting of two psychiatrists, psychologists, social workers and General nurses were responsible for delivering services. All patients who came to the clinic were registered and each of them had a psychiatric record. After evaluation each of the patient was issued a booklet, which contains information- such a sociodemographics, drugs details and the diagnosis. All patients using the out reach services at the Taluk level and the District hospital receive free drugs for a period of one month. The psychotropic drugs included a wide range of drugs such as conventional drugs, atypical, mood stabilizers like lithium, carbamazepine and sodium vaproate in addition to antiepileptic drugs.
The District mental health program had training component for primary care personnel like medical officers, health workers and other functionaries. A substantial amount of money was spent on training these personnel but they were used to triage patients to mental health services rather than using the manpower to deliver mental health care in primary care settings. It is sad that the program manager and the monitoring committee have not looked into these issues and make changes appropriately so that there is linear growth in the DMHP program.

The DMHP in Vizianagaram was continued for a period of three years and stopped after that because of lack of funds. It was amazing to note that with one installment the DMHP was stretched for a period of three years and subsequently the program was stopped defeating the purpose for which the program was meant.

Information education and communication activity was developed by the DMHP team and circulated to the entire district and that has been a remarkable achievement with respect to dissemination of information.

The DMHP in Mahaboobnagar has been plagued with man problems and it has not taken off so far inspite of sanction and release of funds. The most important difficulty has been the unwillingness of the psychiatrist after the HOD psychiatry was transferred to Hyderabad. Even though he is appointed as the State nodal officer no significant change was possible in so far as equipping the DMHP team with the necessary human resources required to manage the program.

Evaluation of DMHP Maharashtra

SL NO	Name of the District	Year of Initiation	Nodal Institutions
	Buldhana	**2004**	Regional Mental Hospital, Nagpur
	Amaravathi	**2006**	Government medical college, Nagpur
	Jalgaon	**2006**	Government medical college , Dhule
	Parbhani	**2009**	General Hospital, Parbhani.

There are four DMHPs in the State of Maharashtra at the present. Out of this only three are functional and the DMHP has not started in Parbhani. Jalgoan is the only district where funds have been used effectively while in other district utilization of the funds has been very poor. The staff position in two of the DMHPs has been very poor while in the other two staff have been appointed and they are working.

DMHP staff position in the State of Maharashtra

SL No	Name of the DMHP site	Number of vacancies	Number of personnel managing the DMHP
1	**Parabhani**	**Nil**	**6 –** (psychiatrist psychologist, social workers, one nurse, one clerk and orderly.)
2	**Amaravathi**	**All the posts are vacant**	Nil
3	**Jalgoan**	**Clerk's post was vacant**	**10 –** (1psychiatrist 1psychologist, 1 social

			workers, 4 nurses, 3 nursing orderly's)
4	**Buldhana**	**All posts are vacant**	Nil

Impact of the District mental health problem in terms of service delivery

SL NO	**Name of the DMHP site**	**Years since inception of DMHP**	**Total number of new patients**	**Total number of old patients-follow up visits**	**Total number of inpatients**	**Total**
1	Parabhani	NK	0	0	0	0
2	Amaravathi	5 years	17362* both old and new patients		1108	18470
3	Jalgoan	5 years	2473	12117	729	15319
4	Buldhana	7 years	12207	17283	1841	31331
	Total					**65120**

In-patients facilities in the DMHP districts

SL NO	**Name of the DMHP site**	**Number of inpatient beds**
1	Parabhani	Nil
2	Amaravathi	10 beds
3	Jalgoan	10 beds
4	Buldhana	10 beds
5	Total	30 beds

Disability certification to facilitate disability welfare benefits

SL NO	Name of the DMHP site	Mental retardation	Mental illness	Total
1	Parabhani	Data not available	Data not available	Data not available
2	Amaravathi	Data not available	Data not available	Data not available
3	Jalgoan	Data not available	Data not available	Data not available
4	Buldhana	Data not available	Data not available	Data not available
	Total	Data not available	Data not available	Data not available

Capacity building of primary care personnel in DMHP districts

SL NO	Name of the DMHP site	Number of medical officers trained	Number of paramedical staff trained	Total number of non medical personnel	Total
1	Parabhani	0	0	0	0
2	Amaravathi	0	0	0	0
3	Jalgoan	0	0	0	0
4	Buldhana	0	0	0	0
	Total	0	0	0	0

Training of primary health care personnel.

Of the four DMHP sanctioned districts in the State of Maharashtra not a single primary care personnel have been trained so far. The reasons for not training the medical officers is not know. This clearly suggests that no proper guidelines were issued to the state or the implementing district or that the nodal officer and the program officer have just not understood the program in its entirety. **No attempt is made to integrate mental health into the existing general health services**

Mental health services

Mental health services in the three districts out of the four sanctioned has been using the out reach service model in some of the Taluks of the districts. The out reach clinics are conducted once week on a regular basis since the inception of the program. Each of the clinics maintains some nominal information about the patient, which is recorded at the time of registration. Patients who come for follow up are seen at the clinic and dispensed medication free of cost. It is important to note that though all the four DMHP sites were provided with funds only three are functional and one has not taken off so far because no psychiatrist in the Government pool was willing to take up the job to work as district psychiatrist

IEC activities

Funds for information, education and communication activity was provided for each of the DMHP sites. It was found that utilization of the allocated funds were very poor.

In-patient services

Three of the four sites had inpatient services for person who required acute care. The acute care occurred as part of medical words in the General hospital. This implies that there were no identified groups of professional associated with acute psychiatric care in the district. It is important to note that acute psychiatric care back up is critical for development of psychiatric services in the district.

Support and Supervision

The nodal officer did not provide any support and supervision during the implementation of the DMHP. This part of the program is very crucial to develop the de-centralized psychiatric services. This loop could be the lifeline to improve motivation on the part of health professional to enhance the community based mental health care.

Monitoring

Three out of four centers were seeing person with mental health problems on a regular basis. But how many of the identified patients were regular, how had dropped out and how many were irregular is not known. Similarly, no monitoring occurred with respect to the implementation of the DMHP either from the State nodal officer or the nodal agency responsible for the implementation of the mental health program. Monitoring is a very essential aspect of community-based program when ever decentralized services are set up in the community.

Involvement of the district administration and district health officials in the DMHP

Involvement of the district administration and the district health officials is said to smoothen the operational aspect of the program. The effective implementation may be

enhanced with involvement of the district administration since many of the logistic and administrative problems could be solved within a short period of time.

Role of the Nodal officer

The State nodal officers and district nodal officer has an important role to play in nurturing personnel associated with implementation of the DMHP. Often, lack of involvement of the nodal officer can result in a great degree of apathy in implementation. For example even though funds were available no IEC activities were done to educate the community about the mental health program in the District. Similarly, training for primary care personnel(Medical Officers, health workers and other functionaries) was not done despite availability of funds. The nodal officer who is supposed to give information about the program and give over all directions to the program has failed miserable resulting in poor implementation of the program.

Barriers to integrate mental health into general health services.

Based on the field visit and evaluation of the current status of the DMHP the following issues could be identified as barriers for poor implementation of the DMHP.

- Lack of understanding about the various components of the DMHP.
- Lack of training for the implementing psychiatrist and other personnel about the nitty gritty issues of the DMHP.
- Lack of coordination between the state nodal officer, nodal agency and the implementing officials.
- Lack of guidelines for implementation of DMHP.
- Lack of time line for implementation of the DMHP.
- The existence of nodal agency, nodal officer at the district and state nodal officer is very complex situation and very difficult to coordinate resulting in problems.
- Lack of conceptual clarity about the implementation and processes involved in the program.
- Lack of guidelines for recruiting other mental health professionals for the DMHP team.
- Inability of the State Government to absorb the staff into regular government service is a major barrier in recruiting staff.
- Lack of data base of people who have used service is a serious limitation in understanding the benefits and coverage of the of the DMHP.
- Release of funds on a regular basis and coordinating this process on the part of the State Government has been a major issue.
- Developing a consensus about the IEC material that should be part of the DMHP kit. At present there is no consensus with respect to this. Each of the implementing agencies plans an IEC activity based on their experience and wisdom.
- The state of Maharashtra has not explored the possibility of appointing program officers who are non-psychiatrists to implement DMHP. In many cases lack of psychiatrist has been a reason for the stalemate in implementation. such a model

has been used in some of the states like HARYANA, MADHYAPRADESH, GUJARAT, JAMMU & KASHMIR and KARNATAKA.

OVERALL SUGGESTIONS & RECOMMENDATIONS

Lesson learnt from the review of DMHPs in four States

1. Floating the idea of DMHP has made it possible to provide mental health for the poor at District and Taluk level.
2. Usefulness of the this scheme promoted by the ministry of health, Government of India has enabled the states to start mental health services which could not have been possible left to the states.
3. Lack of sensitization for nodal officers, district psychiatrist and other members of the DMHP team has been an important barrier in the implementation of the program.
4. Non availability of guidelines for implementation and amendments made in the guidelines either as a hard copy or in the ministry web site has been the source of major confusion.
5. There is need for training the State nodal officers, program officers and psychiatrist in the implementation of DMHP. Lack of this has been a major limitation in implementation.
6. Funds should be released in time so that program is not affected because of lack of funds. In some of the districts the problems has been getting funds in time.
7. The out reach model of delivering mental health care at the Taluk and District level is inappropriate and should be stopped immediately.
8. No uniformity in resources and approaches has been an issue. Since it is not possible to achieve uniformity across the country, some degree of consensus should arrived at with respect to key model of implementation based on the existing reality.
9. Where ever District administration is involved in keeping a track of what is happening to the DMHP there has been lot of progress. In ability to sort minor or an other kind of logistic and administrative difficulty could result in stagnation and non progress.
10. Implementation of the DMHP should rest with the department of Public health of that department which deals with primary health care. One program officer who is either a psychiatrist or four month rained program officer should be in-charge of implementing the DMHP.
11. The program officer / psychiatrist should be involved in raining the medical officers or the paramedical workers so that an ongoing relationship is established.
12. Medical officers and program officers should be transferred to a DMHP district only so that the resource is not wasted. One of the major problems in Tamil Nadu and Karnataka is the transfer of medical officers resulting in depletion of the resources.
13. The drug list for management of mental health problems and epilepsy is too long and not based on any scientific rationale. Drug budgets are quickly exhausted because of purchasing expensive drugs.
14. Most of the districts implementing DMHP have reported service utilization by large number of patients. It is impossible to ascertain how are using the services and have benefited from it since there is no information about regularity,

irregularity, drop out, migration, no change, exacerbation and complete remission. Hence it is important to deliver mental health care at the primary health care level where all of the above is possible. Technically reduction in treatment gap for mental health problem (**one of the objectives of DMHP is possible only with this approach**)

15. Lack of periodic reviews of the DMHP is an important reason for poor performance. This will facilitate correction if there are faults in the implementation of the program.
16. No uniformity in IEC activity.
17. No uniformity in nodal agency- in some districts it is the district surgeon, while in others it is the Head, department of psychiatry, in some places it the principal of the medical college and in some others it is the secretary/ commissioner of the department of health and family welfare.
18. Lack of State and central monitoring committee makes the DMHP officers less accountable. Monitoring should occur every month both at the State and Central level so that there is linear growth in the DMHP.

CONCLUSIONS

It was heartening to note that mental health care has really moved from the four walls of the mental hospital to the community. This is a very positive development. The District mental health program was envisaged to achieve the following objectives

- To provide sustainable basic mental health services to the community and to integrate these services with other health services;
- Early detection and treatment of patients within the community itself;
- To ensure that patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities;
- To take pressure off the mental hospitals;
- To reduce the stigma attached towards mental illness through change of attitude and public education;
- To treat and rehabilitate mental patients discharged from the mental hospitals within the community

It is unfortunate that some of the above objectives are not achieved ***because of the approach used to deliver mental health care in the DMHP s***ites is not appropriate to meet the needs of the population. There are wide variations in the implementation of DMHP. The evaluation suggests that each State has its strengths and limitations. The involvement of the public health system has been the highest in the State of Karnataka, which truly reflects the spirit of the comprehensive community based program like the DMHP. It is very encouraging to note that a large number of ill individuals and their families have benefited from the DMHP. However, it is very difficult to infer the actual number accurately since there is no data base which one can refer to at the present time.

The following mid course correction needs to made for the DMHP

1. The primary care personnel should be the health care professional to deliver mental health care.
2. The primary health centre should be the outlet of care for most of the mental health problems.
3. Those patients who cannot be handled in primary care settings should be referred for specialist opinion in the district hospital so as to initiate appropriate action ie admission or diagnostic review or initiation of appropriate management plan and the same should be communicated to the primary care doctor.
4. All patients who are initiated on treatment should be followed at the primary health centre and the paramedical workers should track the treated patients every month and report the same to their medical officer. Depending upon the situation the medical officer should initiate appropriate action to bring the patient back into treatment or educate the patient and family about the illness and side effects or facilitation of admission if the patients has not responded well to the interventions at home.
5. The psychiatrist should meet all the trained medical officers to hand hold them periodically so that their ability to take care of mental health problems increases over a period of time. THIS IS CRITICAL TO ENSURE INTEGRATION OF MENTAL HEALTH INTO GENERAL HEALTH CARE.
6. All essential drugs should be available in primary health centers and medical officers should be educated to use it appropriately. The DMHP team should stick a list of drugs that should be purchased for the DMHP. Allowing freedom and brining in flexibility can results in disastrous consequences such as purchasing atypical which can be expensive. Because we are not taking into consideration total coverage for mental health problems in the District as a whole, on is not able to realize that drug budget allocated is too little to meet the medication needs of the population in the entire district.
7. Medical officers and paramedical workers should be trained for three days and one day respectively at least two times a year.
8. The psychiatrist should be part of the training team since he is likely to interact with all the trained medical officers on a regular basis.
9. The current arrangement of the department health services providing mental health care in the taluk and district hospital, medical colleges providing training in a centralized facility like medical college and the Institute of mental health or mental hospitals managing the IEC needs urgent revision. The psychiatrist and the deputy director/ joint director should be two officers who should manage the program.
10. There should be uniform IEC materials available for all the DMHPs.
11. The State nodal officer should be the person who coordinates the entire DMHP in the State. He/She should be provided with all the facilities to manage the program. Further, he /she should be paid well to carry out the tasks if he is not a serving officer in the government. If he nodal officer is a serving officer in the government he/she be provided adequate facilities to carry out his responsibilities.

12. He/she should be asked to attend all the relevant meetings held at the level of the central Government or the State Government.
13. There is need to constitute a state level and district level expert committee to over see the implementation of the DMHP. The DMHPs should be reviewed every six months and an annual meeting should be organized so that successes and failures in the implementation is well-understood and appropriate action taken to solve the same.
14. The State nodal officer should be the key official who facilitates the processes for effectively implementation of the DMHP.
15. There is need to maintain a data base of patients registered in every primary health centre so that each one them are tracked every month so that treatment adherence is addressed at the primary health centre itself. This is a very critical component of mental health in primary care. It is this approach that will reduce treatment gap, help person recover from serious mental health problems and importantly the primary care personnel can effectively make this possible.
16. All the District hospital should have inpatient facility and in case there are difficulties, the State nodal officer should facilitate setting up such a facility with coordination between the district administration- (collector) and other officers in the district.
17. Persons who were issued disability identification cards have not received benefits so far – particularly the mental ill individuals. This issues needs very urgent attention.
18. The Ministry of health and family welfare Government of India should issue clear guidelines about the implementation of the DMHP. The State nodal officer should ensure that these guidelines are disseminated to all the psychiatrists and the other health department officials.
19. These is an urgent need to revise the salary of the psychologists and the social workers. The present salary is too less to attract any one to the DMHP job.
20. The psychologists and social workers should be issued job description so that they are aware of their roles and tasks. They should be engaged in role appropriate tasks so as to ensure the right kind of care for the needy in the in the District.
21. All the DMHP staff should receive refresher training annual at the state headquarters and the State nodal officer should facilitate this.
22. The psychologist, social workers, clerk , support staff should be made permanent once the state government takes over the DMHP. It is impossible for unhappy staff to deliver any effective mental health care in the community.
23. The psychiatrist should network with agencies in the community to facilitate rehabilitation of the treated mentally ill individuals using the resource available in the district.

Strengths and Limitations in implementation of DMHP State wise

Name of the State	# DMPHs	Strengths	Limitations
Tamil Nadu	**12**	• Mental health services once week in all the taluks of the DMHP district • DMHP is specialist driven. • A large number of persons with a wide range of mental health problems receive care. • Most of the Districts have 10 beds for acute care except three DMHP sites. • Psychologists, social workers and nurses were trained in the implementation of DMHP. • The State nodal officer is a senior psychiatrist, very proactive and extremely responsive to the needs of the staff manning the DMHP. • Active liaison with DDROs to issue disability cards to access welfare benefits. • Many of the DMHPs have network with NGOs • Mental health records are maintained for patients admitted in the district hospital only. • Drugs are procured though the state drug logistic society. • Many innovations in the IEC material	• Minimal number of Primary care doctors and paramedical workers were trained but no integration occurred. • No mental health care at the primary health care level. • No coordination between the public health, health services and the department of medical education. • Though psychologists and social workers are posted in each of the DMHP sites- there is no role clarity. • Discrepancy seen in the salary between the psychologist and social workers. • Psychologists are not allowed to do simple psychometric tests and social workers are not involved in counseling.

		development. • Some of the districts have been taken over by the State of Tamil Nadu.	• Significant strain in relationship between the psychiatrist and other members of the team. • Various activities in the DMHP is done by different departments with significant lack of coordination. • Primary care doctors and health workers are very unhappy that they are not included in the program. • No monitoring of the DMHP on a regular basis. • Poor flow of funds from the MOH GOI to the state.
Andhra Pradesh	**4**	• Mental health services occurred once week in selected taluks. • DMHP is specialist driven program in the State of Andhra Pradesh • A large number of persons with a wide range of mental health problems receive care. • Acute care facility for in patients care is present in three out of the 4 districts. • Psychologists, social workers and nurses were employed in only three districts. • The State nodal officer is a senior psychiatrist.	• Minimal number of primary care doctors and paramedical workers were trained but no integration has occurred. • No mental health care at the primary health care level. • No coordination between the public health, health services and the department of medical education.

		• Mental health records are maintained for patients admitted in the district hospital only. • Drugs are procured though the state drug logistic society. • Couple of the districts have been taken over by the State of Andhra Pradesh after the central funds have stopped .	• Though psychologists and social workers are posted in each of the DMHP sites- there is no role clarity. • They are unhappy with the salary. • Significant strain in relationship between the psychiatrist and other members of the team. • Various activities in the DMHP are carried out by different departments with significant lack of coordination. • Primary care doctors and health workers are very unhappy that they are not included in the program. • No monitoring of the DMHP on a regular basis. • Poor flow of funds from the MOH GOI to the state.
Maharashtra	**4**	• Mental health services occurred once week in selected taluks. • DMHP in Maharashtra is a specialist driven program. • A large number of persons with a wide	• Minimal number of primary care doctors and paramedical workers were trained but no integration has occurred.

		range of mental health problems receive care. • Acute care facility for in patients care is present in three out of the 4 districts State. • Psychologists, social workers and nurses were employed in only three districts. • The State nodal officer is a senior psychiatrist. • Mental health records are maintained for patients admitted in the district hospital only. • Drugs are procured though the state drug logistic society. • Couple of the districts have been taken over by the State of Maharashtra after the central funds have stopped.	• No mental health care occurs at the primary health care level. • No coordination between the public health, health services and the department of medical education. • Though psychologists and social workers are posted in each of the DMHP sites- there is no role clarity. • They are unhappy with the salary. • Various activities in the DMHP are done by different departments and there is no coordination between them. • Primary care doctors and health workers are very unhappy that they are not included in the program. • No monitoring of the DMHP on a regular basis. • Poor flow of funds from the MOH GOI to the state.
Karnataka	**4**	• Mental health services as part of the DMHP	• Discrepancy seen

		occurred at the level of primary health centers in the State of Karnataka • Psychologists were encouraged to do simple psychometric tests and social workers are not involved in counseling. • More than 80% of medical officers and health workers and ANMs were trained and nearly one third of them were actively providing care in primary care settings. integration occurred. • Psychologists and social workers are posted in each of the DMHP sites- there is lot of clarity in what they should do. • Monitoring of the DMHP on a regular basis. • Implementation of the DMHP was done through program officers specially trained for this purpose. • A large number of persons with a wide range of mental health problems received care by primary care doctors supported by the program officer.. • All the four district head quarters hospital had 10 beds for acute care and these facilities were managed by the psychiatrists .	in the salary between the psychologist and social workers. • Primary care doctors and health workers required regular supervision which could not be provided by the program officer since he had responsibility of other programs. • Poor flow of funds from the MOH GOI to the state. • Many medical officers and health workers were not motivated and often considered mental health care work as additional work.

		• Psychologists, social workers and nurses were trained in the implementation of DMHP. • The State nodal officer is a senior psychiatrist, who very proactive and extremely responsive to the needs of the staff manning the DMHP. This officer has experience in implementation of DMHP. • Most of the disabled are able to access welfare benefits. • Many of the DMHPs have network with NGOs • Mental health records are maintained for patients admitted in the district hospital only. • Mental health records are kept in the primary health of those patients who were using the services. • Drugs are procured though the state drug logistic society. • Extensive IEC activities were launched in all the DMHP districts.	

Way forward- recommendations for future.

Review of the DMHP in the four States has revealed useful insights. Based on the findings of the review by the department of psychiatry NIMHANS the following recommendation may be considered.

Ministry Govt of India

1. Operation Guidelines manual about implementation of DMHP should be available in all the districts so as to ensure uniformity. The guidelines should focus on integration of mental health in primary care settings, with identification of roles and tasks of the medical officers, health workers and psychiatrists. The priority for the first year should total coverage of person with severe mental disorders and rest of the problems in subsequent years with addition of promotional activity from the year two of implementation.
2. It should be made mandatory that all the program officers/ districts psychiatrists/ nodal officers should be trained in using these guidelines.
3. Constitute a committee of people with experience in implementation of mental health program at the central level so that they are able to give the appropriate support to the States on a regular basis.
4. Funds should be released in time to the States and the District head and the program officer/ psychiatrist should be a joint account holder of the funds.
5. The ministry should identify a committee to finalize IEC material that should be used uniformly all over the country with scope for making modification depending on the local needs taking into consideration cultural and religious realities.
6. The Ministry should appoint an officer of the rank of Director mental health who has experience in implementation of National programs. This job should be made attractive with some incentives.
7. Invest Money to develop a mental health data base for the nation which could be accessed at the level of primary health centre.
8. Outputs from this data base should be basis for review of the DMHP State wise.
9. The Ministry should insist that all the staff working for the DMHP should be subsequently absorbed into the State service or invest money to support their salaries for rest of their service. It has been seen that States have problems in taking over such a commitment in the long run and therefore many of these jobs are vacant.
10. Ministry should launch a scheme of incentives for medical officers- preference in postgraduate seats (**Details should be worked out**) or out of turn promotion from medical officer to District level officer for his or her good work.
11. The ministry should insist that the implementing department should be a department engaged in public health work- the medical colleges, department

of health services and department of medical education or mental hospital should be kept out of it to ensure smooth implementation of DMHP becomes coordination becomes easy.

12. The ministry should consider handing over the responsibility of implementation of DMHP by one of the institutes in the country with experience in implementation of national programs. Alternatively the secretary Ministry of Health and family welfare should be chairperson of a committee in charge of implementation of the mental health program in the country with full autonomy to use the funds.
13. The institute responsible for implementation of DMHP should run all the relevant courses for effective implementation
14. Create a provision for online submission of UTILISATION CERTIFICATES and obtain acknowledgement so that there is no confusion what so ever.
15. Launch fellowships so that post graduates who have completed their training could work as program officers in the implementation of DMHP during which period he/she will receive the same amount of salary like the senior resident. Persons with such an experience should have preference in taking up academic positions later on in their professional life. This will serve as an incentive to work in the community to strengthen the community based psychiatric services in the country.
16. Funds to the implementing district will be routed to the District health officer of the district. He should have a joint account with the program officer. Dispersing funds to the principal of the medical college, dean of the medical college of the District surgeon should stopped to facilitate smooth functioning of the DMHP.
17. Upscale the implementation to cover the entire country within the next five years.

State Governments

1. The State Government should appoint one nodal officers from the department of public health to manage the mental health program at the State level.
2. The state should form a committee of experts to guide the mental health program and the members should be those who have experience in community based mental health program or those who have experience in implementing national mental health program. Appointment to the committee should not be based on the position a person occupies. It has been found that formation of such committees consisting of the Head of the psychiatry departments have not been helpful in the past.
3. In case there are no psychiatrists, they should consider training medical officers who have completed 5 years service to work as program officers for implementation of DMHP. **THEY SHOULD STRICTLY ADHERE TO ONE PROGRAM ONE-OFFICER POLICY.** Multiplicity of tasks ahs not yielded results so far hence they should enforce this kind of a policy.

4. The program officers if transferred should be transferred only to a DMHP District and not otherwise. In case an officer if interested in working as a program officer should give an undertaking that he will not choose to take up higher studies during his tenure as program officer.
5. Essential drugs should be purchased through the drug logistic society and the purchase should be only for the list provided by the expert committee and not based on the whim and fancy of the specialist.
6. Shortage of psychiatrist should not deter the State Governments to innovate. Four months training for program officers and one training for medical officer to work as mental health officer/ psychiatrist for the purpose of mental health act should be actively explored.
7. All the District health officer, or Chief medical officer , program officers and the nodal officers should be trained in implementation of the DMHP before they assume the responsibility.
8. The District health officer or the Chief medical officer who is the administrative head of the Distrcit every month should review the DMHP program and forward the review findings to the central and State monitoring committee.
9. The District collector or the Deputy commissioner or the chief executive officer of the zilla parishad should review the DMHP program once in very three months and initiate action appropriate to facilitate linear growth of the program.
10. The authorized officer or the panel should certify all the person with permanent and temporary disability or the board and the beneficiary should receive welfare benefits as a matter of right. The coverage should commensurate with the number of the disabled. The financial welfare benefits should be deposited in respective person bank account so that barriers such as middlemen should be done way with.

Medical Council of India

- The Medical Council of India should make psychiatry an examination subject so that a fixed number of theory classes are done in addition to practical training during the undergraduate.
- All the postgraduates – surgery, medicine, pediatrics, obstetrics and gynecology also should undergo mandatory training for three months and will have 50 marks paper in their qualifying examination.
- One month of mandatory training during internship should enforced.

Mental health authority

Mental health authorities may monitor the progress in implementation of mental health program by making DMHP an agenda in their meetings.

Trouble shooting about delays could hasten the process, reduce delays and initiate administrative action.

National Human Rights Commission

- The National Human Rights Commission should actively monitor the implementation of DMHP every 6 months so that omissions in development of the mental health program occurs as desired.
- If there are lapses in the implementation of the DMHP or underutilization of the funds provided by the Government of India, the Principal secretary Health and family welfare should be made accountable.

Non Governmental Voluntary agencies

- Credible NGOs should be encouraged to implement DMHP on their own using the state government infrastructure on Public private partnership.
- The implementation is not piecemeal but all the components of the DMHP as decided by the Ministry of Health Government of India.