Evaluation of District Mental Health Programme

Final Report

Submitted to

Ministry of Health and Family Welfare

Reflecting Reality Strategically and Intelligently

Executive Summary

The main objective of the evaluation was to assess the functioning of DMHP objectively and critically and to suggest future expansion of the scheme along with improvement in implementation if any, based upon the evaluation. ICMR, a division of Planman Consulting (India) Pvt. Ltd. visited 20 DMHP districts and 5 Non-DMHP districts (as control) for the above purpose. The DMHP beneficiary Districts were chosen proportionately from 9th and the 10th plan period. The following are the main highlights of the study:

- 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 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 recognise 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 counselling 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.

Recommendations & Suggestions

- It is recommended to strengthen the services at Sub-Center, PHC, CHC level so that the services become more accessible to the patients.

- Central Government in consultation with State Governments should ensure continuity of DMHP beyond the plan period. It is suggested to gradually shift financial burden to State Government to be ensured by an undertaking to this effect and integration of mental health services in State and District Programme Implementation Plan (PIP).

- Ensure regular flow of allocated funds. Irregular flow of fund has affected the implementation of programme adversely.

- Initiation of programme should be ensured in time bound manner after the receipt of funds.

- Ensure appointment of Psychiatrists and other staff exclusively for DMHP and their continuity by ensuring remuneration at the prevailing market rate.

- It is recommended to increase the PG training seats (M.Phil., Clinical Psychology, PSW, etc.) in the country so that more qualified manpower will be available for the programme.

- Training should be imparted regularly. Increase the frequency and ensure it is imparted to all the personnel implementing the programme. The trained personnel should be retained or if transferred to other DMHP districts only.

- The DMHP team needs to be trained on Programme Management and organizational activities
  - Also ensure refresher training and on-job training with the focus on local challenges.
  - Special training for ANMs and PHC level – for diagnosis, treatment and ensuring the involvement of family members and community._

- Ensure effectiveness of treatment through proper mix of medication and counselling.

- Evolve proper mechanism for drop out cases by ensuring availability of psychiatric social worker and community nurse to follow up the drop out cases.

- Active involvement of community based organisations/leaders for organising awareness programme w.r.t .– place, time and maximum impact area.

- A need for strong IEC for awareness creation/stigma reduction was felt. Mass publicity of awareness programme using local media – print, audio (community radio) and visual (local TV channels)

  - Organising camps/ classes in schools, colleges & other Educational Institutions. There is felt need for promotive components like suicide prevention, workplace stress management, school and college counseling services.

- Integration/ coordination of mental health programme with other health programme viz. ICDS, NRHM

  - Regular inflow of medicines and availability at health centre.

  - Drug procurement mechanism should be streamlined to reduce delay in procurement and achieve economy of scale (e.g. Tamil Nadu model)

  - Ensuring proper organisational structure

  - Supervision and monitoring of DMHP activities by State Health Society

  - It was observed that implementation of DMHP has resulted in availability of basic mental health services at district/sub-district level. As such it is recommended to expand this programme to other districts of the country.

  - Central and State Mental Health Authority are statutory bodies under the Mental Health Act, 1987 for regulation, development, direction and co-ordination with respect to Mental Health Services. However, it has been observed that due to lack of secretarial support these bodies are not able to discharge their role effectively. Adequate support should be provided to them.

  - Continuous monitoring and reporting as well as regular external evaluation is recommended for mid-course correction.

  - This could be addressed by training the DMHP team in organizational skills, networking and involvement of all stakeholders (district health system, district administration, PRIs, CBOs, etc.) in the programme.

Status of DMHP operation

Name of districts	Plan Period	Programme Implementation Level	Manpower	Training Programme	Referral Services	Availability of medicines	Awareness Programs
Delhi	**9th and 10th Plan**	District level	1 Psychiatrist, 1 Psychologist, 1 Psychiatric Social Worker, 1 Statistician, 4 Staff Nurse, 1 Nursing Orderly, 1 helper, 1 driver	Held during 9th plan period	Present	Available	Awareness camps are organized regularly
Kurukshetra	**9th Plan**	District level	1 Psychiatrist, 1 Clinical Psychologist, 1 Record keeper, 1 Lady peon	Held only in 1999	Present	Available	An awareness rally was held recently
		Health Center Level					
Kanpur	**9th Plan**	District level	1 Psychiatrist, 1 Clinical Psychologist, 1 Psychiatric Social Worker, 1 Record keeper	11 training programs were held for MO, ANM and other health workers	Present	Available	Multi Specialty Awareness Programs were conducted
		Health Center Level					Yes
Bankura	**9th Plan**	District level	1 Psychiatrist, 1 Psychologist, 1Psychological Social Worker and Staff nurse	Trained staff had been transferred. New MO and staff have not been trained	Present	Available but irregular supply leading to shortage of medicines	Diagnostic camps organized
		Health Center Level					Diagnostic camps organized
Nagaon	**9th Plan**	District level	1Psychologist, 1 Receptionist, 1 peon, Visiting psychiatrist from Guwahati Medical College	Held	Present	Available	Awareness level enhanced using IEC leaflets and booklets
		Health Center Level					Awareness camps were organized

Name of districts	Plan Period	Programme Implementation Level	Manpower	Training Programme	Referral Services	Availability of medicines	Awareness Programs
Raigad	**9th Plan**	District level	1 Psychiatrist, 4 Psychiatric Nurse (initially), 1 Social worker	Held but no formal training to any staff	Present	Available	Partly successful in raising the awareness level
		Health Center Level		PHC level health personnel were trained but not with the DMHP funds	Yes	Available	Lack of spread of awareness
Navsari	**9th Plan**	District level	1 Psychiatrist, 4 Staff Nurses, 1 Clerk, 2 Workers, 1 Driver	Psychiatrists under DMHP organised training but the frequency was less.	Yes	Available	High awareness level by virtue of frequent awareness sessions, school health programmes
		Health Center Level		Medical Officers received training.	Yes	Available	High awareness level by virtue of frequent awareness sessions, school health programmes
Sikar	**9th Plan**	District level	1 Psychiatrist, 4 staff nurses from the general ward	Held in 1998 for MO and CHC/PHC staff	Present	Not available since DMHP was not functional	Awareness spread during diagnostic camps
		Health Center Level					Yes
Shivpuri	**9th Plan**	District level	1 Psychiatrist (initially), 1 Clinical Psychologist, 1 Trained Social Worker, 4 Male Nurses, 1 Statistician cum Clerk, 1 driver	Only 1 training was organized	Not happened	Available	Diagnostic camps were held as part of awareness programmes.

Name of districts	Plan Period	Programme Implementation Level	Manpower	Training Programme	Referral Services	Availability of medicines	Awareness Programs
		Health Center Level					12 Awareness Camps were organised with the help of IEC materials
Dhamtari	**10th Plan**	District level	1 Psychiatrist (initially), 1 Clinical Psychologist, 1 Psychiatrist Social Worker, 1 Nurse (initially), 1 Clerk	Not held	Not happened	Available	Very limited number of awareness programmes
		Health Center Level					No Awareness Programmes
Raebareli	**10th Plan**	District level	1 Psychiatrist, 1 Clinical Psychologist, 1 Psychiatric Social Worker, 1 Psychiatric Nurse, 1 Record keeper, 1 Nursing Orderly	Held in 2005	Present	Available	Awareness camps are organised at the District
		Health Center Level					Yes
Tinsukia	**10th Plan**	District level	1 Clerk, 1 Peon and 1 Accountant at the Nodal Office, 1 Psychiatrist at DH (not employed under DMHP)	Held	Yes	Not available since DMHP was not functional	Awareness programme held by DMHP team and local leaders using IEC materials
		Health Center Level	1 Psychiatrist at FRU				Awareness camps were organised by DMHP team and the Sarpanch, teachers with the help of IEC materials

Name of districts	Plan Period	Programme Implementation Level	Manpower	Training Programme	Referral Services	Availability of medicines	Awareness Programs
Puri	**10th Plan**	District level	1Clinical Psychologist, 1 Psychiatrist Social Worker, 1 Clerk, 4 Nurses, 1 Record keeper cum clerk	Not held	Yes	Available	No Awareness camps. Only distribution of leaflets
		Health Center Level					
Prakasham	**10th Plan**	District level	1 Psychologist, 1 Psychiatric Nurse, 3 Counselors 1 Clerk	2 Training programmes were held	Yes	Available	2 awareness camps were organized with IEC materials and general mental health check up was also conducted.
		Health Center Level		1 Training Programme at CHC and 2 Programmes at PHC level were held	Yes	Available	1 Awareness programme at CHC and 2 programmes at PHC were held with the use of IEC materials.
Madurai	**10th Plan**	District level	1 Psychiatrist, 2 Clinical Psychologist, 5 Staff nurses, 1 Social worker, 1 Clerk.	Held	No	Available	Awareness programme held with IEC materials and festivals were conducted in the various taluka level
		Health Center Level		Staff in the PHCs and para-medical staff received training.	Yes	Available	IEC activities including Public lectures, short plays, exhibitions, school awareness programs

Name of districts	Plan Period	Programme Implementation Level	Manpower	Training Programme	Referral Services	Availability of medicines	Awareness Programs
Gulbarga	**10th Plan**	District level	1 Psychologist, 1 Psychiatric Nurse,	Training was imparted to the district doctors	No	Available	1 training camp was organised. with the help of IEC materials and orientations programme
		Health Center Level		Wide spread training was held at the PHCs, CHCs and for the ANMs	Rare	Available	No awareness programme or use of IEC till date.
Buldana	**10th Plan**	District level	1 Psychiatrist, 1 Social worker	Un-officially held but till now no formal training with DMHP allocated funds	Yes	Made available through State Government.	Successfully enhanced awareness level. Mental Health Day and Depression Screening Day were some of the awareness programmes.
		Health Center Level		No fromal training utilizing DMHP funds	Yes		Lack of proper awareness generation mechanism.

Introduction

Introduction to National Mental Health Programme

Milieu

Mental health is undeniably one of our most precious possessions, which needs to be nurtured, promoted, and preserved as best as we can. It is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully, and facing up adversities without loosing the capacity to function physically, psychologically and socially.[1] The World Health Organisation (WHO) defines mental health as '*a positive sense of well being encompassing the physical, mental, social, basic economic, and spiritual aspects of life; not just the absence of disease'*. Mental health is a barometer of the social life of a population and the rising level of morbidity and mortality is a sign of social as well as individual malaise.

The scope of mental health is not only confined to the treatment of some seriously ill patients admitted in mental asylums, but is integrally related to the whole range of health activities that caters to the emotional and psychological well being of the individual. Psychiatric symptoms are common in general population in both sides of the globe. These symptoms such as, worry, tiredness, and sleepless nights affect more than half of the adults at some time, while as many as one person in seven experiences some form of diagnosable neurotic disorder.

The World Bank Report (1993) revealed that the Disability Adjusted Life Year (DALY) loss due to neuro-psychiatric disorder is much higher than diarrhea, malaria, worm infestations and tuberculosis if taken individually. According to the estimates DALYs loss due to mental disorders are expected to represent 15% of the global burden of diseases by 2020.

[1] Anant Kumar; District Mental Health Programme in India: A Case Study, 2005

Since independence, Indian Government has well recognized the need to be proactive in its approach to promote good mental health of its citizens and to provide good quality care to those suffering from mental disorders. But, unfortunately, these efforts are only reflective and confined to various recommendations and meetings. Mental disorders cause an enormous burden on affected individuals, their families and society, although this suffering may not be visible to others. Psychiatrists estimate that about 2 per cent of Indians suffer from mental illnesses, i.e. a staggering 20 million people out of a population of one billion.

Evolution of National Mental Health Programme

During the last two decades, many scattered epidemiological studies have been conducted in India, which show that the prevalence of major psychiatric disorder is about the same all over the world. The prevalence reported from these studies range from the population of 18 to 207 per 1000 with the median 65.4 per 1000 and at any given time, about 2–3 % of the population, suffer from seriously, incapacitating mental disorders or epilepsy. Most of these patients live in rural areas remote from any modern mental health facilities. A large number of adult patients (10.4 – 53%) coming to the general OPD are diagnosed mentally ill [2]. However, these patients are usually missed because either medical officer or general practitioner at the primary health care unit does not ask detailed mental health history. Due to the under-diagnosis of these patients, unnecessary investigations and treatments are offered which heavily cost to the health providers.

Considering the importance and necessity of a national level mental health plan, Government of India formed an expert group in 1980.The group discussed the issue with many important people concerned with mental health in India as

[2] Website of *National Institute of Health and Family Welfare;*, Burden of disease, (http://www.nihfw.org/ndc-nihfw/html/Programmes/National MentalHealth.htm,)

well as with the Director, Division of Mental Health, WHO, Geneva.[3] The group prepared a draft report which was presented in a workshop in New Delhi in July 1981, which was attended by 60 professionals/ experts on mental health. After a thorough discussion, the draft was substantially revised and again presented at the second workshop in August 1982 to a group of experts which not only comprised of psychiatry and medical stream but also experts from diverse field such as education, administration, law and social welfare. Accordingly the final draft was submitted to the Central Council of Health, India's highest health policy making body in August 1982.

The Council, after a thorough discussion, adopted a resolution for launching **National Mental Health Programme (NMHP)** in the same year, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it. The primary **aim** of NMHP has been:-

1. Prevention and treatment of mental and neurological disorders and their associated disabilities.
2. Use of mental health technology to improve general health services.
3. Application of mental health principles in total national development to improve quality of life.

[3] *The National Mental Health Programme: Progress and Problem*; R. Srinivasa Murthy; Mental Health, An Indian Perspective, 1946-2003, Ed. S.P Agarwal; Directorate General of Health Services, MOHFW, 2003

In alignment to the aim the **objectives** of NMHP have been:-

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.

- To encourage application of mental health knowledge in general health care and in social development.

- To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

The **Strategy**[4] of implementing NMHP across the country has been uniform and centrally driven along the given lines:-

- Integration of mental health with primary health care through the NMHP

- Provision of tertiary care institutions for treatment of mental disorders

- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental health Authority.

[4]http://www.nihfw.org/ndc-nihfw/html/Programmes/NationalMentalHealth.htm

The main Goals of NMHP, 1982 plan period as shown in the following box

1. Within one year, each state will have adopted the present plan of action in the field of mental health
2. Within one year, Government of India will have appointed a focal point within the Ministry of Health, specifically for mental health services.
3. Within one year, A National Coordinating Group will be formed comprising representative of all states, senior health administrators and professionals from psychiatry, education, social welfare and other related professionals.
4. Within one year, a task force will have worked out the outline of curriculum of mental health workers identified in different states as the most suitable to apply basic mental health skills, and for medical officers working at PHC's level
5. Within five years, at least 5,000 of the target non-medical professionals will have undergone a two-week training programme on mental health care.
6. Within five years, at least 20% of all physicians working in PHC's will have undergone a two-week training programme on mental health.
7. The creation of the post of psychiatrist in at least 50% of the district within five years.
8. A psychiatrist at the district level will visit all PHC settings regularly and at least once every month, for supervision of mental health programme for continuing education. This programme will be fully operational in at least one district in every state and UP, and in at least half of all districts in some states within five years.
9. Each state will appoint a programme officer responsible for the organization and supervision of the mental health programme within five years.
10. Each State will provide additional support for incorporating community mental health component in the curricula of teaching institutions (within five years).
11. On the recommendation of a task force, appropriate psychotropic drugs to be used at PHC level will be included in the list of essential drugs in India.
12. Psychiatric units with in-patients beds will be provided at all medical college hospitals in the country within five years.

During the first 10 years of NMHP, the initial small scale models of care were systematically evaluated. After evaluation a district level model (DMHP) was developed on the basis of Bellary model (Bellary district of Karnataka). Initially it was implemented in 27 districts of India and later on extended up to 108 districts.

District Mental Health Programme

The major **components** of District Mental Health Programme as adopted by the Ministry of Health and Family Welfare are:-

1. Training programme for all workers in the mental health team at the identified Nodal Institute in the State.
2. Public education in the mental health to increase awareness and reduce stigma.
3. For early detection and treatment, the OPD and indoor services are provided.
4. Providing valuable data and experience at the level of community to the State and Centre for future planning, improvement in service and research.

Agencies like World Bank and WHO have been contacted to support various components of the programme. Funds are provided by the Govt. of India to the State Governments and the nodal institutes to meet the expenditure on staff, equipments, vehicles, medicine, stationary, contingencies, training, etc. for initial 5 years and thereafter they take over themselves. Govt. of India has constituted Central Mental Health Authority to oversee the implementation of the Mental Health Act 1987. The act provides for creation of State Mental Health Authority also to carry out the said functions.

The National Human Rights Commission also monitors the conditions in the mental hospitals along with the Government of India and the States are currently acting on the recommendation of the joint studies conducted to ensure quality in delivery of mental care.

In the ninth plan the programme covered an area of 27 districts spread across different states of India.

10th Five Year Plan[5]

In the tenth plan the NMHP after its internal evaluation by NIMHANS was scaled up to cover 108 districts across India. The major thrust areas for NMHP in the tenth plan have been:-

- District mental health programme in an enlarged and more effective form.
- Modernization of mental hospitals in order to modify their present custodial role.
- Upgrading department of psychiatry in medical colleges/general hospitals.
- Research and training in the field of community mental health.
- Promotional campaign through IEC materials

[5]National Institute of Health and Family Welfare: Ibid

The DMHP also has its share of criticism across the verticals of prestigious mental health institutions in the country. The national strategy of integrating mental health with existing primary care services addresses both the scant resources and the challenges of serving a large and diverse country. While there is no disputing that the country's mental health programmes were initiated with bold and well-meaning objectives, numerous problems continue to thwart implementation of these programmes. Several of the logistical and administrative difficulties have been detailed in public health and psychiatric publications. Significantly, however, a historical and cultural analysis of the major forces that have shaped the discipline is conspicuously absent in the published literature.[6]

[6]Sumeet Jain & Sushrut Jadhav, A Cultural Critique of Community Psychiatry in India.

Rationale and Objective of the Evaluation Study

With this background, a study was undertaken to examine the state of mental health services in India from a public health perspective, considering preventive and promotive aspects of mental health and recognizing the socio-cultural factors in mental health services. The objective of the study was to analyse the implementation of the District Mental Health Programme (DMHP) under the National Mental Health Programme (NMHP). The study largely relied upon the various secondary sources (viz., government reports, policy papers related to mental health published by the Ministry of Health and Family Welfare, Directorate General of Health Services, Planning Commission, and books and articles published in various Journals) for literature review and conceptual clarity on the subject of mental health. Both primary and secondary sources were used to gather information about the services rendered.

The earlier evaluation of the ninth plan was conducted by NIMHANS and in general the ministry and other health institutions felt that before the programme is being planned to be scaled up further across the country, it is essential to have an independent evaluation that will hold the coverage and strength of the programme. Another important facet of this evaluation study is to provide recommendations to improve upon the short comings of the current programme and review not only the implementation but also the programme itself.

The areas of investigation for the independent evaluating body are:-

- To evaluate the performance of DMHP during the 9th & 10th Five Year Plan.
- To assess the availability of services under DMHP in the states.
- To assess the availability & utilization of prescribed drugs under DMHP in the states.
- To review the referral, support & collaboration of PHC, CHC, higher centres.
- To study the awareness level & community perception about the programme & the services available under DMHP.
- To assess the technical expertise of medical officers and health staff who have been trained in basic mental health care.
- To assess the utilization of programme funds & management of the funds at the district level.
- To understand the impact of DMHP on the global mental health scenario in the district.
- To compare DMHP districts with Non-DMHP districts on the awareness level about mental illness
- To recommend suitable changes in the programme strategy to take care of shortfalls and hence making it better within the available resources.

Methodology

SAMPLING METHODOLOGY

In this present study for sample district selection ICMR research team had divided the entire country into five zones - namely – **East, West, North, South and Central**. A total of 20 districts (where DMHP is operational) were selected on the basis of stratified random sampling method.

Reference period:

The information was collected for two plan periods – from 9th plan 10 districts and from 10th plan another 10 districts. Major task was to conduct the evaluation of DMHP programme from the district of the 9th Five Year Plan and 10th Five Year Plan.

Period of survey:

Primary data was collected during 15th of October 2008 to 15th of November 2008.

A three stage stratified sampling method was adopted for ultimate respondent selection. After division of zones each districts were selected through random sampling, so that each districts holds equal weights in the selection method. Again for an unbiased and detailed evaluation of the programme, greater priority has been given to the 9th Plan period by retaining higher sample districts in percentage in comparison to 10th Five Year Plan. It is also to note that while finally selecting the districts for 10th plan, without any loss of generality; it has been decided to do away with the districts where the programme has been initiated in 2006-07 or later. These districts were excluded because funds were released for DMHP only two years back. Therefore ICMR team considered the time period to be too short for assessing the impact of a programme like DMHP in more detail.

While selecting the districts, certain conditions were kept into considerations which are as follows:

- The districts have also been uniformly divided which redefines the target as: 4 districts per zone which is inclusive of the 9th Plan and the 10th Plan, except the Central zone, where there has been a deficit of one district and it has been met up by taking an additional district from Delhi under the North zone.
- In order to capture the perception of Medical professionals, beneficiaries/ patients/ and community members, the target size of the total sample was fixed at 2000. Further to maintain the uniformity, the sample for each zone was fixed at 400. Therefore, district wise sample was fixed at 100.
- The sample size of 100 from each district per zone has been further distributed as: **60 respondents from the beneficiaries, 30 respondents from the community and 10 respondents have been selected from the people under the Health System.**

The table given below shows the total division of the zones and states and the total number of District Hospitals under those respective areas.

Table 1.Sample coverage for DMHP:

Sl No.	Zones & States	District Hospitals		9TH PLAN	District Names	10TH PLAN	District Name
		Count	%				
	South	**23**	**21.3%**	**1**		**3**	
1	Andhra Pradesh	6	26.1%	1	**Medak**	1	**Prakasham**
2	Kerala	5	21.7%				
3	Tamil Nadu	8	34.8%			1	**Madurai**
4	Karnataka	4	17.4%			1	**Gulbarga**
	East	**24**	**22.2%**	**2**		**2**	
5	West Bengal	4	16.7%	1	**Bankura**	1	**Jalpaiguri**
6	Assam	6	25.0%	1	**Nagaon**	1	**Tinsukia**
7	Tripura	2	8.3%				
8	Sikkim	1	4.2%				
9	Mizoram	2	8.3%				
10	Meghalaya	2	8.3%				
11	Nagaland	2	8.3%				
12	Arunachal Pradesh	2	8.3%				
13	Manipur	3	12.5%				
	West	**18**	**16.7%**	**3**		**1**	

Sl No.	Zones & States	District Hospitals		9TH PLAN	District Names	10TH PLAN	District Name
		Count	%				
	South	**23**	**21.3%**	**1**		**3**	
12	Rajasthan	1	5.6%	1	**Sikar**		
13	Maharashtra	6	33.3%	1	**Raigard**	1	**Buldana**
16	Gujarat	8	44.4%	1	**Navsarai**		
15	Goa	1	5.6%				
16	Dadra Nagar Haveli	1	5.6%				
17	Daman & Diu	1	5.6%				
	North	**25**	**23.1%**	**3**		**2**	
18	Delhi	2	8.0%	1	**South**	1	**North-West**
19	Chandigarh	1	4.0%				
20	Uttar Pradesh	10	40.0%	1	**Kanpur**	1	**Raebareli**
21	Punjab	3	12.0%				
22	Haryana	3	12.0%	1	**Kurukshetra**		
23	Himachal Pradesh	2	8.0%				
24	Jammu & Kashmir	4	16.0%				
	Central	**18**	**16.7%**	**1**		**2**	
25	Orissa	8	44.4%			1	**Puri**
26	Madhya Pradesh	5	27.8%	1	**Shivpuri**		
27	Chattisgarh	5	27.8%			1	**Dhamtari**
	Total DH Hospitals	**108**	**100.0%**	**10**		**10**	

The statistical methods followed for the final selection of the beneficiaries form each of the zones are as listed below in a step by step manner. While choosing the beneficiaries for interviews, the procedure of **"Purposive Sampling"** was followed, in the sense that every third patient coming for the treatment was interviewed.

Following the pyramidal structure present in Indian Health System, after the selection of a district, all the hospitals/ dispensaries institutions falling under the district health system were identified viz. District Hospitals, Community Health Centers (CHCs), Primary Health Centers (PHCs) and Sub-centers. This was done to capture the trickle-down effect of the DMHP Programme and better representation of the Health personnel and the beneficiaries.

Table 2, contains the list of the District Hospitals, the Community Health Centers, the Primary Health Centers and the location of the Nodal Offices which were targeted and this has been done taking into consideration the **"Multi-stage Sampling Procedure"**. States which does not follow the pyramidal

structure of the health system (Delhi) different mechanism was adopted for hospital or dispensaries selection. In Delhi, unlike other states two clinics one from the North-west district and the other one from the South district were selected.

Besides DMHP districts ICMR research team also selected 5 other non-DMHP districts (from Uttar Pradesh, Rajasthan, Haryana, West Bengal and Maharashtra) as control districts. Here field researchers only canvassed the community level questionnaires (30) to compare the awareness level about mental illness with the DMHP districts.

Table 2.Targeted Institutions in sample districts:

Zones	States	Districts	Plan period	Name of District Hospital	Location of Nodal Offices	Location of DMHP running CHCs visited	Status	Location of DMHP running PHCs visited	Status
South	Andhra Pradesh	Medak	9th Plan	District Head Quarter Hospital	IMH, Hyderabad	Sangareddy and Sadashivpet	Not operational	Babnagar	Not operational
		Prakasham	10th Plan	APVVP District hospital	Guntur Medical College, Guntur	Kandukuru and Markapuram	operational	No PHC is active under DMHP	-
	Tamil Nadu	Madurai	10th Plan	Rajaji Government Hospital	Institute Of Mental Health, Chennai	Ursilampatti Taluk Hospital	Operational	No PHC is active under DMHP	-
	Karnataka	Gulbarga	10th Plan	Gulbarga District Hospital	District Hospital, Gulbarga	Afzalpur	Operational	kooli	Operational
East	West Bengal	Bankura	9th Plan	Bankura Sammelani Medical College and Hospital	State Mental Health Authority	Bishnupur, Amarkanak and Chatna Rural hospitals	Operational	No PHC is active under DMHP	-
		Jalpaiguri	10th Plan	Sadar Hospital, Jalpaiguri	North Bengal Medical College, Darjeeling	Maynaguri Rural Hospital	Operational	Belacoba Block PHC	Operational
	Assam	Nagaon	9th Plan	B. P. Civil Hospital	Gauhati Medical College	Hojai	Not operational	No PHC is active under DMHP	-
		Tinsukia	10th Plan	L. G. B. Civil Hospital	Assam Medical College	Doomdooma	Not operational	No PHC is active under DMHP	-
West	Maharashtra	Raigard	9th Plan	Civil Hospital	Maharashtra Institute Of Mental Health, Pune	Sub district Hospital Penn	Operational	No PHC is active under DMHP	-
		Buldana	10th Plan	Zila Samanya Rugnalaya	Government Medical College, Aurangabad	Rural hospital Mehkar	Operational	Janephal and Dongaon	Operational

Zones	States	Districts	Plan period	Name of District Hospital	Location of Nodal Offices	Location of DMHP running CHCs visited	Status	Location of DMHP running PHCs visited	Status
	Rajasthan	Sikar	9th Plan	Sri Kalyan District Hospital	S. M. S. Medical College, Jaipur	Piprali, Kudan	Operational	Singhashan, Tarpura, Dujod, Kashikabaas	Operational
	Gujarat	Navsari	9th Plan	M. G. G. Hospital	At the same hospital	Gandevi, Vasda	Operational	Jalalpur, Arda	Operational, Not now
North	Uttar Pradesh	Kanpur	9th Plan	U. H. M. Kanpur	C. S. M. Medical University U.P., Lucknow	Sarsaul	Operational	Not required	-
		Rai-Bareli	10th Plan	Rana Beni Madhav District Hospital	C. S. M. Medical University U.P., Lucknow	Lalganj, Bachrava.	Operational	Maharajganj	Operational
	Delhi	South	9th Plan	Chhatarpur Dispensary	IHBAS at Dilshad Garden	Don't exist	-	Don't exist	-
	Delhi	North West	10th Plan	Babu Jagjivan Ram District Hospital	IHBAS at Dilshad Garden	Don't exist	-	Don't exist	-
	Haryana	Kurukshetra	9th Plan	L. N. J. P. Hospital	PGIMS at Rohtak	No CHC is active under DMHP	-	No PHC is active under DMHP	-
Central	Madhya Pradesh	Shivpuri	9th Plan	Shivpuri District Hospital	Gwalior Mansik Arogyashala	Pohri, Kohlaras, Narwar, Badarbas	Operational	Berad	Operational
	Chhatisgarh	Dhamatari	10th Plan	Dhamtari District Hospital	Pt. J. N. M. Medical College, Raipur	No CHC is active under DMHP	-	No PHC is active under DMHP	-
	Orissa	Puri	10th Plan	District headquarter hospital	S.C.B Medical College,Cuttak	Rebana ,Nuagaon and Chandanpur	Not operational	Siruli and Bramhagiri	Not operational

Study Parameters

ICMR, Planman started this study in November 2008. A situation analysis was conducted after going through various reports, articles and other published material. The team also interacted with various experts including psychiatrists from private and public sector to understand their views and importance of NMHP and DMHP. For initiating the discussion, guidelines on point of investigation were prepared on three broad parameters - Health System, Beneficiaries and Community. This has been shown in following matrix:

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
Capacity Building The role of the various branches of Health Systems is prominent as an agency receiving the training. Therefore here the pertinent questions are:- i. The content of training ii. Applicability of the trainings iii. Duration of training iv. Experiences/gains of the trainees v. Significance of trainings vi. Refreshers Training vii. Satisfaction from these trainings viii. Recommendations regarding improving these trainings Another major component of trainings is the in-job trainings that happen within the health systems. ix. At each level of the hierarchy the in-job trainings take place? How they were imparted at each level? Under what situation were they imparted, etc? Who has the onus in imparting these trainings?	1. **Awareness** i. Source of information regarding mental illness ii. Seriousness of mental illness iii. Is mental illness curable? iv. Counseling regarding the illness v. Counseling regarding social stigma associated with mental illness vi. Use of IEC materials in addressing counseling vii. Scope for dialogue in counseling viii. Simplification of diagnosis and treatment process ix. Experience x. Constraints and resistance in counseling and stages of treatment xi. Recommendation and suggestions	**Awareness** i. What is the awareness of the community regarding mental illness ii. Source of information regarding mental illness – Do health workers spread awareness regarding mental illness in the community iii. Seriousness of mental illness iv. Is mental illness curable/hereditary/genetic? v. Information regarding the types of mental illness vi. Information regarding reducing social stigma associated with mental illness vii. Use of IEC materials in giving information viii. Scope for dialogue in informative sessions ix. Simplification of diagnosis and treatment process x. Experience with health workers spreading awareness in the community xi. Recommendation and suggestions

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
DH CHC PHC Sub-Center **2. <u>Diagnosis</u>** In the section of diagnosis at the level of health structure, the personnel were taught to diagnose the symptoms of mental illness. In this section the pertinent questions are:- i. What are the various kinds of mental illness they were taught to diagnose? ii. Experiences pertaining to diagnosis iii. Constraints in diagnosis iv. Assistance in diagnosis – cooperation from seniors in the system v. Number of diagnosis before and after the programme vi. Disorder wise diagnosis	**<u>Diagnosis</u>** Impact of diagnosis for the beneficiary i. Who identified the mental illness at the primary level – 1st one to identify? ii. 1st point of contact with a health worker – who and how? iii. Time duration between identification of an ailment to actual diagnosis iv. Explanation of the diagnosis to the patient and the family member v. Counseling following diagnosis vi. Addressing of stigma associated with mental illness vii. Experience with the process of diagnosis – in case of changes in diagnosis viii. Behavior of health personnel responsible for diagnosis ix. Point of satisfaction and dissatisfaction x. Recommendation regarding the handling of diagnosis with the health worker	

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
3. Treatment The health system was upgraded to deal with the management of mental illnesses. The workers were trained not only to diagnose mental health disorders but also to provide basic treatment for the same. The pertinent questions in this section are:- i. Basic amenities available for treatment – disorder wise/center wise ii. If the environment in and outside the system appropriate for treatment iii. Types of mental illness that the system at a particular level is capable of treating iv. A typical cases v. Barrier analysis vi. Coordination and support from other health workers vii. Personal experience viii. No of treatment before and after the programme	**2. Treatment** i. Time duration between diagnosis and initiation of actual treatment ii. Point of contact during this phase iii. Duration of the treatment – complete as well as ongoing iv. Necessity of treatment v. Expectation in regard to treatment vi. Experience with treatment vii. Satisfaction with treatment viii. Dissatisfaction with treatment ix. Availability of drugs during treatment x. Availability of health personnel during treatment xi. Behavior of health personnel responsible for treatment xii. Total expenditure on treatment xiii. Physical, Financial, emotional and social problems faced during treatment	

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
4. **Referral** Another important facet of the programme is referral. Once a Doctor at the PHC/CHC identifies the symptoms of mental illness in a patient and realizes he or she cannot treat it, then the health worker is to refer the patient to appropriate or concerned personnel. The important questions relevant here are:- i. Stages of referral ii. Conditions under which referral is practiced – criterion/basis/type of illness wise iii. Chain of referral – level wise iv. Out layer and drop out cases from the referral chain v. Are the health worker supposed to follow up with patients post referral? vi. Experiences on referral cases vii. Barriers in referral viii. Recommendations to make referral effective ix. No of referral before and after the programme – also disorder wise	3. **Referral** i. Point of 1st referral ii. Time duration between screening and referral iii. Satisfaction with the point of contact with the health worker during this period. iv. Point of 2nd referral if any v. Satisfaction with the point of contact with the health worker during this period. vi. Satisfaction with the system of referral care vii. Experience with referral care in terms of distance, expense, mode of transport, frequency of visit, etc viii. Recommendation if any	

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
5. Drugs + Personnel i. Drug list made available under the programme w.r.t. illness ii. Availability of the drugs in the health center – Regularity of inflow and outflow iii. Usage of the drugs iv. Chain of movement of unused drugs v. Constrains in accessing drugs and solutions to the problem vi. Patients perception on taking of drugs from the health centers vii. Confidence of health workers on administering drugs after initial diagnosis viii. Availability of personnel in the health centers who prescribe the drugs – center wise ix. Experience sharing x. Recommendation	**4. Availability of drugs and personnel** i. Availability of drugs ii. Availability of appropriate health workers iii. Cost incurred for treatment iv. Total expenditure in terms of physical, financial and social capital at each step of treatment v. Satisfaction with treatment vi. Experience with diagnosis, treatment and referral at each level vii. Recommendation if any	

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
6. Budget Allocation of funds and their utilization are central to any programme. Pertinent questions in this section are:- i. Allocation of funds ii. Time taken for transfer of funds iii. Duration of time between allocation of funds and transfer of funds iv, Duration of time between actual transfer of funds and roll out of the programme v. Amount of fund utilized vi. Action taken in case of under-utilisation – was UC issued? Time taken for issue? What if it was not issued? Etc. vi. Spread of expenditure vii. Unused funds – what happens to them? viii. Constraints in utilizing the funds ix. Are the funds sufficient? x. Probable loop holes in optimal use of funds xi. Recommendations if any. xii. Allocation of funds in spreading awareness in the community about mental illness.		

Health Systems (Health Systems)	Beneficiary (Direct + Indirect)	Community
7. <u>Awareness</u> In order to understand the success of the programme, it is important to know what the health workers involved in implementing the programme feel about DMHP and also what the health workers feel about the perception of the community regarding the programme. i. What is mental illness? ii. Is mental illness curable? iii. What is the purpose of DMHP? iv. Experiences with DMHP? v. Recommendations to make the programme better vi. What do the beneficiaries think about the programme? vi. What does the community think about mental illness and its treatment? vii. Experiences with the community and the beneficiary.		

Comparative Analysis of DMHP

Status of DMHP in selected districts

ICMR, Planman Consulting research and field team visited 20 districts and office of nodal officer responsible for implementing the DMHP in the specific districts in order to gather information on the following aspects:

1. To collect the documents related to allocation and component wise utilisation of funds along with other documents related to implementation of program.
2. Assess/ evaluate the perception of health staff responsible for implementing the program
3. Assess/ evaluate the perception of beneficiaries/ patients or their family members with respect to diagnosis and treatment or counseling received and satisfaction level with the treatment
4. Assess/ evaluate the awareness and perception of community members on mental illness.

The research and field team also tried to make some observation by recording the status of health institutions responsible for implementing the program. It was found that in few districts the DMHP was being implementing but also found out that in few of the Ninth Plan districts the DMHP are no longer operational or are being operated with meager resources as the State governments have failed to take over the program in these districts.

The status of DMHP, at the time of survey, can be gauged from the following table:

Snapshot on the status of DMHP in selected districts under the study		
Sl. No.	**Districts**	**Status**
IXth Plan Districts		
1	**Delhi – South**	Still Running with the fund allocated for dist North - west
2	**Kurukshetra (Haryana)**	Still Running
3	**Kanpur (Uttar Pradesh)**	Still Running
4	**Bankura (West Bengal)**	Currently running in only one satellite clinic, Bishnupur
5	**Nagaon (Assam)**	Completed in June 2002 but not taken by State Government
6	**Shivpuri (Madhya Pradesh)**	Completed in April 2008 but not operational now
7	**Raigad (Maharashtra)**	Not running since October 2008
8	**Navsari (Gujarat)**	Completed and taken by State Government
9	**Sikar (Rajasthan)**	Completed in 2004 but not taken by State Government
10	**Medak (Andhra Pradesh)**	Was operational till December 2008
Xth Plan districts		
11	**Delhi – North west**	Still Running (originally started during the IXth plan with the fund allocated for South district
12	**Raebareli (Uttar Pradesh)**	Still Running
13	**Buldana (Maharashtra)**	Still Running
14	**Dhamtari (Chhattisgarh)**	Still Running
15	**Gulbarga (Karnataka)**	Still Running
16	**Madurai (Tamil Nadu)**	Still Running
17	**Prakasham (Andhra Pradesh)**	Still Running
18	**Puri (Orissa)**	Still Running
19	**Tinsukia (Assam)**	No longer operational due non receipt of second installment of fund.
20	**Jalpaiguri (West Bengal)**	Money received by the Nodal Office, equipments purchased, staffs recently appointed in Dec '08

- The table above shows that out of 10 district which were selected for DMHP in ninth plan period, 5 districts are still running the program. They are – Delhi, Kurushetra (Haryana), Kanpur (Uttar Pradesh), Navsari (Gujarat) and Medak (Andhra Pradesh). In District Bankura (West Bengal), the program is in operation in only one of the satellite clinics, Bishnupur. In the rest of 4 districts the program has been discontinued. In the case

of Delhi (Dist South), though the program started during the IXth Plan period, it is still continuing with fund allocated for Dist North-west.

- The table also shows the status of 10 districts under the Xth plan period. All these districts have received only first installment. Out of these 10 districts, the DMHP at the time of survey was operational in 8 districts. In Dist Tinsukia (Assam), which has also received the first installment, the program is not running as there are no funds available. Whereas, in the case of Jalpaiguri (West Bengal), the fund has been received by the nodal office but the program has not yet started. They were still at the initial stage of buying equipments and appointing the staff till December 2008. In Delhi (Dist North West), the program had started during the Ninth Plan itself, with fund allocated for Dist South and is still continuing.

Allocation and Utilisation of Funds for DMHP

In order to understand, the allocation and utilisation of funds, the research team collected the year wise receipt and utilisation certificate from the nodal offices mainly responsible for spending the funds for different components. The research team also collected the documents from MOHFW related to year wise and component wise amount allocated for implementing program ***(See Annexure -)***. Based on the allocated amount as per the norms for each of the year, analysis was carried out to understand the extent of utilisation of fund for different components of DMHP which are – allocation for Salary, Medicines/ stationary/ contingencies, Equipment/ Vehicle etc., Training and IEC.

The table below shows the total funds received by the districts under the ninth and tenth plan and their utilisation.

District wise allocation of funds and their utilisation					
	Total fund received	**Total fund utilized**	**Percentage Utilization**	**Balance amount to be received**	**% of balance amount**
IXth Plan Districts					
Bankura (West Bengal)	**5,965,000**	**5,989,718**	**100.4%**	5,605,000	48%
Sikar (Rajasthan)	**10,997,000**	**7,983,420**	**72.6%**	573,000	5%
Navsari (Gujarat)	**9,170,000**	**4,326,597**	**47.2%**	2,400,000	21%
Kurukshetra (Haryana)	**9,170,000**	**5,813,276**	**63.4%**	2,400,000	21%
Kanpur (Uttar Pradesh)	**6,841,428**	**2,625,626**	**38.4%**	4,728,572	41%
Delhi – Dist. South	**11,570,000**	**11,498,525**	**99.4%**	0	0%
Shivpuri (Madhya Pradesh)	**4,071,428**	**4,175,394**	**102.6%**	7,498,572	65%
Raigad (Maharashtra)	**4,650,000**	**1,717,849**	**36.9%**	6,920,000	60%
Nagaon (Assam)	**8,142,039**	**7,424,292**	**91.2%**	3,427,961	30%
Xth plan Districts					
Dhamtari (Chattisgarh)	**2,620,000**	**1,341,686**	**51.2%**	8,630,000	77%
Tinsukia (Assam)	**2,620,000**	**2,557,575**	**97.6%**	8,630,000	77%
Gulbarga (Karnataka)	**2,620,000**	**1,751,533**	**66.9%**	8,630,000	77%
Puri (Orissa)	**2,620,000**	**1,360,513**	**51.9%**	8,630,000	77%
Delhi – Dist. North West	**2,620,000**	**2,568,133**	**98.0%**	8,630,000	77%
Raebareli (Uttar Pradesh)	**2,620,000**	**2,397,496**	**91.5%**	8,630,000	77%
Buldana (Maharashtra)	**2,620,000**	**11,748**	**0.4%**	8,630,000	77%
Madurai (Tamilnadu)	**2,620,000**	**2,190,205**	**83.6%**	8,630,000	77%
Prakasham (Andhra Pradesh)	**2,620,000**	**1,904,438**	**72.7%**	8,630,000	77%

- As per the Ninth plan, a total 1,15,70,000 *(one crore fifteen lakh seventy thousand)* was schedule to be allocated for each of the districts selected under the ninth plan. The fund is generally allocated in five installments. The nodal officer is supposed submit the utlisation certificated an accordingly, MOHFW (Govt. if India) allocates the next and subsequent installments. If the nodal office fails to submit the utilisation certificate,

the funds for the next installment is withheld till the time utilisation for the previous installment is submitted.

- The table above clearly shows that only one district (Delhi – South) had received the full amount allocated under the plan period, followed by District Sikar, which received nearly Rs. one crore eleven lakhs. The table also shows the balance fund for each of the district selected under the study. As discussed earlier, most of the districts are liable to receive the balance fund only after they submit the utilisation certificates of the previous installments.
- The table also shows the percent utilisation of the allocated fund at the time of survey as per the utilisation certificate submitted by the districts. It shows that only 3 of the districts which have almost utilised the total amount they received. Delhi, as discussed earlier had received the total amount of 1,15,70,000, had utilized over 99%. Delhi has been implementing the program in the two districts – South and North-west.
- Dist Bankura West Bengal) had received Rs 59,65,000 and had utilised all the funds. Similarly Dist Shivpuri in Madhya Pradesh, which received nearly 40, 71,000 had also utilized the entire amount. Both the above districts are still to get 48% and 65% of balance amount allocated under the ninth plan.
- In the case of tenth plan districts, all the districts selected under the received have only received the first installment i.e. Rs. 26,20,000 of the total amount of Rs 1,12,50,000 *(one crore twelve lakh fifty thousand)*. Therefore each of the district selected here are liable to get balance 77% of the total allocated amount. As far as utilisation is concerned, three of the districts have utilised over 90% of their first installment. They are – Delhi (98%), Dist Tinsukia, Asssam (97.6%) and Dist Raebareli, Uttar Pradesh (91.5%). In the case of Dist Buldana, less than 1% of fund was utilised at the time of survey.

Component wise utilisation of funds

As discussed earlier, the ICMR, Planman research team had collected the relevant documents from the MOHFW related to component wise allocation of funds such as Salary, Medicines/ stationary/ contingencies, Equipment/ Vehicle etc., Training and IEC. Accordingly the research team worked ratios related to allocation and utilisation, depending upon the number of installments received.

Therefore, the table below shows the allocation and utlisation of first three components i.e. (i) Salary, (ii) Medicines/ stationary/ contingencies and (iii) Equipment/ Vehicle etc.

Allocation and utilisation: Salary, medicine and equipment

	Salary			Medicines/ stationary/ contingencies			Equipment/ Vehicle etc		
	Allocated	Spent	% utilised	Allocated	Spent	% utilised	Allocated	Spent	% utilised
IXth Plan Districts									
Bankura (West Bengal)	1,928,889	589,640	31%	1,549,638	3,198,729	206%	900,000	1,824,508	203%
Sikar (Rajasthan)	3,768,438	4,572,847	121%	3,038,750	752,181	25%	900,000	856,715	95%
Navsari (Gujarat)	3,470,000	2,081,272	60%	2,800,000	562,514	20%	900,000	1,075,393	119%
Kurukshetra (Haryana)	3,470,000	3,299,456	95%	2,800,000	901,073	32%	900,000	743,063	83%
Kanpur (UP)	2,318,412	1,996,843	86%	1,867,184	598,783	32%	900,000	0	0%
Delhi – Dist. South	4,670,000	6,048,068	130%	3,800,000	4,371,588	115%	900,000	269,517	30%
Shivpuri (MP)	1,154,485	3,326,638	288%	919,269	373,625	41%	900,000	432,967	48%
Raigad (Maharashtra)	1,369,767	0	0%	1,094,186	487,129	45%	900,000	1,230,720	137%
Nagaon (Assam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Xth Plan Districts									
Dhamtari (Chattisgarh)	870,000	870,000	100%	450,000	227,313	50.5%	600,000	244,373	40.7%
Tinsukia (Assam)	870,000	566,417	65.1%	450,000	618,966	137.5 %	600,000	886,716	147.8%
Gulbarga (Karnataka)	370,000	153,939	41.6%	850,000	449,449	52.9%	200,000	182,157	91.1%
Puri (Orissa)	870,000	714,509	82.1%	450,000	349,791	77.7%	600,000	296,213	49.4%
Delhi - North West	870,000	1,538,191	177.8%	450,000	1,029,942	228.9 %	600,000	0	0.0%
Raebareli (UP)	870,000	1,931,581	222%	450,000	222,339	49.4%	600,000	149,048	24.8%
Buldana (Maharashtra)	870,000	0	0.0%	450,000	0	0.0%	600,000	9,390	1.6%
Madurai (Tamil Nadu)	870,000	705,250	81.1%	450,000	935,000	207.8 %	600,000	0	0.0%
Prakasham (AP)	870,000	1,054,146	121%	450,000	252,415	56.1%	600,000	519,553	86.6%

- The analysis shows that the spending on salary has been in the range of min 31% to maximum 288%. Six of the districts in ninth and tenth plan have spent over and above the allocated amount. For example, in the case Dist Shivpuri (Madhya Pradesh) 188% above the allocated amount have been spent on the salary components. This is followed by the Dist Raebareli in Uttar Pradesh (122%), Delhi for the tenth plan period (76.8%) and for the ninth plan period (30%) and Sikar (Rajasthan) and Prakasham (Andhra Pradesh) which had spent 21% above the allocated fund for the salary components. Although component wise allocation and utlilisation has been decided by the MOHFW. Any districts which want to spend above the allocated funds seek the prior authorization from the MOHFW. In the case of Dist Buldana in Maharashtra, no amount has been shown or spent on the Salary and Medicine etc. components. Many districts, which are showing the under utilisation are using the doctors and other health personnel which are getting their regular salary from the state government. In many cases it was also revealed that funds allocated for the salary component remained unutilized as there was unavailability of required manpower especially psychiatrist or psychologists. The amount of salary for the psychiatrists and clinical psychologists, as fixed by the MOHFW, was considered to be low and therefore most of these could not be retained for a long period. In many of the other cases it was revealed that psychiatrist from the other hospitals, such district hospitals, are used therefore under utilisation of funds allocated for the salary.
- Allocation and utilisation of other two components also shows the similar trend. In the case of expenses on medicines, maximum has been recorded in the case of Delhi (130% from the fund allocated for the tenth plan) followed by followed by Madurai in Tamilnadu and Bankura in West Bengal (almost 105%). However, in the case of Buldana in Maharashtra, no expenses have been shown in their utilisation certificates. As per the nodal officer the fund was received in May 2007. Requisition for medicines has already been sent but they are yet to receive that. However, in the case of component related to equipments, 3 distict have shown that no fund has been utilised for this purpose. They are Kanpur (Uttar Pradesh), Delhi (North West) and Maduari (Tamil Nadu). In the case of Delhi, equipments and vehicjle purched for the other district – South – are also being utilised for the Dist South- west. Two of the districts have shown over utilisation under this head. They are – Dist Bankura (103%), Tinsukia (47.8%) and Raigad (37%).

If all these expenses are contrasted with the expenses on the other two components, Training and IEC, a very different picture emerges out of the analysis. This could be gauged from the table below:

Allocation and utilisation: training and IEC						
	Training			IEC		
	Allocated	Spent	% utilised	Allocated	Spent	% utilised
IXth Plan Districts						
Bankura	**1,093,237**	107,400	10%	**493,237**	269,441	55%
Sikar	**1,200,000**	962,904	80%	**847,750**	838,773	99%
Navsari	**1,200,000**	492,768	41%	**800,000**	114,650	14%
Kurukshetra	**1,200,000**	788,423	66%	**800,000**	81,261	10%
Kanpur	**1,177,916**	30,000	3%	**577,916**	0	0%
Delhi - South	**1,200,000**	535,792	45%	**1,000,000**	273,560	27%
Shivpuri	**784,053**	14,332	2%	**313,621**	27,832	9%
Raigad	**918,605**	0	0%	**367,442**	0	0%
Nagaon	**N.A**	NA	NA	**N.A**	NA	NA
Xth plan Districts						
Dhamtari	**500,000**	0	0%	**200,000**	0	0%
Tinsukia	**500,000**	387,247	77%	**200,000**	98,229	49%
Gulbarga	**900,000**	862,044	96%	**300,000**	103,944	35%
Puri	**500,000**	0	0%	**200,000**	0	0%
Delhi - North West	**500,000**	0	0%	**200,000**	0	0%
Raebareli	**500,000**	82,435	16%	**200,000**	12,094	6%
Buldana	**500,000**	0	0%	**200,000**	2,358	1%
Madurai	**500,000**	300,000	60%	**200,000**	250,000	125%
Prakasham	**500,000**	30,347	6%	**200,000**	47,977	24%

- None of the districts under study had reported to have utilised the entire amount allocated for training purpose. Dist Gulbarga in Karnataka (tenth plan district) is the only one which has reported to utilise its 96% of amount allocated for training purpose. This followed by Sikar in Rajasthan (80%) and Tinsukia in Assam (77%). In fact four of the districts have not shown any expenses incurred on training. They are - Raigad and Buldana in Maharashtra, Dhamtari in Chattisgarh, Puri in Orissa and Delhi (North-west). Most of these districts fall under the tenth plan period. They have received only first installment. But they are supposed to start the work after they had trained their people for the purpose. In the case of Delhi, the staff was reported to be trained as they are responsible for implementing in the other district (South). However, they

are also yet to conduct training for the General health staff or the refresher training for the older staff. However, three of the districts under ninth plan had shown hardly any expenses on the training purpose – They are Raigad (0%), Shivpuri (2%), and Kanpur (3%). This could be point of concern as effectiveness of the program could be seriously hampered using untrained staff.

- Similar situation was found in the case of fund utilised for IEC, which include campaign for the awareness of the community members in the districts of operation. Madurai and Sikar were the only two districts which had shown the entire fund utilised, allocated for the purpose of IEC. In the ninth plan, there were 3 districts where fund allocated for this purpose had shown 0% utilisation. They are –Puri in Orissa, North-West district of Delhi and Dhamtari in Chattisgrah. In district Buldana (Maharashtra) a meager amount of Rs 2000 only (1% of the allocated fund) has been spent on awareness campaign. There is only one district of ninth plan (Sikar, Rajasthan) which has reported to spent 99% of the fund allocated on the community awareness program.

The above analysis clearly indicates that expenditure on the components like salary, medicines etc. and equipment and vehicle has been as per the programme. However, expenditure on the training and IEC components which requires a lot of ground work, 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.

This could be addressed by training the DMHP team in organizational skills, networking and involvement of all stakeholders (district health system, district administration, PRIs, CBOs, etc.) in the programme.

Perception of Health Professional on DMHP

Sample Coverage:

It was decided to target 10 health personnel from each of the 20 districts, who are responsible for implementing the DMHP in their district. However, during the course of survey it was found that in three of the selected district, the DMHP has not started. The following table shows the status of DMHP covered in the ninth and tenth Five Year Plan periods.

Sample profile in the achieved targeted districts.

The following table shows the number of health personnel with respect to their designation

District wise achieved sample of health personnel implementing DMHP

	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others	Total
Sikar	4			2	6		1	1	14
Bankura					9		1		10
Kanpur				1	3	3	2	1	10
Raebareli	3	1	1	1	1	1	2		10
Navsari	1			2	6		1		10
Puri		1		1	8				10
Gulbarga		1			6	1	2		10
Prakasham	1			1	1	4	1	2	10
Nagaon				3	3	1		1	8
Buldana	1		1	2	1		2		7
Raigad	3		1		3				7
Tinsukia	3					4			7
Delhi	3	1	1	1					6
Shivpuri	3	1		1					5
Madurai	3	1				1			5
Raipur	1	1	1					1	4
Kurukshetra	1	1						1	3
Total	**27**	**8**	**5**	**15**	**47**	**15**	**12**	**7**	**136**
Row%	**19.9%**	**5.9%**	**3.7%**	**11.0%**	**34.6%**	**11.0%**	**8.8%**	**5.1%**	

- Altogether 136 health personnel were interviewed during the course of survey from the 17 districts where the DMHP has been implemented.

- In 9 of the districts targeted the ICMR could not meet the desired sample of 10 health personnel because of either non appointment of staff for DMHP or their unavailability at the time of survey. In the case of Dist Kurushetra in Haryana, the team could target only 3 of the health personnel, followed by 4 in Dist Raipur (Chattisgarh), 5 each in Dist Madurai (Tamilnadu) and Shivpuri (Madhya Pradesh), 6 in Delhi (all the staffs are from IHBAS responsible for implementing DMHP in 2 of the districts – South and North–West), 7 each in Ditricts of Tinsukia (Assam), Raigad and Buldana (both from Maharashtra) and 8 in Naogaon (Assam).
- Highest numbers of health personnel were interviewed in Dist Sikar of Rajasthan (14). However, 2 of the Psychiatrists interviewed were no longer associated with DMHP, as the Program is no longer in operation. Other staff members who were interviewed in Sikar were interviewed in the same districts but since the program not running, they are also no longer associated with program. Their perception relates to the period when the program was being implemented.
- In rest of 7 district, the team was able achieve the target sample which was 10 per districts.
- Designation wise profile shows that the team interacted with 47 (34.6%) Medical Officers of CHCs and PHCs, 27 (19.9%) Psychiatrists including the nodal officers and main doctor responsible for implementing the program, 15 each (11%) of the Psychiatric Nurses and Health workers and 8 (5.9%) Clinical Psychologists. Apart from these health personnel, the ICMR team also interacted with 12 ANMs who are responsible for implementing the program at the Sub-Centre levels.

Health workers perception on purpose of DMHP

In order to understand the overall perception of health workers on DMHP and its working, doctors and other medical staff responsible for implementing the program were asked about their perception on purpose of DMHP. The analysis could help in recommending the suitable suggestions for enhancing the effectiveness of DMHP program in the districts already covered and also in other districts which are supposed to be covered in the 11th plan period.

Purpose of DMHP: Designation wise perception

		Total	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others
Spreading Awareness	Count	115	24	5	5	14	37	14	11	5
	Col %	84.6%	88.9%	62.5%	100.0%	93.3%	78.7%	93.3%	91.7%	71.4%
Integrating Mental Health and General Health services	Count	95	24	6	4	10	30	8	9	4
	Col %	69.9%	88.9%	75.0%	80.0%	66.7%	63.8%	53.3%	75.0%	57.1%
Capacity Building of Health Personnel for the management of mental illness	Count	85	26	7	3	13	30	4	1	1
	Col %	62.5%	96.3%	87.5%	60.0%	86.7%	63.8%	26.7%	8.3%	14.3%
Prioritizing Mental Health issue	Count	62	15	4	3	7	27	2	3	1
	Col %	45.6%	55.6%	50.0%	60.0%	46.7%	57.4%	13.3%	25.0%	14.3%
Total	**Count**	**136**	**27**	**8**	**5**	**15**	**47**	**15**	**12**	**7**
	Col %	**100.00%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Sum may not add due to multiple responses

- **"Spreading Awareness"** was found to be the main purpose of DMHP as reported by nearly 85% of medical personnel contacted during the survey.
- **Integrating mental health and general health services** was identified as the second most important purpose of DMHP (69.9%).
- However, designation wise analysis shows that in the case of **Psychiatrists and Clinical Psychologists,** the main purpose of DMHP is **Capacity building of health personnel for the mental illness.** Whereas, spreading awareness is the second most important purpose of DMHP.

Therefore, analysis clearly shows that there exit some difference of opinion among the health personnel with respect to main purpose of DMHP.

Perception on Training

One of the component of DMHP is to train the Medical Officers and other health staff, who deputed for implementing the program. DMHP allocates the separate fund for this purpose. In the each of the district, this fund is used to train the existing staff for the first three years. It is through the proper and regular training of the health personnel under DMHP that the proper diagnosis could be conducted for the treatment of mentally ill people. It also helps in enhancing the capacity building of the institutions responsible for treatment of mentally ill people falling in the catchments area.

During the course of survey, health personnel were asked whether they were imparted training or not. The response of the medical personnel could be gauged from the table below.

District wise response on training			
	Yes	**No**	**Total**
Buldana	14.3%	85.7%	**7**
Bankura		100.0%	**10**
Kanpur	100.0%		**10**
Raebareli	40.0%	60.0%	**10**
Kurukshetra		100.0%	**3**
Nagaon	87.5%	12.5%	**8**
Navsari	80.0%	20.0%	**10**
Delhi	50.0%	50.0%	**6**
Puri		100.0%	**10**
Raigad	57.1%	42.9%	**7**
Raipur		100.0%	**4**
Shivpuri	100.0%		**5**
Sikar	64.3%	35.7%	**14**
Tinsukia	100.0%		**7**
Madurai	20.0%	80.0%	**5**
Gulbarga	100.0%		**10**
Prakasham	60.0%	40.0%	**10**
Total	**55.1%**	**44.9%**	**136**

- Overall, only 55% of the medical personnel interviewed confirmed that they received training for implementing the DMHP in their area.
- All the health personnel interviewed in Kanpur (Uttar Pradesh), Shivpuri (Madhya Pradesh), Tinsukia (Assam) and Gulbarga (Karnataka) confirmed that they had received the training.
- However, none of the health personnel contacted in Kurushetra (Haryana), Puri (Orissa) and Raipur (Chattisgarh) reported that they had

received training for implementing DMHP in their area. This shows that either health personnel contacted in these districts were appointed after the third year of the plan period when the DMHP was launched in that particular district or the training was not at all conducted in that district.

Effectiveness of training

The major objective of training program was to effectively implement the DMHP in the district. Therefore, in order to gauge the effectiveness of such training program, health personnel contacted in each district was asked to rate the effectiveness of such training program on a scale of 1 to 5, where 1 stands for Not useful and 5 for very useful. Nearly all the respondents (9 out of 10) agreed that the training was useful. Only 9.3 % were neutral or could not assess the effectiveness of such training program. The following table also shows the profile (of medical personnel) wise ranking on the effectiveness of training programs

Designation wise perception on effectiveness of training

		Total	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others
Very Useful	Count	51	10	3	3	8	15	5	5	2
	Col%	68.0%	62.5%	100.0%	100.0%	80.0%	68.2%	41.7%	83.3%	66.7%
Somewhat Useful	Count	17	4	0	0	1	5	7	0	0
	Col%	22.7%	25.0%	0.0%	0.0%	10.0%	22.7%	58.3%	0.0%	0.0%
Neutral (Can't Say)	Count	7	2	0	0	1	2	0	1	1
	Col%	9.3%	12.5%	0.0%	0.0%	10.0%	9.1%	0.0%	16.7%	33.3%
Total	**Count**	**75**	**16**	**3**	**3**	**10**	**22**	**12**	**6**	**3**
	Col%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

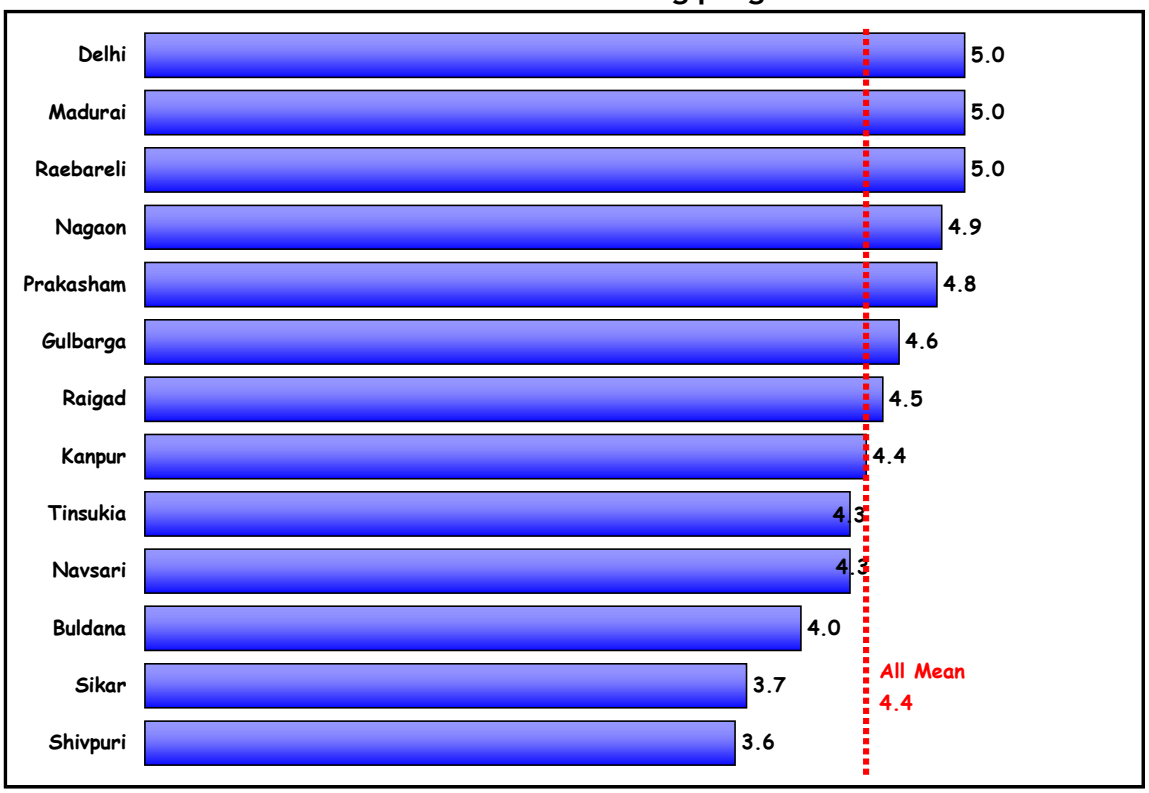
- Psychiatrists are the most important medical personnel who not only supervise training but also responsible for implementing the DMHP in the selected districts. Over 87% of them considered the training to be useful. However, 25% had reported the training to be somewhat useful.
- All the Clinical psychologist and Psychiatric Social Workers found the training to be very useful. This was followed by Psychiatric nurse and ANMs, where 8 out of 10 found the training to be very useful.
- In the case of Health workers, majority of them (58.3%) found the training to be somewhat useful.
- Therefore, overall it can be concluded that the training imparted to the medical personnel was useful for implementing the DMHP in districts covered under the survey.

Satisfaction with the training program

Satisfaction level derived from the training program										
		Total	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others
Very Satisfied	Count	41	8	2	3	8	10	5	3	2
	Col %	54.7%	50.0%	66.7%	100.0%	80.0%	45.5%	41.7%	50.0%	66.7%
Somewhat Satisfied	Count	28	6	1	0	1	11	7	2	0
	Col %	37.3%	37.5%	33.3%	0.0%	10.0%	50.0%	58.3%	33.3%	0.0%
Neutral (Can't Say)	Count	3	1	0	0	1	0	0	0	1
	Col %	4.0%	6.3%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	33.3%
Somewhat Not Satisfied	Count	1	0	0	0	0	1	0	0	0
	Col %	1.3%	0.0%	0.0%	0.0%	0.0%	4.5%	0.0%	0.0%	0.0%
Not Satisfied	Count	2	1	0	0	0	0	0	1	0
	Col %	2.7%	6.3%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	0.0%
Total	Count	75	16	3	3	10	22	12	6	3
	Col %	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

- More than half of the health personnel (54.7%) interviewed during the survey were very satisfied with the training program. Other 37.3% reported that they were somewhat satisfied.
- Level of satisfaction was found to be highest among the Psychiatrist social workers. All of them reported that they were very satisfied. This was followed by Psychiatric Nurses (80%), Clinical Psychologists and clerk and other staff (66.7%) and psychiatrists and ANMs (50%).
- Overall only 3 of the medicals personnel had reported that they were not satisfied (somewhat of fully) with the training program.

District wise level of satisfaction with training program:



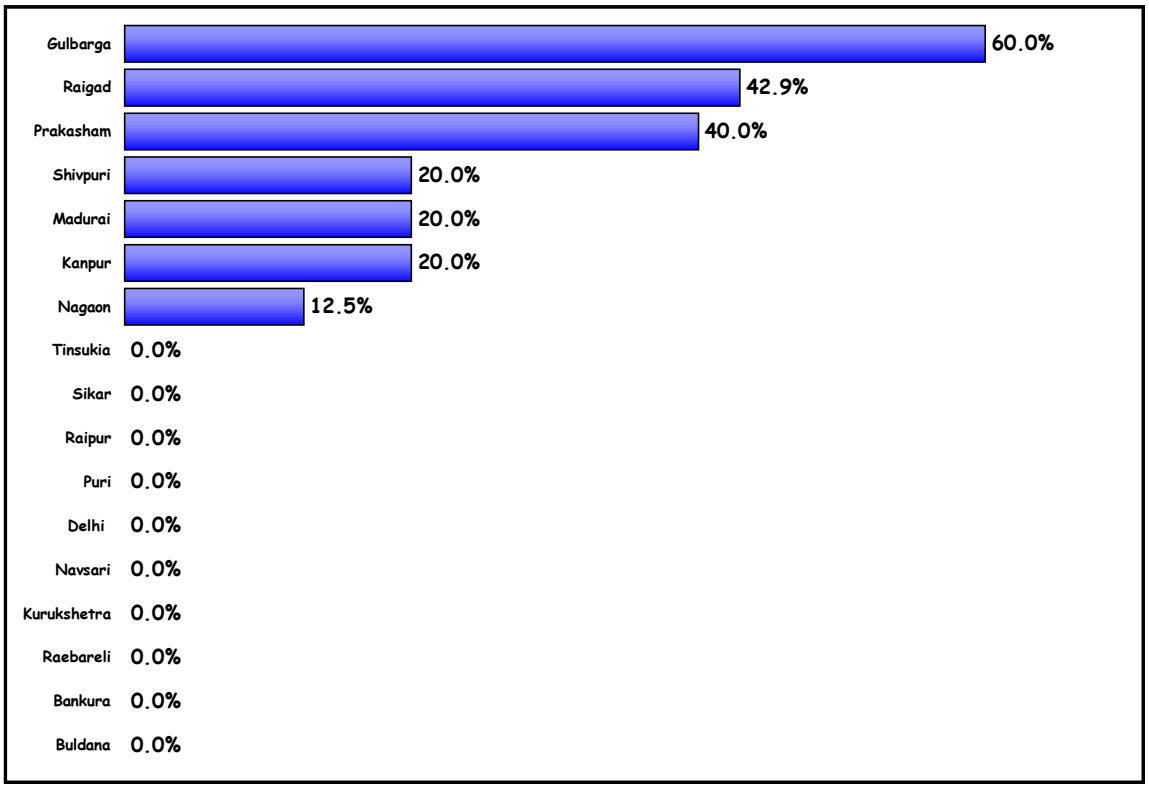
The graph above analyses the average satisfaction level regarding the effectiveness of the training of all the health personnel across all the districts covered in the survey. The respondents were asked to quantify their perception level on a scale of 1 to 5 where 1 refers to "Not Satisfied" and 5 refer to "Very Satisfied".

- The average level of satisfaction of all the health personnel who have undergone training for all the districts has been found to be 4.4 which is on a higher scale approaching "very satisfied".
- The respondents who were found to be having the highest level of satisfaction (5 on scale of 1to 5) were from Delhi, Madurai and Raebareli.
- This is followed by districts Nagaon and Prakasham where average score was estimated to be 4.9 and 4.8 respectively.
- Two of the other districts have attained the score above average level (4.4). They are Gulbarga in Karnataka (4.6) and Raigad in Maharashtra (4.5).
- Rests of the districts, as shown in the graph above have scored below the average. In fact Shivpuri in Madhya Pradesh and Sikar in Rajasthan scored below 4 at 3.6 and 3.7 respectively.

Perception on refresher training

The important component like training of the DMHP staffs which is meant for the capacity building of the personnel become much more effective through conducting the refresher training programs. This not only further enhances the skill of the medical personnel but also equip them to handle the location factors. The graph below displays the status of refresher training in the districts covered under the study.

District wise perception on the refresher training



- Out of 17 districts shown in the above graph, medical personnel in only 7 districts confirmed that they had the refresher training program. This was reported by 60% of the medical personnel contacted in district Gulbarga, followed by over 40% in Raigad (Maharashtra) and Prakasham (Andhra Pradesh). Whereas, in Shivpuri (Madhya Pradesh), Madurai (Tamilnadu) and Kanpur (Uttar Pradesh) around 20% of the respondents underwent refresher training program. Similarly in Nagaon (Assam) only 12.5% had the refresher training program.

Suggestions for improving the training program

Health personnel were asked to recommend their suggestion for improving the training program. Major recommendations have been listed in the table below with respect to various medical personnel.

Recommendations of the health personnel regarding improvements in the training process

		Total	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others
The frequency of trainings should be increased	Count	**86**	21	4	2	9	37	5	6	2
	Col %	**63.2%**	77.8%	50.0%	40.0%	60.0%	78.7%	33.3%	50.0%	28.6%
Simple Language to be used while imparting the trainings	Count	**81**	12	3	2	7	30	11	12	4
	Col %	**59.6%**	44.4%	37.5%	40.0%	46.7%	63.8%	73.3%	100.0%	57.1%
Making the content more simpler with more case studies and examples	Count	**77**	15	4	3	7	30	9	7	2
	Col %	**56.6%**	55.6%	50.0%	60.0%	46.7%	63.8%	60.0%	58.3%	28.6%
Making the IEC materials more customized and specific for each of the districts	Count	**64**	14	3	4	6	26	3	6	2
	Col %	**47.1%**	51.9%	37.5%	80.0%	40.0%	55.3%	20.0%	50.0%	28.6%
The people imparting the training should be more approachable	Count	**54**	12	---	1	6	22	4	7	2
	Col %	**39.7%**	44.4%	---	20.0%	40.0%	46.8%	26.7%	58.3%	28.6%
None	Count	**2**	---	---	---	1	---	1	---	---
	Col %	**1.5%**	---	---	---	6.7%	---	6.7%	---	---
Others*	Count	**10**	2	---	---	1	3	2	---	2
	Col %	**7.4%**	7.4%	---	---	6.7%	6.4%	13.3%	---	28.6%
Total	**Count**	**136**	**27**	**8**	**5**	**15**	**47**	**15**	**12**	**7**
	Col %	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- **Increasing frequency of the training program** was most highly recommended suggestions across all the medical personnel. This was recommended by nearly 4 out of 5 psychiatrists and medical officers contacted during the survey.
- **Training in the simple language** was the other suggestion, recommended by nearly 3 out 5 (59.6%) of the medical personnel. In fact all the ANMS responsible for the sub centre had recommended these suggestions.
- **Making the content simple by using case studies** was recommended by over 56% of the respondents. The percentage was found to be uniform across all the medical personnel. Similarly, **Using district specific customized IEC materials** were also recommended by nearly half of the medical personnel. This was suggested by 4 out 5 (80%) of the psychiatric social workers contacted during the survey. Other suggestions also included such as **"Training should be imparted by experienced medical professionals"**.

Diagnosis and Facilities

In any health system, diagnosis and facilities go hand in hand. There is no denying the fact that for proper diagnosis of any health problems, facilities and infrastructure plays a key role. Diagnosis is much important because it helps to identify the reasons behind the patients' problems. In mental health treatment, counseling is one of the vital components in the diagnosis and treatment process. More importantly, a separate room should always be maintained for diagnosis as it helps maintain privacy for every individual patient and their problems. The DMHP staffs were asked to report one or more of the following mentioned facilities that they avail at their respective destinations.

Facilities at the health center that assist in diagnosis

Districts		Presence of counselor who interacts personally to help in trust building	Separate room for diagnosis	Telephonic assistance from nearest psychiatrist for diagnosis of complex cases	Assistance from visiting Psychiatrist for diagnosis of complex cases	None of the above	Total
Buldana	Row %	71.4%	57.1%	28.6%	71.4%	0.0%	7
Bankura	Row %	50.0%	90.0%	0.0%	40.0%	10.0%	10
Kanpur	Row %	20.0%	50.0%	40.0%	0.0%	0.0%	10
Raebareli	Row %	50.0%	70.0%	0.0%	0.0%	10.0%	10
Kurukshetra	Row %	0.0%	100.0%	0.0%	0.0%	0.0%	3
Nagaon	Row %	37.5%	75.0%	50.0%	25.0%	0.0%	8
Navsari	Row %	0.0%	20.0%	80.0%	70.0%	0.0%	10
Delhi	Row %	66.7%	83.3%	0.0%	50.0%	16.7%	6
Puri	Row %	60.0%	50.0%	10.0%	10.0%	0.0%	10
Raigad	Row %	100.0%	100.0%	85.7%	42.9%	0.0%	7
Raipur	Row %	100.0%	25.0%	50.0%	50.0%	0.0%	4
Shivpuri	Row %	100.0%	40.0%	40.0%	40.0%	0.0%	5
Sikar	Row %	7.1%	35.7%	14.3%	35.7%	50.0%	14
Tinsukia	Row %	0.0%	57.1%	42.9%	28.6%	42.9%	7
Madurai	Row %	60.0%	40.0%	60.0%	60.0%	0.0%	5
Gulbarga	Row %	50.0%	80.0%	0.0%	0.0%	20.0%	10
Prakasham	Row %	100.0%	90.0%	10.0%	40.0%	0.0%	10
Total	Row %	**47.8%**	**61.8%**	**27.9%**	**31.6%**	**11.0%**	**136**

- Overall analysis of the opinion as revealed by the DMHP staff shows that **"maintaining separate room for diagnosis"** is the facility that assists the most in diagnosis. More then 3 out of 5 of the health personnel were found to have reported the same. Nearly half of the entire staffs (47.8%) felt that **"presence of counselors in their center"** can be very helpful as they help in personal interaction and trust building with the patients.
- All the health personnel interviewed in Kurukshetra in Haryana and Raigad in Maharashtra and more than 9 out of 10 in Bankura (West Bengal) and Prakasham (Andhra Pradesh) agreed that **separate room for diagnosis** is the most helpful factor in diagnosis.

- The second highest reported facility reporting the **presence of a counselor for personal interaction** was agreed by every DMHP staffs from Raigad, Raipur in Chhattisgarh, Shivpuri in Madhya Pradesh and Prakasham in Andhra Pradesh.
- The proportion of respondents preferring the facilities like **taking assistance from visiting psychiatrist** or **telephonic assistance from nearest psychiatrist for dealing with complex cases** is on the lower side. In case of Navsari (Gujarat) and Buldana (Maharashtra), 70% preferred the former while another 80% in Navsari reported about the later.

Health personnel perception on drugs

Perception on supply of drugs

As per the guidelines of DMHP, all the beneficiaries are to be provided with medicines free of cost. Like other treatment programmes, the government has always wanted to reduce the burden of increasing out-of-pocket expenses. This has been one of the important mottos, since the DMHP was implemented. The health personnel were asked about their perception and responses on various issues related to the provision of medicines.

The following table shows the responses of the DMHP staffs across the districts regarding the availability of drugs.

Do you have regular inflow of drugs for mental illness?				
Districts		**Yes**	**No**	**Total**
Sikar	Row %	0.0%	100.0%	14
Tinsukia	Row %	0.0%	100.0%	7
Bankura	Row %	10.0%	90.0%	10
Nagaon	Row %	25.0%	75.0%	8
Raebareli	Row %	40.0%	60.0%	10
Puri	Row %	40.0%	60.0%	10
Buldana	Row %	42.9%	57.1%	7
Kanpur	Row %	50.0%	50.0%	10
Kurukshetra	Row %	66.7%	33.3%	3
Raipur	Row %	75.0%	25.0%	4
Navsari	Row %	80.0%	20.0%	10
Shivpuri	Row %	80.0%	20.0%	5
Delhi	Row %	83.3%	16.7%	6
Gulbarga	Row %	90.0%	10.0%	10
Raigad	Row %	100.0%	0.0%	7
Madurai	Row %	100.0%	0.0%	5
Prakasham	Row %	100.0%	0.0%	10
Total	Row %	**52.9%**	**47.1%**	**136**

Regarding the supply of drugs, the DMHP staffs were asked to give their opinion regarding the regular inflow of drugs to their respective centers.

- On an average, more than 1 out of every 2 (52.9%) health personnel, contacted during the survey, confirmed that they do get a regular inflow of drugs.
- All DMHP staffs from the districts of Prakasham (A.P), Madurai (T.N) and Raigad (Mahrashtra), followed by 90% form Gulbarga (Karnataka) reported that there has been a regular inflow of drugs to their hospital.

➢ However, none of the DMHP personnel in Tinsukia in Assam and Sikar in Rajasthan reported that the supply of drug was regular.

Perception on quantity of drugs supplied

After enquiring about the regularities in the supply of drugs, the quantitative aspect in the supplies of drugs were also taken into consideration. The health personnel were henceforth asked to reveal their perception on the quantity of drugs that are being supplied.

Do you think that the supplies of drugs are sufficient?						
Districts		Quiet Sufficient	Sufficient	Not Sufficient	Don't Know	Total
Bankura	Row %	---	10.0%	90.0%		10
Nagaon	Row %	---	12.5%	62.5%	25.0%	8
Tinsukia	Row %	---	14.3%	71.4%	14.3%	7
Raebareli	Row %	---	40.0%	10.0%	50.0%	10
Sikar	Row %	---	28.6%	71.4%	---	14
Raipur	Row %	25.0%	25.0%	50.0%	---	4
Buldana	Row %	14.3%	42.9%	42.9%	---	7
Kurukshetra	Row %	---	66.7%	33.3%	---	3
Shivpuri	Row %	40.0%	40.0%	20.0%	---	5
Navsari	Row %	60.0%	30.0%	10.0%	---	10
Raigad	Row %	71.4%	28.6%	---	---	7
Puri	Row %	50.0%	50.0%	---	---	10
Delhi	Row %	33.3%	66.7%	---	---	6
Kanpur	Row %	20.0%	80.0%	---	---	10
Prakasham	Row %	40.0%	60.0%	---	---	10
Gulbarga	Row %	40.0%	60.0%	---	---	10
Madurai	Row %	100.0%	---	---	---	5
Total	**Row %**	**28.1%**	**39.3%**	**26.7%**	**5.9%**	**136**

➢ Overall 3 out of 5 of the health personnel from all the districts taken together felt that the supplies of drugs are sufficient. In fact 28% had also reported it to be **"quite sufficient".** However, the analysis also reveals that more than one-fourth (26.7%) were of the opinion that the quantity of drug supply to be **"not sufficient"**.

➢ All the DMHP staffs interviewed in the district of Madurai (Tamil Nadu) were of the opinion that the supplies of drugs are **quiet sufficient**. This was followed by Raigad (Maharashtra), where 71.4% of the staffs reported the same.

➢ Supply of drugs was reported to be insufficient, mostly from Bankura (West Bengal), where almost 90% reported the same. This was followed by TInsukia in Assam and Sikar in Rajasthan (71.4% each) and Nagaon in Assam

(62.5%). Insufficient supply was also reported by half the health staffs interviewed in Raipur (Chattisgarh).

Dealing with Shortages in Drug Supply

It had also been intended to know from the health personnel the measures that they generally take and practice whenever they fall in the situation like shortage of drugs.

District wise perception in case of shortage of drugs

Districts		Prescribe the drugs to be purchased by the patient	File requisition for drugs	Ask the patients to wait till drugs arrive	Nothing is done	Others	Total
Buldana	Row %	57.1%	85.7%				**7**
Bankura	Row %	80.0%	80.0%				**10**
Kanpur	Row %	40.0%	60.0%				**10**
Raebareli	Row %	30.0%	40.0%	30.0%	20.0%		**10**
Kurukshetra	Row %	33.3%	33.3%	33.3%			**3**
Nagaon	Row %	62.5%	25.0%	12.5%		12.5%	**8**
Navsari	Row %	50.0%	42.9%			7.1%	**1**
Delhi	Row %	83.3%				16.7%	**6**
Puri	Row %	70.0%	50.0%				**10**
Raigad	Row %	71.4%	14.3%			14.3%	**7**
Raipur	Row %	100.0%	25.0%				**4**
Shivpuri	Row %	40.0%	40.0%	20.0%			**5**
Sikar	Row %	64.3%	7.1%		7.1%	21.4%	**14**
Tinsukia	Row %	85.7%	57.1%			14.3%	**7**
Madurai	Row %		60.0%	40.0%		20.0%	**5**
Gulbarga	Row %		100.0%			30.0%	**10**
Prakasham	Row %	90.0%	90.0%				**10**
Total	**Row %**	**58.1%**	**50.7%**	**5.9%**	**2.2%**	**8.8%**	**136**

- Overall situation shows that close to 58% of the health staffs **"prescribe the drugs to be purchased by the patients from the market"** while another 50% generally **"file requisition for drugs"**.
- The trend of prescription of drugs to be purchased from the market was reported by almost all the medical personnel (100%) in Dist Raipur (Chattisgarh) followed by Dist Prakasham in Andhra Pradesh (90%), Tinsukia in Assam(85.7%), Delhi (83.3%) and Dist Bankura in West Bengal (80%).
- Overall around 6 % of the medical personnel also reported that they usually ask the patient to wait for medicines till they arrive in the hospital. In other words, the patients are not given the medicines instantly showing the time lag between the diagnosis and medication.

- Overall 8.8% have also reported that they take other steps such as procuring medicines from other centers running the DMHP in the same districts or provide the alternate medicines applicable with respect to the illness diagnosed. This trend was found to be highest in Dist Gulbarga in Karnataka (30%), followed by Sikar in Rajasthan (21.4%) and Madurai in Tamil Nadu (20%).

Perception on availability of funds for DMHP

Funds form the most important part in the implementation of any programme. The success and failure of any programme can be attributed to the adequacy and scarcity of funds. With a view to capture the effectiveness of DMHP to its fullest extent, the financing of the programme has also been addressed.

The DMHP staffs were asked to report their perception and opinion regarding the allotment of funds that was sanctioned to their respective venues.

Do you think the funds allocated for your center to implement DMHP are adequate?

Districts		Availability of fund is adequate	Availability of fund is not adequate	Don't know/Can't Say	Total
Buldana	Row %	57.1%		42.9%	**7**
Bankura	Row %		70.0%	30.0%	**10**
Kanpur	Row %			100.0%	**10**
Raebareli	Row %		30.0%	70.0%	**10**
Kurukshetra	Row %			100.0%	**3**
Nagaon	Row %	37.5%	25.0%	37.5%	**8**
Navsari	Row %	50.0%		50.0%	**10**
Delhi	Row %		100.0%		**6**
Puri	Row %	40.0%	60.0%		**10**
Raigad	Row %	42.9%	42.9%	14.3%	**7**
Raipur	Row %	25.0%		75.0%	**4**
Shivpuri	Row %	20.0%	60.0%	20.0%	**5**
Sikar	Row %	14.3%		85.7%	**14**
Tinsukia	Row %		100.0%		**7**
Madurai	Row %	60.0%	0.0%	40.0%	**5**
Gulbarga	Row %	100.0%			**10**
Prakasham	Row %	30.0%		70.0%	**10**
Total	Row %	**28.7%**	**27.2%**	**44.1%**	**136**

- Overall analysis shows that 44% of the health personnel interviewed during the survey had no opinion on the adequacy of fund.

- Rest of the health personnel were almost equally divided on adequate and inadequate of funds allocated for implementing DMHP in a plan period.
- In Delhi and Tinsukia (Assam) all the medical personnel contacted had reported that that the allocated fund was inadequate. In contrast all the medical personnel from Dist Gulbarga in Karnataka reported that the allocated fund was adequate.

Following table shows the designation wise opinion on the allocation of funds for DMHP.

Designation wise views on allocation of funds for DMHP

		Total	Psychiatrist	Clinical Psychologist	Psychiatric Social Worker	Psychiatric Nurse	Medical Officer	Health Worker	ANM	Clerk & Others
Availability of fund is adequate	Count	**39**	8	3	2	5	14	5	2	0
	Col %	**28.7%**	29.6%	37.5%	40.0%	33.3%	29.8%	33.3%	16.7%	0.0%
Availability of fund is not adequate	Count	**37**	11	3	2	2	15	4	0	0
	Col %	**27.2%**	40.7%	37.5%	40.0%	13.3%	31.9%	26.7%	0.0%	0.0%
Don't know/Can't Say	Count	**60**	8	2	1	8	18	6	10	7
	Col %	**44.1%**	29.6%	25.00%	20.0%	53.3%	38.3%	40.0%	83.3%	100.0%
Total	Count	**136**	**27**	**8**	**5**	**15**	**47**	**15**	**12**	**7**
	Col %	**100.00%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0 %**	**100.0%**	**100.0%**	**100.0%**

- Most of the ANMs (83.3%) had no opinion on the funds allocated for implementing the DMHP program.
- Among the Psychiatrists, who were contacted during the course of survey, more than 40% opined that that fund allocated was inadequate. Whereas, around 30% were of the view that the allocated was adequate. However, majority (44.1%) had no opinion.
- Secondly, among the medical officers, who had major responsibilities in CHCs and PHCs, over 30% had opined about the inadequacy of the funds allocated.

Overall perception on the success of DMHP

During the course of interview with Health personnel responsible for implementing DMHP were also recorded in the form of unstructured questions.

Most of the health workers were of the opinion that that mental illness is like any other diseases and that it can be cured with early detection, proper medication and diagnosis and regular follow ups. They also have the knowledge about the stages of severity of mental illness, its causes and treatment. Many of them also pointed about the importance of training component in DMHP which has helped them to learn the right attitude to deal with the patients with politeness and friendliness with the mentally ill people in their area.

Health personnel perception on the community awareness about mental illness revealed that generally people have mixed opinion regarding its curability. Overall the awareness level of the people, as revealed by the health workers, is considered to be average. It is considered very low at the peripheral level but at the urban and semi urban set up the scenario has been improving. This clearly shows that the DMHP, which included diagnosis and treatment of mentally ill people and also creating awareness about mental illness in the community, has been more effective at the District head quarter level but at the ground level which includes the periphery of the district towns as well as the rural areas, the program has yet to see its success.

Perception of Beneficiaries about DMHP

1. Sample Characteristics.

Under the TOR it was decided to cover a sample of 60 beneficiaries/ patients or their family members from each of the district where the DMHP program was running at the time of survey. However, in many cases the team could not meet the sample because of unavailability of requisite number of beneficiaries.

District wise sample

The table below shows the actual city wise and category wise sample achieved during the survey.

District wise actual sample achieved		
Districts	**Sample**	**%**
Bankura, W.B	52	5.4%
Delhi	62	6.5%
Kanpur, U.P	60	6.3%
Kurushetra, Haryana	61	6.4%
Nagaon, Assam	60	6.3%
Navsari, Gujarat	60	6.3%
Puri, Orissa	55	5.7%
Raebareli, U.P	50	5.2%
Raigad, Mah	60	6.3%
Shivpuri, M.P	60	6.3%
Sikar, Rajasthan	32	3.3%
Tinsukia, Assam	60	6.3%
Buldana, Maharashra	63	6.6%
Dhamtari, Chhattisgarh	43	4.5%
Madurai, T.N.	59	6.2%
Gulbarga, Karnataka	60	6.3%
Prakasham, A.P.	60	6.3%
Total	**957**	**100.0%**

A total of 957 respondents (patients) were interviewed during the survey, with the highest in District Buldana (Maharashtra) (63, 6.6%) and lowest in Sikar (Rajasthan) (32, 3.3%). The probable reason for low coverage in Sikar was on account of non operation of DMHP in the district.

Gender wise distribution

District wise Gender wise sample distribution				
Districts		**Female**	**Male**	**Total**
Bankura, W.B	Count	23	29	**52**
	%age	44.2%	55.8%	
Delhi	Count	35	27	**62**
	%age	56.5%	43.5%	
Kanpur, U.P	Count	25	35	**60**
	%age	41.7%	58.3%	
Kurukshetra, Haryana	Count	22	39	**61**
	%age	36.1%	63.9%	
Nagaon, Assam	Count	33	27	**60**
	%age	55.0%	45.0%	
Navsari, Gujarat	Count	32	28	**60**
	%age	53.3%	46.7%	
Puri, Orissa	Count	12	43	**55**
	%age	21.8%	78.2%	
Raebareli, U.P	Count	25	25	**50**
	%age	50.0%	50.0%	
Raigad, Mah	Count	23	37	**60**
	%age	38.3%	61.7%	
Shivpuri, M.P	Count	26	34	**60**
	%age	43.3%	56.7%	
Sikar, Rajasthan	Count	12	20	**32**
	%age	37.5%	62.5%	
Tinsukia, Assam	Count	27	33	**60**
	%age	45.0%	55.0%	
Buldana, Maharashra	Count	25	38	**63**
	%age	39.7%	60.3%	
Dhamtari, Chhattisgarh	Count	17	26	**43**
	%age	39.5%	60.5%	
Madurai, T.N.	Count	21	38	**59**
	%age	35.6%	64.4%	
Gulbarga, Karnataka	Count	26	34	**60**
	%age	43.3%	56.7%	
Prakasham, A.P.	Count	23	37	**60**
	%age	38.3%	61.7%	
Total	**Count**	**407**	**550**	**957**
	%age	**42.5%**	**57.5%**	

- A total of 407 (42.5%) of the achieved sample were female as against 550 (57.5%) male showing a dominance of male beneficiaries/ patient seeking treatment under DMHP.
- Highest percentage of female patients was found in Delhi, 56.5% as against 42.5% at the national level. This was followed by Dist. Nagaon in Assam (55%) and Dist. Navsari in Gujarat (53.3%)

- The lowest percentage of female patients was found in Districts Puri in Orissa (21.8%) followed by Dist. Madurai in Tamil Nadu (35.6%)

Age wise sample

The following table shows the age distribution achieved during the survey.

District wise age wise sample distribution							
Districts	**Up to 15 yrs**	**> 15 - 20 Yrs**	**>20 - 25 yrs**	**> 25 - 35 yrs**	**> 35 - 45 yrs**	**>45 yrs**	**Total**
Bankura, W.B	1.9%	21.2%	7.7%	42.3%	25.0%	1.9%	**52**
Delhi	8.1%	4.8%	11.3%	41.9%	19.4%	14.5%	**62**
Kanpur, U.P	10.0%	11.7%	13.3%	38.3%	13.3%	13.3%	**60**
Kurukshetra, Haryana	3.3%	3.3%	24.6%	27.9%	16.4%	24.6%	**61**
Nagaon, Assam	8.3%	13.3%	15.0%	26.7%	23.3%	13.3%	**60**
Navsari, Gujarat	10.0%	8.3%	13.3%	30.0%	26.7%	11.7%	**60**
Puri, Orissa	21.8%	9.1%	16.4%	27.3%	10.9%	14.5%	**55**
Raebareli, U.P	16.0%	24.0%	8.0%	18.0%	32.0%	2.0%	**50**
Raigad, Maharashtra	8.3%	3.3%	15.0%	28.3%	20.0%	25.0%	**60**
Shivpuri, M.P	3.3%	10.0%	10.0%	25.0%	28.3%	23.3%	**60**
Sikar, Rajasthan	9.4%	9.4%	6.3%	28.1%	31.3%	15.6%	**32**
Tinsukia, Assam	1.7%	8.3%	16.7%	40.0%	26.7%	6.7%	**60**
Buldana, Maharashtra	22.2%	4.8%	14.3%	25.4%	15.9%	17.5%	**63**
Dhamtari, Chhattisgarh	7.0%	9.3%	11.6%	23.3%	25.6%	23.3%	**43**
Madurai, T.N.	1.7%	10.2%	18.6%	25.4%	18.6%	25.4%	**59**
Gulbarga, Karnataka	6.7%	8.3%	11.7%	13.3%	25.0%	35.0%	**60**
Prakasham, A.P.	18.3%	16.7%	20.0%	20.0%	11.7%	13.3%	**60**
Total	**89**	**97**	**135**	**272**	**204**	**160**	**957**
	9.3%	**10.1%**	**14.1%**	**28.4%**	**21.3%**	**16.7%**	

- In the total sample of 957, maximum number of respondents were found in the age group of >25-35 (28.4%) followed by age group of >35-45 (27.9%) and >45 (16.7%)
- However, almost 1 out 10 (9.3%) of patients also belonged in the age group of less than 15 years (9.3%) closely followed 10 – 15 years (10.1%) Therefore almost 1 out 5 was less than 20 years of age.

Civil Status of Beneficiaries

The following table shows the status of respondents/ beneficiaries with respect to their marital status.

District wise sample showing civil status of the beneficiaries/ patients					
Districts	**Single**	**Married**	**Separated/ Divorced**	**Widow (er)**	**Total**
Bankura, W.B	40.4%	59.6%	0.0%	0.0%	**52**
Delhi	37.1%	59.7%	0.0%	3.2%	**62**
Kanpur, U.P	30.0%	70.0%	0.0%	0.0%	**60**
Kurukshetra, Haryana	34.4%	62.3%	3.3%	0.0%	**61**
Nagaon, Assam	63.3%	18.3%	18.3%	0.0%	**60**
Navsari, Gujarat	38.3%	56.7%	0.0%	5.0%	**60**
Puri, Orissa	52.7%	45.5%	0.0%	1.8%	**55**
Raebareli, U.P	46.0%	54.0%	0.0%	0.0%	**50**
Raigad, Mah	46.7%	50.0%	0.0%	3.3%	**60**
Shivpuri, M.P	21.7%	71.7%	0.0%	6.7%	**60**
Sikar, Rajasthan	34.4%	65.6%	0.0%	0.0%	**32**
Tinsukia, Assam	36.7%	56.7%	6.7%	0.0%	**60**
Buldana, Maharashtra	50.8%	38.1%	7.9%	3.2%	**63**
Dhamtari, Chhattisgarh	30.2%	60.5%	7.0%	2.3%	**43**
Madurai, T.N.	33.9%	61.0%	3.4%	1.7%	**59**
Gulbarga, Karnataka	33.3%	56.7%	1.7%	8.3%	**60**
Prakasham, A.P.	61.7%	36.7%	0.0%	1.7%	**60**
Total	**392**	**515**	**28**	**22**	**957**
	41.0%	**53.8%**	**2.9%**	**2.3%**	

- In the total sample of 957, more than half (53.8%) of the patients were found to be married. Whereas, over 2 out of 5 (41%) were unmarried.
- Around 3% of the beneficiaries were divorcees and other 2.3% were widow(er)
- Maximum percentage of married patients/ beneficiaries was found in district of Shivpuri in Madhya Pradesh, closely followed by Dist Kanpur in Uttar Pradesh and Dist. Sikar in Rajasthan.
- Whereas, highest percentage of patients who were single were found in Dist Nagaon in Assam (63.3%), closely followed by Prakasham in Andhra Pradesh (61.7%) and Puri in Orissa (52.7%).

Education Status of Beneficiaries

The following table shows the status of respondents/ beneficiaries with respect to their education level.

District wise sample showing education status of beneficiaries/ patients								
		Under-graduate	Graduate	Post Graduate	Prof. Qualifi-cation	Class X and below	Illite-rate	Total
Bankura, W.B	%age	51.9%	48.1%	0.0%	0.0%	0.0%	0.0%	**52**
Delhi	%age	22.6%	4.8%	1.6%	0.0%	54.8%	16.1%	**62**
Kanpur, U.P	%age	75.0%	15.0%	8.3%	1.7%	0.0%	0.0%	**60**
Kurukshetra, Haryana	%age	50.8%	14.8%	4.9%	0.0%	13.1%	16.4%	**61**
Nagaon, Assam	%age	98.3%	1.7%	0.0%	0.0%	0.0%	0.0%	**60**
Navsari, Gujarat	%age	36.7%	1.7%	0.0%	0.0%	26.7%	35.0%	**60**
Puri, Orissa	%age	92.7%	7.3%	0.0%	0.0%	0.0%	0.0%	**55**
Raebareli, U.P	%age	10.0%	0.0%	0.0%	2.0%	68.0%	20.0%	**50**
Raigad, Mah	%age	95.0%	1.7%	0.0%	0.0%	0.0%	3.3%	**60**
Shivpuri, M.P	%age	11.7%	8.3%	11.7%	3.3%	36.7%	28.3%	**60**
Sikar, Rajasthan	%age	0.0%	6.3%	6.3%	0.0%	43.8%	43.8%	**32**
Tinsukia, Assam	%age	73.3%	26.7%	0.0%	0.0%	0.0%	0.0%	**60**
Buldana, Maharashtra	%age	82.5%	7.9%	0.0%	1.6%	7.9%	0.0%	**63**
Dhamtari, Chhattisgarh	%age	58.1%	7.0%	4.7%	0.0%	18.6%	11.6%	**43**
Madurai, T.N.	%age	8.5%	6.8%	0.0%	3.4%	69.5%	11.9%	**59**
Gulbarga, Karnataka	%age	98.3%	1.7%	0.0%	0.0%	0.0%	0.0%	**60**
Prakasham, A.P.	%age	61.7%	35.0%	3.3%	0.0%	0.0%	0.0%	**60**
Total	**Count**	**540**	**110**	**22**	**7**	**182**	**96**	**957**
	%age	**56.4%**	**11.5%**	**2.3%**	**0.7%**	**19.0%**	**10.0%**	

- More than half (56.4%) of the patients were found to be undergraduate. Whereas, nearly 2 out of 5 (19%) had attended schools but below class X and other 10% were illiterates.
- Over 1 out of 10 (11.5%) were graduates and 2.3% were found to be post graduates. Altogether 7 (0.7%) were also professionally qualified. Most of these professionally qualified came from Madurai in Tamil Nadu (3.4%) and Shivpuri in Madhya Pradesh (3.3%).

Family size of Beneficiaries

The table below shows the number of family members in the house where the patients/ beneficiaries stay.

District wise sample with respect to number of family members of beneficiaries				
	less than 3	3-5	More than 5	Total Count
Bankura, W.B	0.0%	25.5%	65.5%	52
Delhi	4.8%	54.0%	42.0%	62
Kanpur, U.P	6.6%	70.0%	23.4%	60
Kurukshetra, Haryana	6.6%	35.1%	61.7%	61
Nagaon, Assam	1.7%	37.6%	53.2%	60
Navsari, Gujarat	5.0%	71.7%	23.3%	60
Puri, Orissa	9.1%	65.1%	23.8%	55
Raebareli, U.P	4.0%	53.5%	32.6%	50
Raigad, Mah	6.7%	77.9%	8.5%	60
Shivpuri, M.P	3.3%	39.9%	55.0%	60
Sikar, Rajasthan	9.4%	73.4%	20.0%	32
Tinsukia, Assam	5.0%	71.7%	23.3%	60
Buldana, Maharashtra	11.1%	60.9%	32.7%	63
Dhamtari, Chhattisgarh	14.0%	0.0%	0.0%	43
Madurai, T.N.	13.6%	0.0%	0.0%	59
Gulbarga, Karnataka	5.0%	32.7%	0.0%	60
Prakasham, A.P.	6.7%	0.0%	0.0%	60
Total	**62** **6.5%**	**582** **60.8%**	**313** **32.7%**	**957**

- The analysis shows that majority of patients/ beneficiaries were staying in the family with 3 to 5 members (60.8%). This was found to be highest in the case of Dist Raigad in Maharashtra (77.9%), followed by Dist Sikar in Rajasthan (73.4%) and Dist Navsari in Gujarat (71.7%).
- Overall nearly 3 out 10 (32.7%) beneficiaries were staying with family size of more than 5 members. This trend was found highest in Dist Bankura, in West Bengal, reported by over 65% of respondents. This was followed by Dist of Kurukshetra in Haryana (61.7%) and Dist Shivpuri in Madhya Pradesh (55%)
- Only 6.5% of beneficiaries contacted had a family size of less than 3 members. This was reported highest in the case of Dist Dhamtari in Chhattisgarh (14%), followed by Dist Madurai in Tamil Nadu (13.6%) and Dist Buldana in Maharashtra (11.1%).

Perception on Services

Service Provision - First point of contact with Medical Institutions

Under DMHP, the each of the districts were supposed to train medical personnel at CHC, PHC and Sub centre level so that they can treat the mentally ill people in their Area. The main objective was to bring the medical services for mentally ill people at their door step. The other main objective of the DMHP was to reduce the pressure on the mental health hospitals for treating basic level of mental illness such as Neurosis.

Following table shows the provision of services by the health institutions.

First point of contact with the medical institutions							
	Sub centre	PHC	CHC	Dist Hosp	Mental Hosp	Others	Total
Bankura, W.B		2.1%		97.9%			52
Delhi			3.2%	46.8%	50.0%		62
Kanpur, U.P	11.9%	22.0%	1.7%	62.7%	1.7%		60
Kurukshetra, Haryana			1.6%	98.4%			61
Nagaon, Assam		1.7%	11.7%	81.7%		5.0%	60
Navsari, Gujarat		5.0%	10.0%	80.0%	3.3%	1.7%	60
Puri, Orissa	9.3%	7.4%	27.8%	53.7%	1.9%		55
Raebareli, U.P	8.2%	24.5%	28.6%	30.6%		8.2%	50
Raigad, Maharashtra		8.3%	1.7%	73.3%	16.7%		60
Shivpuri, M.P		1.7%	6.7%	75.0%	13.3%	3.3%	60
Sikar, Rajasthan		15.6%	28.1%	56.3%			32
Tinsukia, Assam		13.3%	5.0%	80.0%	1.7%		60
Buldana, Maharashtra	3.4%	8.6%	6.9%	53.4%	25.9%	1.7%	63
Dhamtari, Chhattisgarh						100.0%	43
Madurai, T.N.				63.6%	4.5%	31.8%	59
Gulbarga, Karnataka	12.3%	38.6%	35.1%		8.8%	5.3%	60
Prakasham, A.P.	11.7%	31.7%	38.3%	16.7%	1.7%		60
Total	**35**	**110**	**122**	**581**	**84**	**25**	**957**
	3.7%	**11.5%**	**12.7%**	**60.7%**	**8.8%**	**2.5%**	

- The table above shows that out of 957 beneficiaries contacted, around 9% were still directly availing their services, as first point of contact from the Mental hospitals. The trend was found to be highest in the case of Delhi, where one out of two patients (50%) contacted directly approached the

mental hospitals for getting their treatment. The possible reasons could be availability of a mental hospital and their accessibility for the people staying in the Delhi DMHP districts – Jahangirpuri and Chattarpur. Delhi is the only case where grant allocated during 9th plan period was utilised for two districts, rather than one. Delhi was followed by Buldana in Maharashtra, where out of 55 patients/ beneficiaries contacted over one out of four (25.9%) directly accesses the mental hospitals.

- Overall analysis shows that 3 out 5 patients (60.7%) had accessed the District hospitals as their first point of contact. Whereas, in the case of CHCs (12.7%) and PHCs (11.5%), percentages of patients accessing these institutes were found to be low. Further, this was found to be very low in the case of Sub Centres (3.7%).
- Therefore, the main objectives of DMHP for providing the services to the mentally ill people at the ground level are found to be low. This requires a comprehensive analysis in terms of provision of services and training to the medical personnel at the CHC, PHC and especially at the sub centre level.

Diagnosis – Illness diagnosed by the medical professional

The tables below shows the kind of mental illness diagnosed and conveyed to the patients or their family members during their first contact with the medical institutions/ professionals. It should be noted here that in many cases the patients were unaware of the illness they are suffering. ICMR research team had to make efforts in translating the symptoms or the illness in to the medical terminology. Most of the patients were aware about their illness in the local vernacular language. Based on the broad categories of mental illness, the beneficiaries are distributed in to the categories such as Neurosis (Depression, Anxiety, Hysteria), Psychosis (Acute, Recurrent and Chronic), Epilepsy, Mental Retardness and Addiction (Alcohol and Drugs)

District wise illness diagnosed by the medical professional							
	Neurosis	Psychosis	Epilepsy	Mental Retardness	Addiction	couldn't say	Total
Bankura, W.B	69.2%	30.8%					52
Delhi	83.9%		17.7%				62
Kanpur, U.P	51.7%	16.7%	11.7%	10.0%	3.3%	6.7%	60
Kurukshetra, Haryana	45.9%	29.5%	14.8%	9.8%			61
Nagaon, Assam	36.7%	56.7%	5.0%	1.7%	6.7%		60
Navsari, Gujarat	56.7%	16.7%	25.0%	3.3%			60
Puri, Orissa	54.5%	20.0%	0.0%	10.9%	10.9%	3.6%	55
Raebareli, U.P	46.0%	14.0%	20.0%	4.0%	18.0%		50
Raigad, Maharashtra	36.7%	30.0%	18.3%	8.3%		6.7%	60
Shivpuri, M.P	46.7%	5.0%	8.3%	11.7%	3.3%	25.0%	60
Sikar, Rajasthan	21.9%	15.6%	18.8%	6.3%	9.4%	28.1%	32
Tinsukia, Assam	31.7%	51.7%	8.3%		8.3%		60
Buldana, Maharashtra	30.2%	22.2%	12.7%	27.0%	6.3%	9.5%	63
Dhamtari, Chhattisgarh	60.5%	30.2%	2.3%		7.0%		43
Madurai, T.N.	71.2%	15.3%			11.9%	1.7%	59
Gulbarga, Karnataka	48.3%	18.3%	18.3%	11.7%	3.3%		60
Prakasham, A.P.	55.0%	28.3%	8.3%	8.3%			60
Total	481	227	107	66	47	42	**957**
	50.3%	**23.7%**	**11.2%**	**6.9%**	**4.9%**	**4.4%**	

Note: Sum may no add because of multiple illnesses diagnosed and conveyed to the patients.

- Overall analysis shows that half (50.3%) of the patients were diagnosed as Neurotic. This was found to be highest in Delhi where 85% of the patients contacted had been diagnosed as neurotic. This was followed by Maduari in Tamilnadu (71.2%) and closely followed by Bankura in West Bengal (69.2%).
- Around one-fourth (23.7%) of the beneficiaries/ patients contacted were suffering from Psychosis which was found be highest in the case of Dist Nagaon and TInsukia, both in Assam, where nearly 51-56% of patients were suffering from this disease. In Delhi none of patient contacted was found be psychotic. The possible reason could that psychotic patient could be directly accessing Mental Hospital and could not be found during the survey.
- Overall around 11% were found to be epileptic. This was found to be highest in the dist of Navsari in Gujarat, reported by almost 25% of the patients contacted. This was followed by Raebareli in Uttar Pradesh (20%).
- In Shivpuri (Madhya Pradesh) and Sikar (Rajasthan), in more than 25% of cases, the nature if mental illness could not be ascertained.

Communication with Doctor

One of the aims of the current study was to understand the level of consciousness of the beneficiaries or their family members with respect to their satisfaction level on the interaction with the doctor. This is only possible though the communication with the doctor. Therefore, the patients and their family members were asked as whether the diagnosis was clearly explained or not. This is clearly shown with the help of the following table:

Was the diagnosis clearly explained?				
	Not at all	Somewhat explained	Clearly explained	Total Count
Bankura, W.B	9.60%	61.50%	28.80%	52
Buldana, Maharashtra	1.60%	22.20%	76.20%	63
Delhi	3.20%	14.50%	82.30%	62
Dhamtari, Chhattisgarh	72.10%	18.60%	9.30%	43
Gulbarga, Karnataka	6.70%	20.00%	73.30%	60
Kanpur, U.P	1.70%	8.30%	90.00%	60
Kurukshetra, Haryana	4.90%	85.20%	9.80%	61
Madurai, T.N.	6.80%	6.80%	86.40%	59
Nagaon, Assam	3.30%	85.00%	11.70%	60
Navsari, Gujarat	1.70%	15.00%	83.30%	60
Prakasham, A.P.	15.00%	61.70%	23.30%	60
Puri, Orissa	10.90%	61.80%	27.30%	55
Raebareli, U.P	32.00%	42.00%	26.00%	50
Raigad, Maharashtra	13.30%	61.70%	25.00%	60
Sikar, Rajasthan	31.30%	40.60%	28.10%	32
Shivpuri, M.P		73.30%	26.70%	60
Tinsukia, Assam		55.00%	45.00%	60
Total	**103**	**415**	**439**	**957**
	10.80%	**43.40%**	**45.90%**	

- Overall 90% of the patients were of the opinion that diagnosis was explained to them. Nearly 46% reported that it was clearly explained whereas, 43.4% were of the opinion that it was somewhat explained. In Kanpur, 90% of the patients reported that it was clearly explained.
- Nearly 11% of the patients or their family members also reported that the diagnosis was not al all explained to them. This was reported to be highest in the case of Dist Dhamtari in Chhattisgarh, where over 7 out of 10 respondents reported the same, followed by Raebareli in Uttar Pradesh (32%).

Treatment with respect and dignity

The following tables show the attitude of doctor with the patient.

Did the medical professional treated with respect and dignity				
	Yes, Definitely	Yes, to some extent	No	Total
Dhamtari, Chhattisgarh	20.9%	74.4%	4.7%	43
Raebareli, U.P	24.0%	62.0%	14.0%	50
Sikar, Rajasthan	43.8%	34.4%	21.9%	32
Prakasham, A.P.	50.0%	50.0%		60
Bankura, W.B	59.6%	40.4%		52
Shivpuri, M.P	66.7%	33.3%		60
Tinsukia, Assam	70.0%	28.3%	1.7%	60
Raigad, Maharashtra	80.0%	20.0%		60
Puri, Orissa	85.5%	14.5%		55
Buldana, Maharashtra	85.7%	14.3%		63
Nagaon, Assam	90.0%	10.0%		60
Navsari, Gujarat	90.0%	10.0%		60
Delhi	90.3%	9.7%		62
Gulbarga, Karnataka	91.7%	8.3%		60
Kanpur, U.P	98.3%	1.7%		60
Kurukshetra, Haryana	98.4%	1.6%		61
Madurai, T.N.	100.0%			59
Total	**724** **75.7%**	**216** **22.6%**	**16** **1.8%**	**957**

- Overall 3 out of the 4 patients (75.7%) reported that definitely they were treated with respect and dignity. Other 22.6% were of the opinion that to some extent doctor treated then with respect and dignity. Only 1.8% disagreed with this and majority of them were from Sikar in Rajasthan (21.9%) followed by Raebareli in Uttar Pradesh.

Perception on time given by medical professionals/ doctors

Satisfaction with the treatment received also depends on the time given to the patients for discussing the illness during the treatment. Based on the time spent with patient, the quality of treatment is determined especially in the case of mentally ill patient. The following table evaluates the perception of patients or their family members on the time given by the medical professionals.

Were you given enough time to discuss your condition and treatment?				
	Yes , definitely	Yes, to some extent	No	Total Count
Bankura, W.B	21.2%	75.0%	3.8%	52
Buldana, Maharashtra	79.4%	19.0%	1.6%	63
Delhi	82.3%	17.7%		62
Dhamtari, Chhattisgarh	18.6%	65.1%	16.3%	43
Gulbarga, Karnataka	90.0%	10.0%		60
Kanpur, U.P	100.0%			60
Kurukshetra, Haryana	100.0%			61
Madurai, T.N.	94.9%	1.7%	3.4%	59
Nagaon, Assam	95.0%	5.0%		60
Navsari, Gujarat	91.7%	8.3%		60
Prakasham, A.P.	33.3%	65.0%	1.7%	60
Puri, Orissa	32.7%	67.3%		55
Raebareli, U.P	38.0%	52.0%	10.0%	50
Raigad, Mah	83.3%	16.7%		60
Sikar, Rajasthan	34.4%	28.1%	37.5%	32
Shivpuri, M.P	40.0%	46.7%	13.3%	60
Tinsukia, Assam	70.0%	30.0%		60
Total	**67.6%**	**28.4%**	**4.0%**	**957**

- Overall 67.6% reported that medical professional definitely given enough time during the treatment to discuss the patients' conditions. Other 28.4% also agreed to this to some extent. Only 4% denied such experience. This was found to be highest with the patients in Sikar, Rajasthan where more than one-third (37.5%) reported that that they were not given enough time for discussing their conditions.

Trust and confidence on medical personnel

All the beneficiaries were asked about their trust and confidence with the medical personnel who treated them during the initial level of their treatment. This is shown in the table below.

Patients/ beneficiaries trust and confidence with the medical personnel				
	Yes , definitely	Yes, to some extent	No	Total
Bankura, W.B	69.2%	30.8%		52
Buldana, Maharashtra	79.4%	19.0%	1.6%	63
Delhi	79.0%	21.0%		62
Dhamtari, Chhattisgarh	20.9%	72.1%	7.0%	43
Gulbarga, Karnataka	96.7%	3.3%		60
Kanpur, U.P	100.0%			60
Kurukshetra, Haryana	95.1%	4.9%		61
Madurai, T.N.	98.3%		1.7%	59
Nagaon, Assam	93.3%	6.7%		60
Navsari, Gujarat	91.7%	8.3%		60
Prakasham, A.P.	43.3%	56.7%		60
Puri, Orissa	56.4%	41.8%	1.8%	55
Raebareli, U.P	36.0%	62.0%	2.0%	50
Raigad, Maharashtra	83.3%	16.7%		60
Sikar, Rajasthan	28.1%	46.9%	25.0%	32
Shivpuri, M.P	50.0%	48.3%	1.7%	60
Tinsukia, Assam	73.3%	23.3%	3.3%	60
Total	**72.8%**	**25.3%**	**1.9%**	**957**

- Overall 72.8% reported that they had full trust and confidence with the medical personnel who treated and other 25.3% had trust and confidence to some extent. Around 2% could not build any trust and confidence with the medical personnel. In Sikar (Rajasthan), however, 25% reported their dissatisfaction as far as trust and confidence with medical personnel is concerned.

Provision of medicines

Under the DMHP, all the beneficiaries treated by the medical institutions are provided free medicines, depending upon the nature of mental illness. All the beneficiaries who were contacted during the course of survey were asked questions related to provision of medicines.

The following table shows the responses of beneficiaries or their family members with respect to provision of medicines.

Were you provided medicines during the treatment			
District	**Yes**	**No**	**Total**
Kurukshetra, Haryana	27.9%	72.1%	61
Dhamtari, Chhattisgarh	34.9%	65.1%	43
Tinsukia, Assam	78.3%	21.7%	60
Raebareli, U.P	82.0%	18.0%	50
Bankura, W.B	84.6%	15.4%	52
Delhi	88.7%	11.3%	62
Puri, Orissa	90.9%	9.1%	55
Kanpur, U.P	91.7%	8.3%	60
Prakasham, A.P.	93.3%	6.7%	60
Nagaon, Assam	95.0%	5.0%	60
Madurai, T.N.	96.6%	3.4%	59
Raigad, Maharashtra	96.7%	3.3%	60
Shivpuri, M.P	96.7%	3.3%	60
Buldana, Maharashtra	96.8%	3.2%	63
Navsari, Gujarat	98.3%	1.7%	60
Gulbarga, Karnataka	98.3%	1.7%	60
Sikar, Rajasthan	100.0%	0.0%	32
Total	**821**	**136**	**957**
	85.8%	**14.2%**	

- Overall 85.8% reported that received the medicines from the medical personnel responsible for treating their mental illness. This was reported by all the 32 beneficiaries contacted in Dist Sikar, Rajasthan.
- However, over 7 out of 10 (72.1%) respondents from Dist. Kurukshetra in Haryana reported that they were not provided medicines by the medical personnel who treated. Most of the time they had to buy medicines from the market. This aspect was also corroborated by the medical personnel that since most of the time the medicines are not available due to delay in the supply therefore patients are advised to buy medicines from the market. This trend was also found to be prevalent in Dist Dhamtari (Chhattisgarh) where 65% of the respondents reported the same.

Explaining purpose of medicines

The respondents were also asked whether they were explained the purpose of medication. This can be gauged from the following table.

Were the purpose of medication explained				
	Yes, clearly	Yes to some extent	No	Total
Bankura, W.B	15.4%	80.8%	3.8%	52
Delhi	67.7%	29.0%	3.2%	62
Kanpur, U.P	38.3%	21.7%	40.0%	60
Kurukshetra, Haryana	1.6%	90.2%	8.2%	61
Nagaon, Assam	61.7%	36.7%	1.7%	60
Navsari, Gujarat	91.7%	8.3%		60
Puri, Orissa	40.0%	60.0%		55
Raebareli, U.P	26.0%	4.0%	70.0%	50
Raigad, Mah	35.0%	53.3%	11.7%	60
Shivpuri, M.P	26.7%	68.3%	5.0%	60
Sikar, Rajasthan	6.3%	21.9%	71.9%	32
Tinsukia, Assam	43.3%	35.0%	21.7%	60
Buldana, Maharashtra	73.0%	14.3%	12.7%	63
Dhamtari, Chhattisgarh	2.3%	20.9%	76.7%	43
Madurai, T.N.	93.2%	1.7%	5.1%	59
Gulbarga, Karnataka	95.0%	5.0%		60
Prakasham, A.P.	51.7%	41.7%	6.7%	60
Total	**456**	**338**	**163**	**957**
	47.6%	**35.3%**	**17.0%**	

- More than 4 out of 5 (83%) patients or their family members confirmed that purpose of medication was explained to the. 47.6% reported that it was clearly explained whereas, 35.3% reported that it was explained to some extent.
- However, there were 17% of respondents who reported that the purpose of medication was not at all explained to them. This was found to be highest among the respondents from Dist Dhamtari in Chhattisgarh, followed by Dist Sikar in Rajasthan and Raebareli in Uttar Pradesh where 7 out of 10 respondents reported the same.

Communication about side effects of medicines

Under the parameters on communication with doctors or the medical personnel at Sub-centres, PHCs, CHCs and District Hospitals, the patients were also asked whether at the time of medication prescribed to them, the possible side effects of medicines were communicated them. This is shown in the following table.

Were you told about the possible side effects of the medications?				
	Yes, clearly	Yes to some extent	No	Total
Sikar, Rajasthan		3.1%	96.9%	32
Dhamtari, Chhattisgarh	2.3%	18.6%	79.1%	43
Bankura, W.B	3.8%	46.2%	50.0%	52
Kurukshetra, Haryana	4.9%	86.9%	8.2%	61
Shivpuri, M.P	5.0%	46.7%	48.3%	60
Madurai, T.N.	10.9%	7.3%	81.8%	55
Nagaon, Assam	11.7%	51.7%	36.7%	60
Kanpur, U.P	18.3%	5.0%	76.7%	60
Raebareli, U.P	20.0%		80.0%	50
Raigad, Maharashtra	20.0%	53.3%	26.7%	60
Prakasham, A.P.	31.7%	41.7%	26.7%	60
Tinsukia, Assam	36.7%	30.0%	33.3%	60
Gulbarga, Karnataka	57.1%	19.0%	23.8%	21
Delhi	59.7%	37.1%	3.2%	62
Buldana, Maharashtra	63.5%	15.9%	20.6%	63
Puri, Orissa	69.1%	27.3%	3.6%	55
Navsari, Gujarat	90.0%	8.3%	1.7%	60
Total	**277**	**284**	**353**	**914**
	30.3%	**31.1%**	**38.6%**	

- Overall 61.4% confirmed that the possible side effects of the medicines were explained to them. However, nearly 2 out of 5 (38.6%) reported that the side effects of the medications were not explained to them. This was found to be highest in Dist Sikar of Rajasthan where almost all (96.9%) reported the same, followed by Dhamtari in Chattisgarh (79.1%) and Kanpur in Uttar Pradesh (76.7%).

Provision of counselling services

Under the District Mental Health Program, there is provision of providing counselling service to the mentally ill people. In order to provide this service, DMHP has a provision of appointment of Clinical Psychologist whose purpose is to assist the patient and their family members in managing emotional psychological distress in order to enhance the treatment method.

The following table shows the perception of beneficiaries with rest to availing of counselling service.

Have you ever taken counseling session from the hospitals you were referred?			
Districts	**Yes**	**No**	**Total**
Kanpur, U.P		100.0%	60
Shivpuri, M.P		100.0%	60
Tinsukia, Assam		100.0%	60
Gulbarga, Karnataka		100.0%	60
Sikar, Rajasthan	3.1%	96.9%	32
Nagaon, Assam	3.3%	96.7%	60
Navsari, Gujarat	3.3%	96.7%	60
Delhi	11.3%	88.7%	62
Kurukshetra, Haryana	11.5%	88.5%	61
Dhamtari, Chhattisgarh	14.0%	86.0%	43
Raebareli, U.P	16.0%	84.0%	50
Prakasham, A.P.	20.0%	80.0%	60
Raigad, Maharashtra	45.0%	55.0%	60
Puri, Orissa	49.1%	50.9%	55
Buldana, Maharashtra	58.7%	41.3%	63
Bankura, W.B	65.4%	34.6%	52
Madurai, T.N.	93.2%	6.8%	59
Total	**225**	**732**	**957**
	23.5%	**76.5%**	

- Out of 957 respondents (patients and family members) contacted only one-fourth contacted confirmed that counselling was provided to them. This was found to highest in Madurai in Tamil Nadu where more than 9 out of 10 confirmed this. In four of the districts (Kanpur, Shivpuri, TInsukia and Gulbarga), none of the patients confirmed of being provided this service.

Accessibility and Cost of availing treatment

In order the estimate the cost of availing treatment by the mentally ill people, it was decided to estimate the distance covered by them to seek treatment and average amount of money they had to spend during visit to the medical institutions covered under the DMHP. The following table shows the distance in km they had to travel each time to meet the doctor/ medical personnel treating them.

Range of distance traveled to seek treatment							
	up to 5 km	>5-10 km	>10 - 25	>25 - 50	>50 - 100 Km	>100 km	Total Count
Bankura, West Bengal	30.8%	11.5%	23.1%	32.7%	1.9%		52
Delhi	64.5%	25.8%	4.8%	4.8%			62
Kanpur, Uttar Pradesh	41.7%	25.0%	26.7%	5.0%	1.7%		60
Kurukshetra, Haryana	21.3%	44.3%	21.3%	9.8%	3.3%		61
Nagaon, Assam	83.3%	6.7%		5.0%	5.0%		60
Navsari, Gujarat	13.3%	26.7%	48.3%	8.3%	3.3%		60
Puri, Orissa	14.5%	18.2%	49.1%	18.2%			55
Raebareli, Uttar Pradesh	88.0%	6.0%	2.0%	4.0%			50
Raigad, Maharashtra	56.7%	6.7%	13.3%	6.7%	3.3%	13.3%	60
Shivpuri, Madhya Pradesh	48.3%	16.7%	6.7%	16.7%	1.7%	10.0%	60
Sikar, Rajasthan	46.9%	9.4%	15.6%	12.5%	6.3%	9.4%	32
Tinsukia, Assam	20.0%	15.0%	20.0%	28.3%	5.0%	11.7%	60
Buldana, Maharashtra	58.7%	6.3%	17.5%	7.9%	3.2%	6.3%	63
Dhamtari, Chhattisgarh	46.5%	11.6%	11.6%	7.0%	14.0%	9.3%	43
Madurai, Tamil Nadu	27.1%	11.9%	16.9%	20.3%	15.3%	8.5%	59
Gulbarga, Karnataka	98.3%		1.7%				60
Prakasham, Andhra Pradesh	10.0%	6.7%	20.0%	25.0%	23.3%	15.0%	60
Total	**45.1%**	**14.9%**	**17.7%**	**12.4%**	**5.0%**	**4.8%**	**957**

- Majority of the respondents (45.1%) reported that they had to travel up to 5 km for availing the services. This was reported almost by all the respondents (98.3%) in Dist Gulbarga, followed by Raebareli in Uttar Pradesh (88%) and Nagaon in Assam (83.3%).
- Nearly 18% (17.7% also reported that they had to travel more than 10 to 25 km. This was found to be highest in the case of Puri in Orissa where nearly half of the respondents (49.1%) reported the same, closely followed by Dist Navsari in Gujarat (48.3%).
- Other 15% had reported the distance to be more than 5 to 10 km, followed by 12.4% who reported more than 25 to 50 km.

- The analysis also shows than 1 out of 10 had also reported that they had to travel more than 50 km to avail the services. Further 4.8% had reported the distance to be more than 100 km. This was mainly reported from Prakasham in Andhra Pradesh, Raigad in Maharashtra, Tinsukia in Assam and Shivpuri in Madhya Pradesh.

The table below shows the average amount spent every time to avail the services.

Average amount spent in order to reach to the hospital					
Districts	**Mean**	**N**	**Minimum**	**Std. Deviation**	**Maximum**
Bankura, W.B	41.0	52	15	17.43	60
Delhi	40.1	62	25	19.28	150
Kanpur, U.P	30.9	60	20	16.03	130
Kurukshetra, Haryana	58.7	61	20	44.52	200
Nagaon, Assam	44.8	60	20	23.82	150
Navsari, Gujarat	28.3	60	13	21.01	160
Puri, Orissa	25.8	55	20	4.76	35
Raebareli, U.P	25.4	50	15	6.26	40
Raigad, Maharashtra	32.5	60	10	33.22	150
Shivpuri, M.P	56.8	60	25	50.11	250
Sikar, Rajasthan	71.7	32	22	70.98	250
Tinsukia, Assam	34.4	60	15	20.89	100
Buldana, Maharashtra	47.0	63	15	48.48	250
Dhamtari, Chhattisgarh	41.5	43	15	39.22	200
Madurai, T.N.	90.3	55	20	74.20	250
Gulbarga, Karnataka	47.0	21	22	48.19	250
Prakasham, A.P.	37.6	60	12	34.95	250
Total	**43.5**	**914**	**10**	**40.54**	**250**

- The analysis shows that a patient has to spend nearly Rs 45 (Rs 43.5), with minimum Rs 10 to maximum Rs 250, to access the service provided under DMHP. This covers only the cost of travel to the hospital, which depends upon the distance of the hospital.
- This minimum average cost was found in the Dist of Raebareli in Uttar Pradesh (Rs 25.40) and Maximum average cost was estimated to be in the Dist of Madurai in Tamil Nadu.

Frequency of visit to the hospitals

The following table shows the number of visits made to the hospitals by the beneficiaries for availing services such as treatment and medicines.

How many times you visit the hospital to seek treatment?					
	Once in a Month	Twice in a Month	Once in 2 months	Once in 3 months	Total
Kurukshetra, Haryana	1.6%	91.8%	6.6%		61
Nagaon, Assam	15.0%	1.7%	41.7%	41.7%	60
Prakasham, A.P.	16.7%	76.7%	6.7%		60
Kanpur, U.P	25.0%	70.0%	5.0%		60
Shivpuri, M.P	25.0%	75.0%			60
Sikar, Rajasthan	25.0%	15.6%	15.6%	43.8%	32
Puri, Orissa	29.1%	58.2%	12.7%		55
Bankura, W.B	30.8%	21.2%	34.6%	13.5%	52
Dhamtari, Chhattisgarh	39.5%	48.8%		11.6%	43
Raebareli, U.P	44.0%	48.0%	4.0%	4.0%	50
Tinsukia, Assam	50.0%	10.0%	30.0%	10.0%	60
Gulbarga, Karnataka	71.4%	19.0%	4.8%	4.8%	21
Raigad, Maharashtra	71.7%	13.3%	11.7%	3.3%	60
Buldana, Maharashtra	82.5%	4.8%	3.2%	9.5%	63
Madurai, T.N.	89.1%	5.5%		5.5%	55
Delhi	98.4%	1.6%			62
Navsari, Gujarat	100.0%				60
Total	**439**	**308**	**96**	**71**	**914**
	48.0%	**33.7%**	**10.5%**	**7.8%**	

- Majority of patients (48%) reported that they visited once in month for treatment. In Navsari (Gujarat) this was reported by all the patients or their family contacted during the survey. However, in Kurukshetra (Haryana) more than 9 out of 10 patients reported that they visited twice in a month to the hospitals. Frequency of visit to the hospitals were found to be lowest in Dist Nagaon (Assam), where most of the patients were either visiting once in 2 months or once in 3 months (reported by 41.7% each).
- Most of the patients (over 82%) confirmed that they meet the same Psychiatrists or doctors during their visits to the hospitals. Few patients (nearly 1 out of 5) also reported that sometime doctors or not available when they visit the hospital on a date of appointment given or the days when doctors/ psychiatrists are supposed to visit.

- **Referral Services**

There are many patients who have been referred to higher level of medical institutions for their further treatment.

Were you referred to some other hospital for higher level of treatment?			
District	**Yes**	**No**	**Total**
Bankura, W.B	1.9%	98.1%	52
Navsari, Gujarat	5.0%	95.0%	60
Kanpur, U.P	11.7%	88.3%	60
Nagaon, Assam	13.3%	86.7%	60
Tinsukia, Assam	18.3%	81.7%	60
Buldana, Maharashtra	27.0%	73.0%	63
Raigad, Maharashtra	28.3%	71.7%	60
Raebareli, U.P	34.0%	66.0%	50
Prakasham, A.P.	40.0%	60.0%	60
Sikar, Rajasthan	46.9%	53.1%	32
Delhi	51.6%	48.4%	62
Puri, Orissa	52.7%	47.3%	55
Kurukshetra, Haryana		100.0%	61
Shivpuri, M.P		100.0%	60
Dhamtari, Chhattisgarh		100.0%	43
Madurai, T.N.		100.0%	59
Gulbarga, Karnataka		100.0%	60
Total	**181**	**776**	**957**
	18.8%	**81.2%**	

- Overall 181 (18.8%) of the total 957 respondents interviewed during the survey confirmed that that they were referred for higher level of treatment. This was found to be highest in Dist Puri in Orissa followed by Delhi where more than 50% of the patients were referred to higher level for their treatment.

We also tried to analyse the movement from one level of institution to other level where these patients were referred for their treatment. This is shown in the table below.

Referral Service: From first point of treatment to the institutions where the patient were referred										
Districts	**ANM to PHC**	**ANM to CHC**	**ANM to DH**	**PHC to CHC**	**PHC to District hospital**	**CHC to District hospital**	**CHC to Mental hospital**	**District hospital to Mental hospital**	**District hospital to district hospital**	**Total**
Bankura, W.B	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1
Delhi	6.3%	0.0%	0.0%	3.1%	0.0%	15.6%	25.0%	31.3%	18.8%	32
Kanpur, U.P	14.3%	0.0%	28.6%	0.0%	28.6%	0.0%	14.3%	0.0%	14.3%	7
Nagaon, Assam	0.0%	0.0%	0.0%	0.0%	12.5%	87.5%	0.0%	0.0%	0.0%	8
Navsari, Gujarat	33.3%	0.0%	0.0%	33.3%	33.3%	0.0%	0.0%	0.0%	0.0%	3
Puri, Orissa	0.0%	3.4%	13.8%	0.0%	20.7%	62.1%	0.0%	0.0%	0.0%	29
Raebareli, U.P	0.0%	0.0%	17.6%	0.0%	41.2%	41.2%	0.0%	0.0%	0.0%	17
Raigad, Maharashtra	0.0%	0.0%	0.0%	5.9%	23.5%	5.9%	0.0%	17.6%	47.1%	17
Sikar, Rajasthan	0.0%	0.0%	0.0%	0.0%	20.0%	53.3%	6.7%	0.0%	20.0%	15
Tinsukia, Assam	0.0%	0.0%	0.0%	0.0%	72.7%	27.3%	0.0%	0.0%	0.0%	11
Buldana, Maharashtra	11.8%	11.8%	0.0%	0.0%	0.0%	41.2%	0.0%	5.9%	29.4%	17
Prakasham, A.P.	4.2%	0.0%	25.0%	4.2%	25.0%	25.0%	0.0%	8.3%	8.3%	24
Total	**4.4%**	**1.7%**	**8.3%**	**2.2%**	**21.0%**	**34.3%**	**5.5%**	**8.8%**	**13.8%**	**181**

- The analysis shows that the maximum referral has been from CHCs to District Hospital, as this was reported by 34.3% of the beneficiaries who were referred to other hospitals. It also shows that 21% of the patients were referred from PHCs to District Hospital.
- Further, 14.3% of the patients were referred to Mental hospitals; 5.5% from CHCs and 8.8% from District Hospitals.
- Nearly 14% of the patients were also referred from District Hospital to other District Hospitals. This may be because of better services in the hospitals of other districts.

Overall trust on doctors/ psychiatrists and satisfaction on different aspects of communication with them

Beneficiaries or their family members were asked to rank on satisfaction derived on various aspects of interaction with the doctors who treated the patients and finally also rank on the overall trust with the doctors. The scale of ranking was on 1 to 10 where 1 denotes as "not satisfied at all" and 10 shows the absolute trust/ satisfaction. The mean derived at the district level was further put on a range of scale and converted in symbols. This is displayed in the table below:

Overall trust and satisfaction on interaction with psychiatrist/ doctor.

Districts	**Overall trust on the doctor**	Treating with courtesy and respect	Listening your concerns carefully	Explaining things in way you could understand	Meeting as and when required	Explaining need and role of medicines prescribed	Explaining probable complications	Giving assurance for future help	Transparent communication with the family members
Madurai, T.N.	▦	┼/■	┼/■	┼/■	┼	┼	┼/■	┼/■	┼
Raigad, Maharashtra	▦	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	▦	▦
Bankura, W.B	┼/■	┼	┼	□/┼	□/┼	□	┼	┼	┼
Tinsukia, Assam	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■
Buldana, Maharashtra	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■
Delhi	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	┼/■	□/┼	┼
Gulbarga, Karnataka	┼/■	┼/■	┼/■	┼/■	┼	┼/■	┼	┼	┼
Kanpur, U.P	┼	▦	▦	┼	□/┼	□/┼	□	□	□
Navsari, Gujarat	┼	┼/■	┼/■	┼	┼	┼	┼	┼	┼
Nagaon, Assam	┼	┼	┼	┼	┼	┼	┼	┼	┼
Kurukshetra, Haryana	┼	▦	▦	┼/■	●/—	—	┼	┼/■	┼/■
Raebareli, U.P	┼	┼	┼	┼	┼	┼	□/┼	┼	┼
Dhamtari, Chhattisgarh	□/┼	□/┼	□/┼	□/┼	□/┼	—	-/□	□	□
Shivpuri, M.P	□/┼	□/┼	□/┼	□/┼	□	□	□/┼	□/┼	□/┼
Puri, Orissa	□/┼	□/┼	□/┼	□/┼	□/┼	□/┼	□	□/┼	□
Sikar, Rajasthan	□	□	□	-/□	□	—	—	-/□	-/□
Prakasham, A.P.	-/□	□	□	-/□	-/□	-/□	—	-/□	-/□

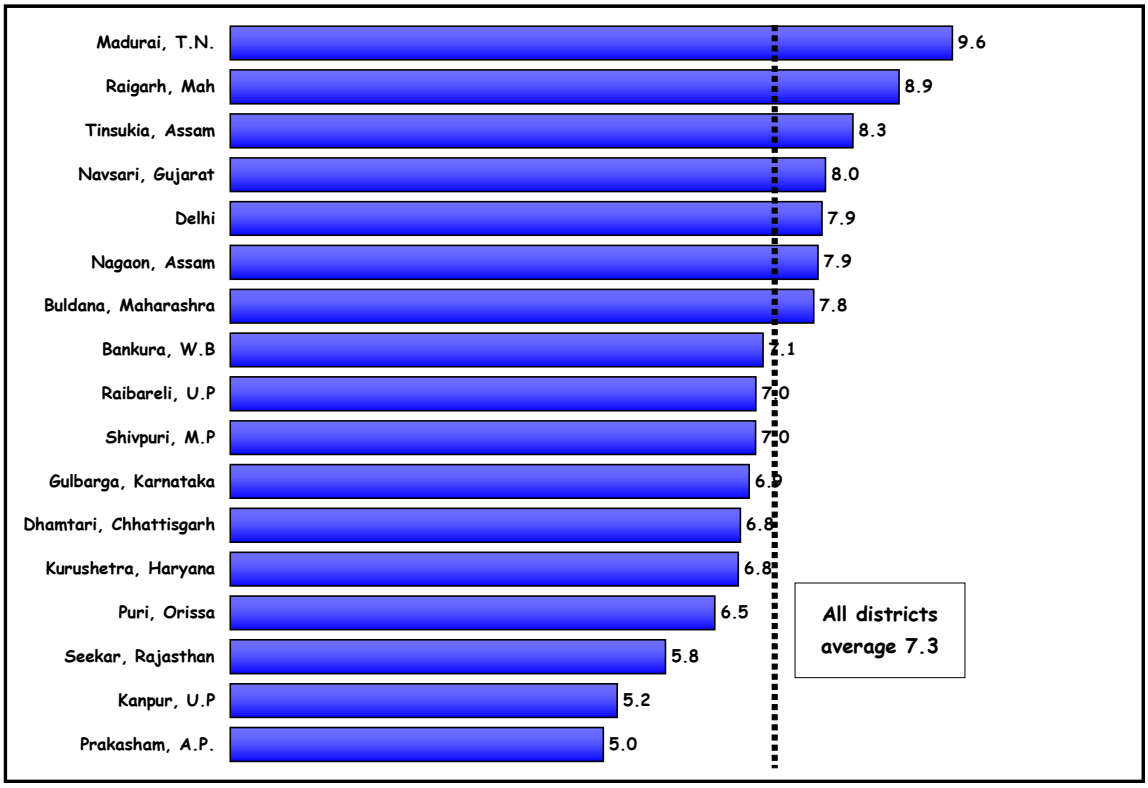
Scale											
1-1.99	●●	2-2.99	●/—	3-3.99	—	4-4.99	-/□	5-5.99	□	6-6.99	□/┼
7-7.99	┼	8-8.99	┼/■	9-10	▦						

- The respondents from Madurai (Tamil Nadu) and Raigad (Maharashtra) assigned highest ranking (9-10) to the overall trust with doctors. However, in Madurai, two of the aspects were ranked lower (7-7.99) they were – "Meeting as and when required" and "Explaining need and role of medicines prescribed or given" On most of the other aspects, respondents in these districts two have ranked between 8-9.
- In five of other districts, the respondents have given ranks between 8-8.99 on overall trust with the doctors, who treated them. These districts are – Bankura (West Bengal), Tinsukia (Assam), Buldana (Maharashtra), Delhi (Chhattarpur and Jehangirpuri) and Gulbarga (Karnataka). However, in Gulbarga (Karnataka), the scoring on four of the aspects were between 7-7.99. These aspects are (i) Meeting as and when required (ii) explaining probable complications, (iii) giving assurance for future help and (iv) Transparent communication with family members.
- The lowest score on overall trust with doctors were attained by Dist Prakasham in Andhra Pradesh (4-4.99) followed by Dist Sikar in Rajasthan (5-5.99).

Overall satisfaction with the quality of service provided under DMHP

Beneficiaries or their family members were asked to rank the on the overall satisfaction they achieved through the DMHP services provided in their districts especially with respect to the treatment they are availing. The scale of ranking was 1 to 10 where 1 denotes as "not satisfied at all" and 10 shows the overall satisfaction.

Overall satisfaction with the treatment availed under DMHP



- The average score was estimated to be 7.3 on a scale of 1-10.
- District Madurai in Tamil Nadu attained the highest score at 9.6 as far as services under the DMHP are concerned
- Madurai was followed by Raigarh in Maharashtra (8.9), Tinsukia in Assam (8.3) and Navsari in Gujarat (8.0).
- Three other districts attained scores above average – they were Delhi and Nagaon, Assam (7.9 each) and Buldana, Maharashtra (7.8).
- All the other districts attained below average score.

Community awareness and perception on mental illness

Under the DMHP, a major component consists of spreading awareness in the community about the mental illness and its cure. It is a general belief that the community perception about the mental illness is devoid of scientific approach and considered as the handiwork of ill spirit and black magic. Mentally ill people are generally considered as harmful and therefore are ill-treated both at family and community level.

District Wise Sample

Under the TOR of the study, it was decided to gauge the community perception about the mental illness and the effectiveness of DMHP's IEC program at the community level. In order to make the study more viable it was decided to cover the DMHP and Non DMHP districts where the perception on various parameters derived from non DMHP districts would be considered as control variable for measuring the effectiveness of program in the DMHP districts. A sample of 30 community members per district was taken to their perception on mental illness. In the case of DMHP district sample was selected from in and around the institutions where DMHP is (being) implemented.Whereas, in the case of non DMHP districts, sample was selected from in and around the district headquarters.

The following table shows the district was distribution in the case of DMHP and non DMHP districts.

District wise sample achieved	
DMHP Districts	**Sample**
Delhi	20
Kanpur (UP)	23
Raebareli(UP)	25
Kurukshetra (Haryana)	29
Dhamtari (Chhattisgarh)	30
Puri (Orissa)	30
Navsari (Gujarat)	30
Sikar (Rajasthan)	30
Raigad	30
Buldana (Maharashtra)	30
Shivpuri (MP)	30
Nagaon (Assam)	30
Tinsukia (Assam)	30
Bankura (West Bengal)	30
Madurai (T.N)	30
Gulbarga (Kar)	30
Prakasham (A.P)	30
Total, all DMHP districts	**487**

The table above shows that in the case of the 4 districts – Delhi (Dist. South and North-west), Kanpur and Raibreli (Uttar Pradesh), and Kurushetra (Haryana) sample achieved has been less than 30. This is because the responses of few respondents were not considered significant (proper) or sample could not be met.

Non DMHP Districts	
District	**Sample**
Bijnore (UP)	30
Ballabgarh (Haryana)	30
Bhivadi (Rajasthan)	30
Thane (Maharashtra)	30
North 24 Parganas (West Bengal)	30
Total, non DMHP districts	**150**

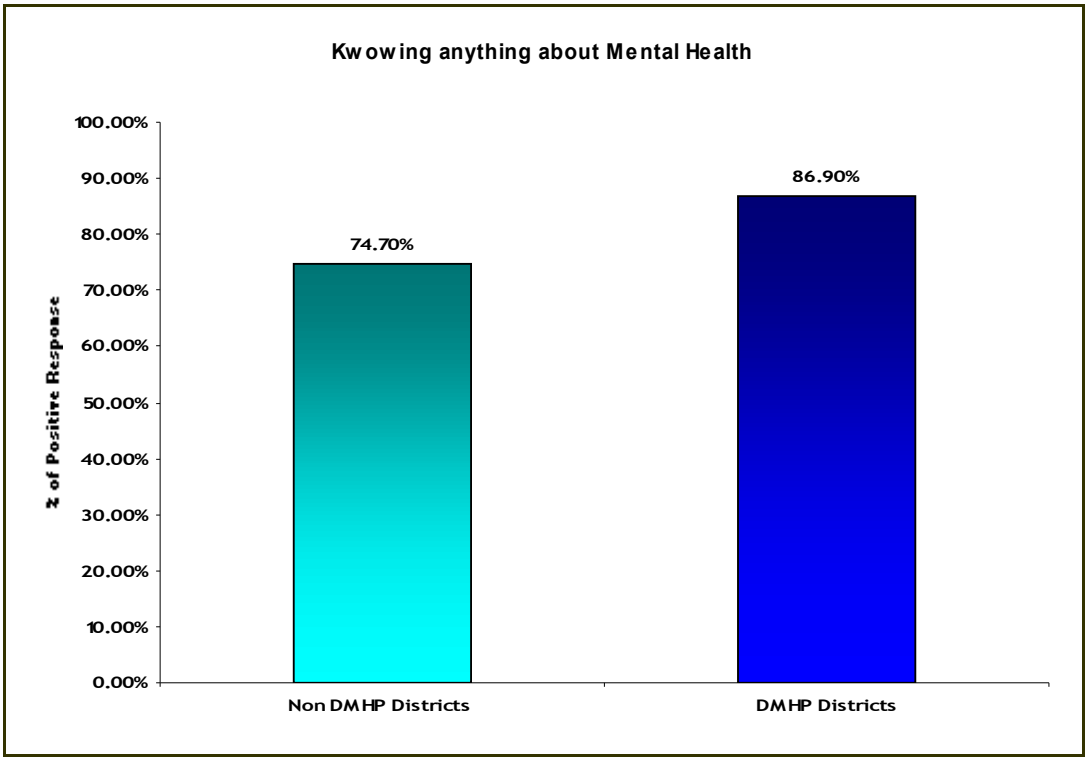
The table above also shows that 5 Non DMHP districts – Bijnore in UP, Ballabgarh in Haryana, Bhivadi in Rajasthan and North 24 Parganas in West Bengal - were selected for considering their average results as control variable for measuring the perception in DMHP districts.

Community awareness about the mental illness

In order to gauge the awareness level of community about illness the respondents were asked whether they know anything or have heard about mental illness. The investigators sometimes used the local colloquial language to get the responses from the members of community. It was tried not to use the negative local terms but community members were sometime referred to the symptoms associated with mental illness. Secondly, the perception was taken at two stages – (i) asking the members of community in a group and

secondly through conducting household survey. Both the methods were applied to meet the desired sample for each districts covered during the survey.

The outcome with respect to DMHP and average of Non DMHP has been shown in the table and graphs below.

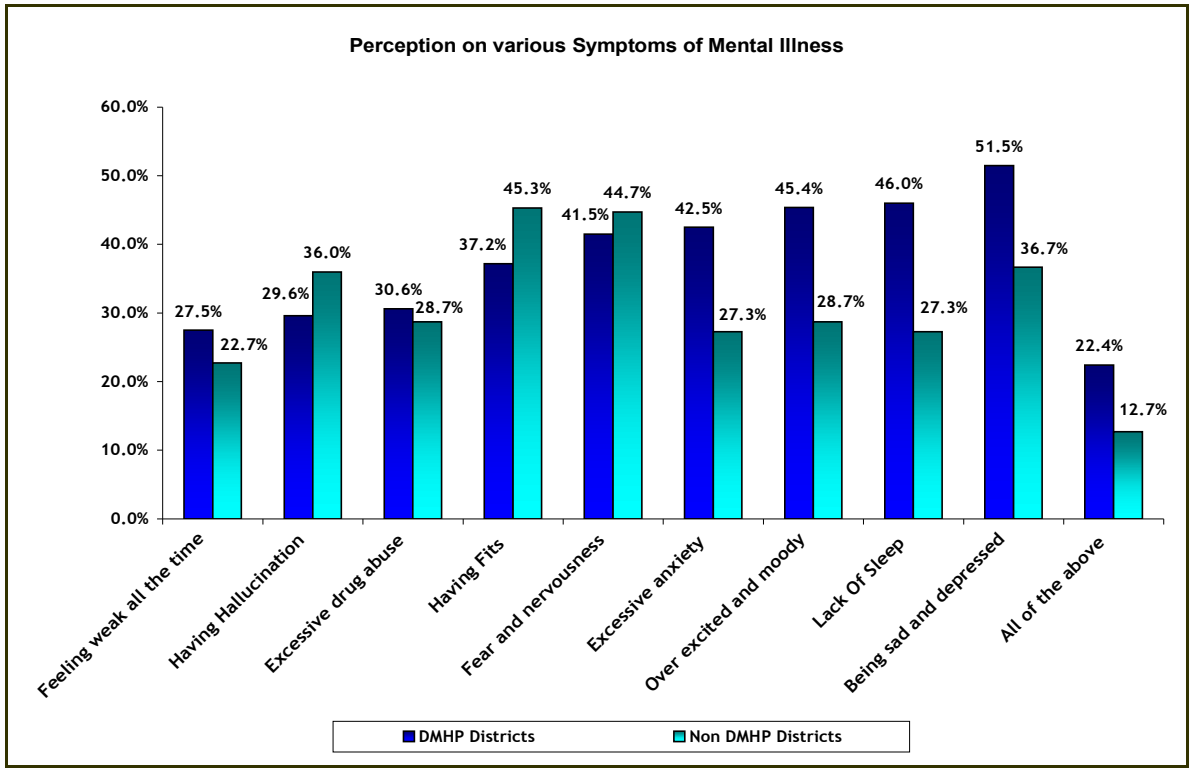


Do you know anything about mental illness			
District	**Yes**	**No**	**Total**
Delhi	100.0%	0.0%	**30**
Raebareli(UP)	100.0%	0.0%	**30**
Puri (Orissa)	100.0%	0.0%	**30**
Navsari (Gujarat)	100.0%	0.0%	**30**
Madurai (T.N)	100.0%	0.0%	**20**
Gulbarga (Kar)	100.0%	0.0%	**25**
Buldana (Maharashtra)	96.7%	3.3%	**30**
Bankura (West Bengal)	90.0%	10.0%	**30**
Kurukshetra (Haryana)	87.0%	13.0%	**23**
Raigad	83.3%	16.7%	**30**
Nagaon (Assam)	83.3%	16.7%	**30**
Tinsukia (Assam)	83.3%	16.7%	**30**
Prakasham (A.P)	82.8%	17.2%	**29**
Sikar (Rajasthan)	76.7%	23.3%	**30**
Dhamtari (Chhattisgarh)	73.3%	26.7%	**30**
Shivpuri (MP)	73.3%	26.7%	**30**
Kanpur (UP)	53.3%	46.7%	**30**
Total DMHP Districts	**86.90%**	**13.10%**	***487***
Non DMHP districts average	***74.7%***	***25.3%***	***150***

- The graph and corresponding table below shows that in the case of DMHP districts 86.9% of the community member contacted during the survey knew about mental illness. In other it could be termed as they were aware about mental illness. This was higher than the 74.7%, which is the average level of awareness found in the Non-DMHP districts.
- District wise analysis shows that awareness level was found to be low as compared to non-DMHP districts' average in the case of three districts – Dhamtari in Chhattisgarh and Shivpuri in Madhya Pradesh (73.3% each) and Kanpur (53.3%).
- In the case of four districts, all the community members contacted were aware about mental illness or they had heard about mental illness. They are Delhi (South and North-West districts), Raebareli in Uttar Pradesh, Puri in Orissa, Navsari in Gujarat, Madurai in Tamil Nadu and Gulbarga in Karnataka.

Community awareness on the symptoms of mental illness

Mental illness is associated with various symptoms in the behaviors of mentally ill people. Therefore, community members who knew something about the mental illness were asked about the various symptoms they knew which shows that person is mentally ill. This variation in the perception between the community members from the DMHP and Non-DMHP districts is shown in the graph and corresponding table below.

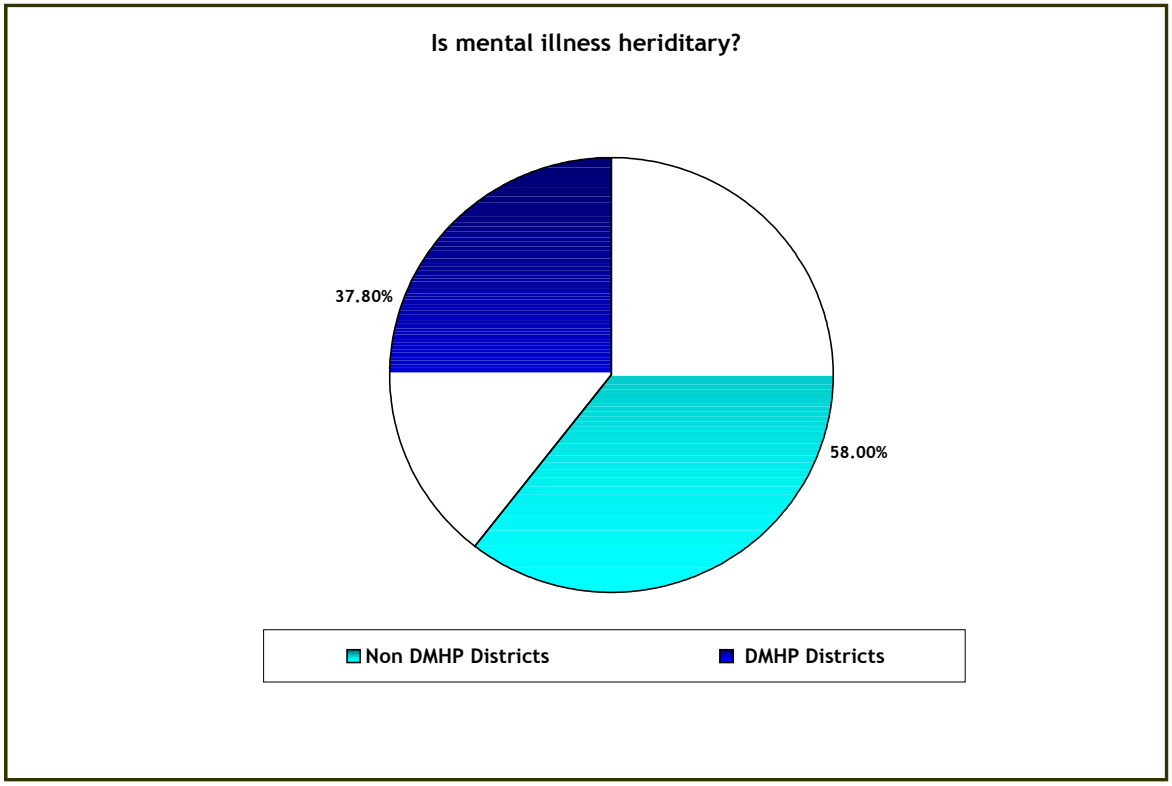


According to you what are the symptoms of Mental illness?

	DMHP districts	Non DMHP districts	Significance level
Feeling weak all the time	27.5%	22.7%	Significant
Having Hallucination	29.6%	36.0%	Significant
Excessive drug abuse	30.6%	28.7%	Non-Significant
Having Fits	37.2%	45.3%	Significant
Fear and nervousness	41.5%	44.7%	Significant
Excessive anxiety	42.5%	27.3%	Significant
Over excited and moody	45.4%	28.7%	Significant
Lack Of Sleep	46.0%	27.3%	Significant
Being sad and depressed	51.5%	36.7%	Significant
All of the above	22.4%	12.7%	Significant
Total	**423**	**112**	

- 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 (moody) (41.4%).
- The analysis also reveals some remarkable variations in responses from DMHP and Non-DMHP districts. In the case of Non-DMHP districts, the percentages of responses in the case of symptoms such as **"Hallucinations", "Fits" and even "Fear and nervousness"** was found to be higher than the DMHP districts. This clearly points out that in the lack of awareness program, which is being initiated in the DMHP districts; community members in non DMHP districts have the tendency to associate the symptoms with the traditional or conservative aspects. Although the difference in the percentage is not highly significant, one can still make out or indicate the impact of the DMHP in the districts where it is being implemented.

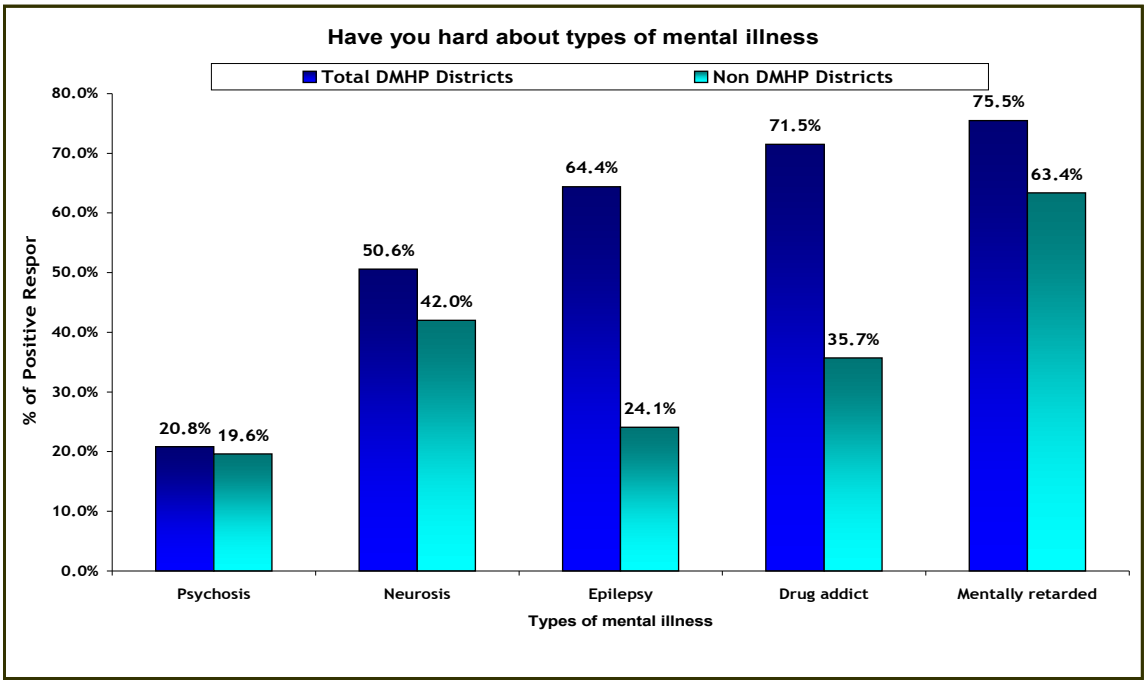
The respondents were also asked about their views on whether the mental illness is hereditary. The responses of the community members are shown in the table below.



Is Mental Illness hereditary?			
Districts	**Yes**	**No**	**Total**
Bankura (West Bengal)	11.1%	88.9%	25
Gulbarga (Kar)	12.0%	88.0%	25
Madurai (T.N)	20.0%	80.0%	30
Delhi	26.7%	73.3%	20
Dhamtari (Chhattisgarh)	27.3%	72.7%	25
Prakasham (A.P)	29.2%	70.8%	20
Navsari (Gujarat)	30.0%	70.0%	22
Shivpuri (MP)	31.8%	68.2%	23
Raigad	32.0%	68.0%	25
Raebareli(UP)	36.7%	63.3%	22
Buldana (Maharashtra)	48.3%	51.7%	30
Kanpur (UP)	50.0%	50.0%	30
Tinsukia (Assam)	52.0%	48.0%	16
Puri (Orissa)	53.3%	46.7%	30
Kurukshetra (Haryana)	60.0%	40.0%	27
Nagaon (Assam)	60.0%	40.0%	29
Sikar (Rajasthan)	65.2%	34.8%	24
Total DMHP Districts	**37.8%**	**62.2%**	**423**
Non DMHP districts average	***58.0%***	***42.0%***	***112***

- The table above shows that in the case of DMHP districts 62.2% of the community members consider mental illness to be hereditary. This was much higher than the 42%, which is the average response found in the non-DMHP districts.
- District wise analysis shows that awareness level was found to be low as compared to non-DMHP districts' average in the case of three districts – Sikar in Rajasthan (34.8%), Nagaon in Assam and Kurukshetra in Haryana (40% each).
- Highest number of respondents who considered that mental illness is not hereditary were found in the case of District Bankura in West Bengal(88.9%) followed by Gulbarga in Karnataka (88%) and Madurai in Tamil Nadu (80%).

Community awareness about types of mental illness



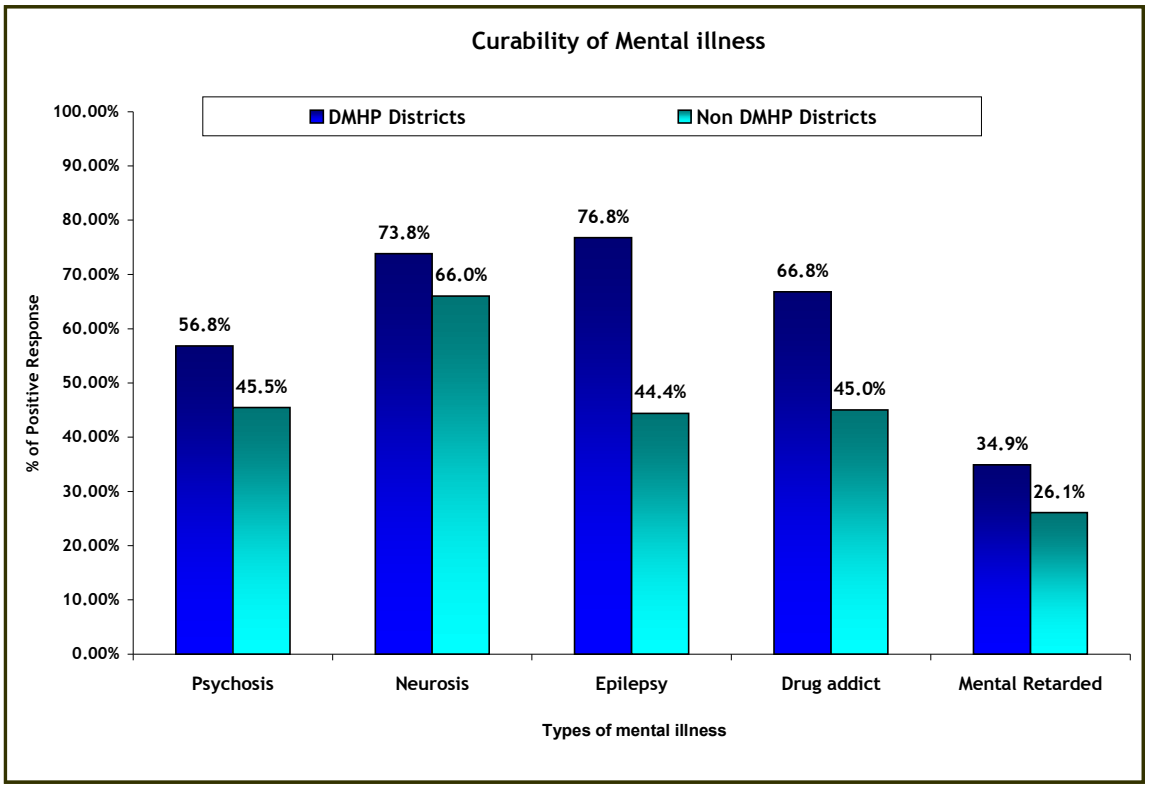
Have you heard about following types of mental illness?						
	Psychosis	**Neurosis**	**Epilepsy**	**Drug abuse**	**Mentally retard**	**All**
Delhi	26.7%	56.7%	90.0%	83.3%	56.7%	30
Kanpur (UP)	31.3%	62.5%	31.3%	87.5%	93.8%	16
Raebareli(UP)	13.3%	50.0%	96.7%	86.7%	100.0%	30
Kurukshetra (Haryana)	30.0%	50.0%	40.0%	10.0%	35.0%	20
Dhamtari (Chhattisgarh)	27.3%	50.0%	86.4%	100.0%	95.5%	22
Puri (Orissa)	16.7%	53.3%	56.7%	46.7%	66.7%	30
Navsari (Gujarat)	23.3%	53.3%	73.3%	80.0%	86.7%	30
Sikar (Rajasthan)	17.4%	43.5%	65.2%	56.5%	73.9%	23
Raigad (Maharashtra)	12.0%	60.0%	92.0%	96.0%	96.0%	25
Buldana (Maharashtra)	34.5%	34.5%	75.9%	86.2%	69.0%	29
Shivpuri (MP)	22.7%	31.8%	27.3%	72.7%	100.0%	22
Nagaon (Assam)	16.0%	68.0%	32.0%	76.0%	44.0%	25
Tinsukia (Assam)	12.0%	44.0%	40.0%	56.0%	96.0%	25
Bankura (West Bengal)	11.1%	37.0%	96.3%	55.6%	100.0%	27
Madurai (T.N)	30.0%	65.0%	44.4%	77.8%	38.9%	20
Gulbarga (Karnataka)	16.0%	40.0%	92.0%	80.0%	76.0%	25
Prakasham (A.P)	20.8%	66.7%	12.5%	58.3%	45.8%	24
Total DMHP Districts	**20.8%**	**50.6%**	**64.4%**	**71.5%**	**75.5%**	**423**
Non DMHP districts average	**19.6%**	**42.0%**	**24.1%**	**35.7%**	**63.4%**	**112**
Significant Level	**Non-significant**	Significant	Significant	Significant	Significant	
Sum may no add due to multiple response						

The respondents were asked bout the types of mental illness they were aware of. Majority of respondents were aware of mentally retardness followed by drug addiction and epilepsy.

The analysis shows that awareness about the types of mental illness were found to be higher in the case of DMHP districts as compared to non-DMHP districts. Secondly, respondents were less aware about psychosis as compared to other illness such as mentall retardness, neuroses, epilepsy and drug addiction.

Community perception about the curability of mentally ill people

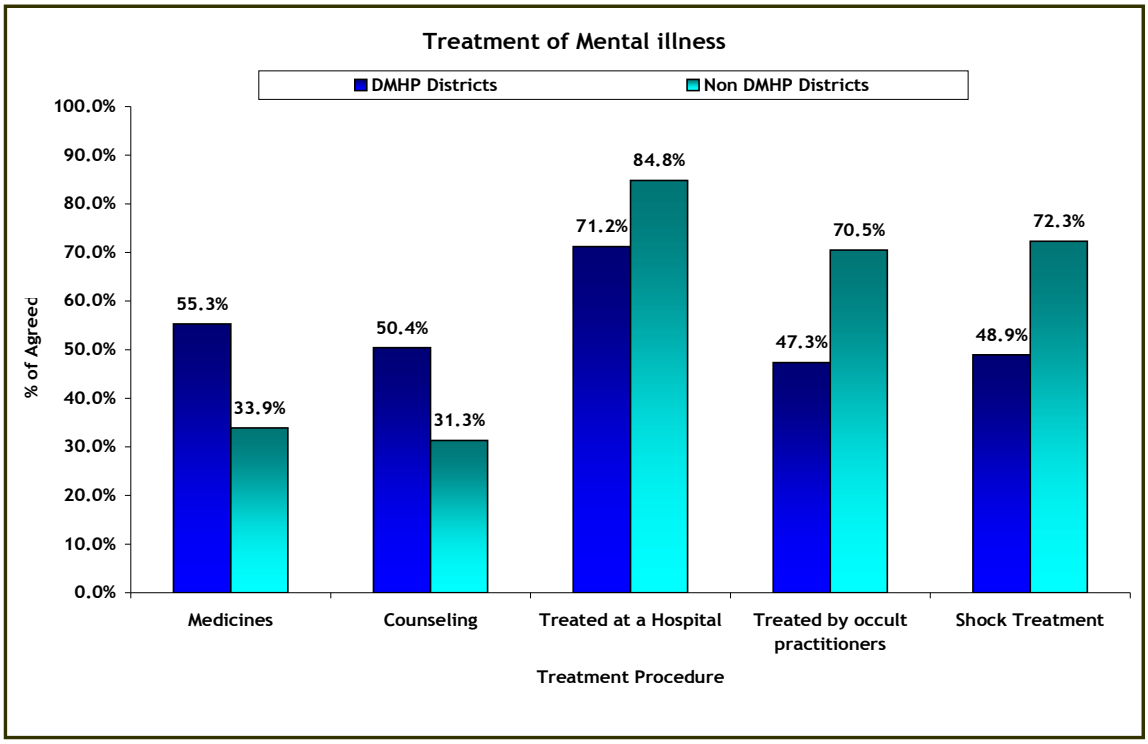
The respondents were also asked about the curability of types of mental illness which they are aware of. The responses of community members varied with the types of mental illness they had reported. The considerable variation was also noticed between the DMHP and the Non-DMHP districts. This could be observed from the table given below.



Are these types of mental illness curable?					
Districts	Psychosis	Neurosis	Epilepsy	Drug addict	Mental Retarded
Delhi	62.5%	88.2%	85.2%	52.0%	52.9%
Kanpur (UP)	40.0%	60.0%	80.0%	71.4%	66.7%
Raebareli(UP)	50.0%	86.7%	62.1%	80.8%	3.3%
Kurukshetra (Haryana)	50.0%	50.0%	50.0%	50.0%	42.9%
Dhamtari (Chhattisgarh)	66.7%	63.6%	73.7%	68.2%	38.1%
Puri (Orissa)	60.0%	81.3%	94.1%	57.1%	50.0%
Navsari (Gujarat)	57.1%	87.5%	86.4%	62.5%	61.5%
Sikar (Rajasthan)	50.0%	50.0%	73.3%	61.5%	23.5%
Raigad	66.7%	60.0%	91.3%	83.3%	54.2%
Buldana (Maharashtra)	70.0%	80.0%	77.8%	84.0%	30.0%
Shivpuri (MP)	80.0%	57.1%	50.0%	75.0%	68.2%
Nagaon (Assam)	50.0%	76.5%	75.0%	78.9%	45.5%
Tinsukia (Assam)	33.3%	72.7%	60.0%	71.4%	4.2%
Bankura (West Bengal)	66.7%	70.0%	76.9%	60.0%	7.4%
Madurai (T.N)	33.3%	84.6%	87.5%	78.6%	28.6%
Gulbarga (Kar)	50.0%	90.0%	73.9%	35.0%	5.3%
Prakasham (A.P)	60.0%	68.8%	66.7%	35.7%	45.5%
Total DMHP Districts	**56.8%**	**73.8%**	**76.8%**	**66.8%**	**34.9%**
Non DMHP districts average	**45.5%**	**66.0%**	**44.4%**	**45.0%**	**26.1%**

- In the case of DMHP districts the curability factor was found to be highest in the case of epilepsy which was overall reported by almost 77% of respondents. This was followed by Neurosis (73.8%), Drug addiction (66.8%) and Psychosis (56.8%). However, only about 35% of respondents perceive that a mentally retard person can be cured.
- There was some variation in the case of responses from Non DMHP districts. As per their responses curability factor was found to be highest in the case of Neurosis (66%), followed by psychosis, drug addiction and epilepsy in the same order. In the case mental retardation, only 26.1% of respondents agreed that that it can be cured.

The respondents were also asked about the methods that should be adopted for treatment of mentally ill people. This was asked to understand the awareness level of the community members on the mental illness as their perception on methods also indicates their behaviour toward the mentally ill people.

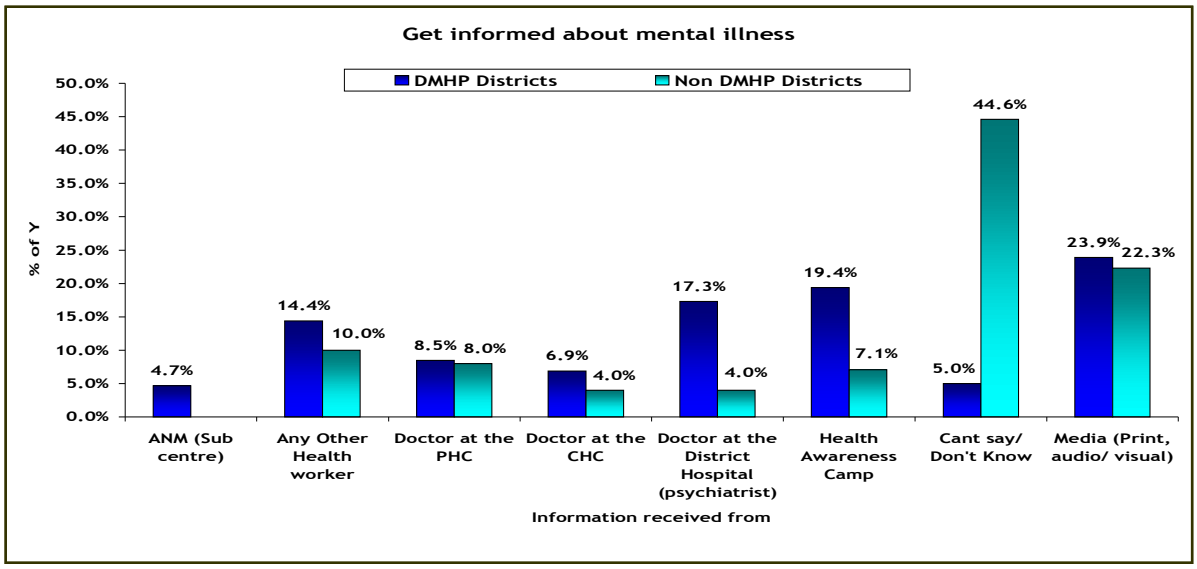


How Can mental illness be treated?							
Districts	**Medicines**	**Counseling**	**Treated at a Hospital**	**Treated by occult practitioners**	**Shock Treatment**	**Can not be cured**	**Total**
Delhi	60.0%	53.3%	76.7%	53.3%	46.7%	13.3%	**30**
Kanpur (UP)	43.8%	37.5%	75.0%	43.8%	50.0%	6.3%	**16**
Raebareli(UP)	56.7%	36.7%	70.0%	40.0%	33.3%	6.7%	**30**
Kurukshetra (Haryana)	50.0%	65.0%	75.0%	65.0%	40.0%	35.0%	**20**
Dhamtari (Chhattisgarh)	54.5%	45.5%	63.6%	63.6%	22.7%	13.6%	**22**
Puri (Orissa)	56.7%	53.3%	73.3%	43.3%	40.0%	3.3%	**30**
Navsari (Gujarat)	63.3%	63.3%	66.7%	40.0%	60.0%	10.0%	**30**
Sikar (Rajasthan)	60.9%	47.8%	65.2%	65.2%	52.2%	17.4%	**23**
Raigad	52.0%	56.0%	68.0%	56.0%	68.0%	24.0%	**25**
Buldana (Maharashtra)	51.7%	51.7%	72.4%	37.9%	65.5%	17.2%	**29**
Shivpuri (MP)	54.5%	45.5%	68.2%	45.5%	36.4%	13.6%	**22**
Nagaon (Assam)	52.0%	56.0%	72.0%	44.0%	52.0%	8.0%	**25**
Tinsukia (Assam)	52.0%	40.0%	72.0%	32.0%	52.0%	8.0%	**25**
Bankura (West Bengal)	51.9%	51.9%	70.4%	29.6%	55.6%	7.4%	**27**
Madurai (T.N)	55.0%	50.0%	75.0%	30.0%	55.0%	40.0%	**20**
Gulbarga (Kar)	60.0%	48.0%	76.0%	68.0%	68.0%	12.0%	**25**
Prakasham (A.P)	58.3%	50.0%	70.8%	54.2%	29.2%	4.2%	**24**
Total DMHP districts	**55.3%**	**50.4%**	**71.2%**	**47.3%**	**48.9%**	**13.5%**	**423**
Non DMHP districts average	**33.9%**	**31.3%**	**84.8%**	**70.5%**	**72.3%**	**32.2%**	**112**
Sum may not add due to multiple response							

- Over I out of 2 respondents from the DMHP districts, against nearly 3 out of 10 in Non DMHP districts, agreed that proper medications and counselling can help in the treatment of mentally ill people.
- Nearly 7 out of 10 in the DMHP districts were of the view that mental illness could only be treated in the hospitals. In the case Non DMHP districts, this was reported by nearly 85% of the respondents.
- The difference in approach of respondents of DMHP and non DMHP districts is clearly evident as far as conservative methods are concerned. For example practice of occult practitioners was suggested by 47.3% of respondents from DMHP districts as against over 70% of Non DMHP respondents. Similarly as against 48.9% of DMHP respondents suggesting shock treatment therapy, over 72% suggested in the case of non DMHP districts.
- Over 13% of DMHP respondents were of the view that mentally ill people could not be treated. This trend was found was found to over 32% in the case of non DMHP districts.
- The above trend clearly signifies the differences in approach towards mental illness in DMHP and non DMHP districts.

Sources of awareness about mental illness

Under DMHP there is provision of spreading awareness about the mental illness in the district where it is being implemented. A comparatives evaluation was carried out on the DMHP and non DMHP districts to understand the sources of awareness to measure the effectiveness of campaign being carries out under the DMHP.



How did you come to know about mental illness and its causes?									
Districts	ANM (Sub centre)	Any Other Health worker	Doctor at the PHC	Doctor at the CHC	Doctor at the District Hospital (psychiatrist)	Health Awareness Camp	Cant say/ Don't Know	Media (Print, audio/ visual)	Total
Delhi	0.0%	3.3%	0.0%	3.3%	26.7%	**10.0%**	0.0%	56.7%	**30**
Kanpur (UP)	0.0%	25.0%	0.0%	0.0%	0.0%	**37.5%**	0.0%	37.5%	**16**
Raebareli(UP)	0.0%	36.7%	0.0%	0.0%	3.3%	**10.0%**	0.0%	50.0%	**30**
Kurukshetra (Haryana)	15.0%	0.0%	5.0%	15.0%	20.0%	**25.0%**	0.0%	20.0%	**20**
Dhamtari (Chhattisgarh)	18.2%	13.6%	9.1%	0.0%	18.2%	**4.5%**	4.5%	31.8%	**22**
Puri (Orissa)	0.0%	10.0%	30.0%	10.0%	20.0%	**0.0%**	26.7%	3.3%	**30**
Navsari (Gujarat)	0.0%	0.0%	0.0%	3.3%	13.3%	**36.7%**	3.3%	43.3%	**30**
Sikar (Rajasthan)	8.7%	26.1%	26.1%	0.0%	8.7%	**4.3%**	0.0%	26.1%	**23**
Raigad	0.0%	4.0%	0.0%	0.0%	44.0%	**4.0%**	8.0%	40.0%	**25**
Buldana (Maharashtra)	3.4%	13.8%	3.4%	13.8%	24.1%	**20.7%**	0.0%	20.7%	**29**
Shivpuri (MP)	0.0%	13.6%	0.0%	0.0%	31.8%	**4.5%**	0.0%	50.0%	**22**
Nagaon (Assam)	28.0%	4.0%	4.0%	0.0%	44.0%	**8.0%**	12.0%	0.0%	**25**
Tinsukia (Assam)	0.0%	28.0%	24.0%	0.0%	8.0%	**16.0%**	12.0%	12.0%	**25**
Bankura (West Bengal)	0.0%	51.9%	22.2%	7.4%	3.7%	**3.7%**	3.7%	7.4%	**27**
Madurai (T.N)	0.0%	5.0%	5.0%	20.0%	5.0%	**65.0%**	0.0%	0.0%	**20**
Gulbarga (Kar)	0.0%	4.0%	0.0%	20.0%	0.0%	**76.0%**	0.0%	0.0%	**25**
Prakasham (A.P)	12.5%	4.2%	12.5%	25.0%	16.7%	**20.8%**	8.3%	0.0%	**24**
Total DMHP dist.	**4.7%**	**14.4%**	**8.5%**	**6.9%**	**17.3%**	**19.4%**	**5.0%**	**23.9%**	**423**
Non DMHP dist. Avg.	**0.0%**	**10.0%**	**8.0%**	**4.0%**	**4.0%**	**7.1%**	**44.6%**	**22.3%**	**112**

- Overall only 19.4% (nearly 1 out of 5) from the DMHP districts had reported that source of awareness as Health awareness camp. In the case of non DMHP districts this was reported by over 7%. This clearly shows the ineffectiveness of health awareness camp being organised in the DMHP districts.
- Majority of respondents in the case of both the DMHP and non DMHP districts had come to know about mental illness through media such as newspapers, TV and radio.
- In the case of DMHP districts, over 17% had come to know about mental illness during their interaction with the doctors/ psychiatrists at the District Hospitals, followed by other health workers. Health worker, as a source of information was also revealed by 10% of respondents from Non DMHP districts.
- The weakest point observed in the above analysis is the Sub centre. Only 4.7% of the respondents from DMHP districts revealed this as a source of information.
- In the case of non DMHP districts over 44% could not point out the exact source of information. This is due to the fact that respondents in these districts were not exposed to the health awareness or any other possible source of information.

Altogether 82 (19.4%) respondents from DMHP districts had reported that they came to know about mental illness and its causes through health awareness camp organised in their area. Therefore, they were also asked about this camp as to when this was organised. The results are shown in the table below:

9.When was the last mental health awareness camp held at your village?

DMHP Districts	Was held only once don't remember when	A week before	A month ago	3 months ago	6 months ago	Don't know/ cant say	was not held at all	more than 6 month ago	Total
Delhi	0.0%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	3
Kanpur (UP)	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	6
Raebareli(UP)	0.0%	0.0%	33.3%	0.0%	33.3%	0.0%	0.0%	33.3%	3
Kurukshetra (Haryana)	20.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	60.0%	5
Dhamtar)i (Chattisgarh	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	1
Navsari (Gujrat)	18.2%	0.0%	0.0%	0.0%	54.5%	0.0%	9.1%	18.2%	11
Sikar (Rajasthan)	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1
Raigad (Maharashtra)	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	1
Buldana (Maharashtra)	16.7%	0.0%	16.7%	16.7%	50.0%	0.0%	0.0%	0.0%	6
Shivpuri (MP)	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1
Nagaon (Assam)	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	2
Tinsukri (Assam)	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	50.0%	4
Bankura (West Bengal)	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1
Madurai (T.N)	0.0%	15.4%	15.4%	7.7%	7.7%	0.0%	0.0%	53.8%	13
Gulbarga (Karnataka)	26.3%	0.0%	0.0%	5.3%	68.4%	0.0%	0.0%	0.0%	19
Prakasham (A.P)	0.0%	0.0%	20.0%	40.0%	40.0%	0.0%	0.0%	0.0%	5
Total	**17.1%**	**3.7%**	**8.5%**	**7.3%**	**32.8%**	**3.7%**	**3.7%**	**23.2%**	**82**

- Majority of the respondents (32.8%) respondents reported that health camp in their area was organised 6 months ago. This was reported by 68.4% from District Gulbarga in Karnataka, followed by 54.5% of from Dist Dhamtari in Chattisgarh and 50% from District Buldana in Maharashta.
- Over 23% reported that health camp in their area was organised 6 months ago. This was reported highest from Dist Kurushetra in Haryana (60%) followed by Dist Bankura in West Bengal (53.8%) and from Districts of Kanpur in Uttar Pradesh, Tinsukia and Naogaon in Assam (50% each).
- Over 17% reported that camp was held once in their area but they are unable to remember its date. Only 8.5% also reported that the camp was held last month and other 3.7%, mostly from Delhi and Madurai in Tamil Nadu, reported that it was held a week before the survey period.

Impact of awareness camps on the community members

In order understand the impact of awareness program, using the IEC methods adopted b the DMHP staff in their area, opinions and perceptions of community were recorded on many of their factors related to mental illness. This practice was adopted both in the DMHP and non DMHP districts in order to make a comparative assessment.

Community perception on various aspects related to mental illness		
Items	**DMHP**	**Non DMHP**
Mental illness is contagious	23.2%	12.7%
Mental Illness is due to evil spirit, black magic	27.9%	50.0%
Mental ill people are harmful and should be avoided	32.0%	64.0%
Mental ill people can not be taken care at home	46.6%	53.3%
Mental ill individuals can have strange experiences like hearing voices and false firm beliefs	70.2%	51.3%
Very well educated and intelligent people can develop mental illness	63.0%	39.3%
Excessive dependence on abusive drugs may cause mental illness	71.5%	36.0%
Epileptic fits can be controlled by taking medicine regularly	87.3%	76.7%
Very effective and safe drugs are available to treat mental illness	77.2%	56.0%
Government has undertaken many initiatives to identify and treat mentally ill people	79.7%	48.7%
Mentally ill individuals should be taken to the nearest health center for treatment	80.7%	50.0%
Mentally ill people needs support and care from the family and the community	85.6%	54.8%
Family, members of community should recognize change and behavior of people and discuss it with their doctors/health workers	86.9%	51.9%
Health workers educate families to involve their mentally ill kith and kin in work related to socialization by maintaining an activity sheet	86.9%	49.7%
Total Sample	**487**	**150**

- The analysis reveals that the impact of organising the awareness to be certainly positive as on most of the aspects, the responses from the DMHP was better as compared to non DMHP districts.
- The lower responses from the DMHP districts, in comparison to the non DMHP districts, on the factors such as “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 the positive attitude of the people in these districts. Such kinds of responses are only possible when people are exposed to the health awareness camps.

Snapshots from DMHP Districts

District Mental Health Programme (DMHP)

Snapshot from Delhi

DMHP was supposed to be initiated in Delhi in the 9th Five Year Plan period in the year 1997. However; DMHP officially began in 2000 from the Chattarpur Dispensary (South District of Delhi) because before that the Delhi Government had not been able to allocate an area in Chattarpur to the nodal Institute for running the programme. Institute of Human Behavior and Allied Sciences (IHBAS) was the Nodal centre implementing the programme in South and North West Districts of Delhi. Delhi health system follows a different model. In Delhi there is a primary hospital, secondary hospitals and the tertiary hospitals. There is no existence of 2nd tier clinics i.e. CHC. Dispensaries and District Hospitals are the units for rolling out government approved health projects in the community. Hence in case of Delhi the DMHP programme is being run through outreach clinics in these government dispensaries and hospitals.

Additionally under the 9th plan itself IHBAS adopted another District, North West district and was running the programme in Babu Jagjiwan Ram hospital in Jehangirpuri where an outreach clinic is run by the DMHP staff who go to Chattarpur. The Babu Jagjiwan Ram Hospital is a district hospital but it does not have any Psychiatric wing/ ward and no psychiatrist. The DMHP out patient department (OPD) is being run there in the space provided by the orthopaedic department of the hospital. The DMHP outreach clinic operates here on two days - Wednesday and Friday. This outreach clinic was run additionally with the funds allocated for running DMHP in Chattarpur (South District) only. This was done because IHBHAS felt that the reach of the programme should be increased because given the availability of health services in Delhi there was no felt need for an in patient care system for Psychiatric patients.

As part of the 10th Plan extension of DMHP, the North West District (where IBHAS was additionally already operating under the 9th plan) was included. So presently they are running both Chattarpur and Jehangirpuri outreach clinics with the fund allocated to them for North West district under the 10th Plan. As the funds to the districts under the 9th plan were discontinued and they were not adopted by the State governments (as

undertaken earlier) IHBHAS continues its programme in Chattarpur with the DMHP funds allocated for Jehangirpuri as per the 10th Plan. Recently Delhi State Government has approved the state adoption of DMHP district.

1. Allocation and Utilization of Funds.

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

	9th Five Year Plan				10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	4,670,000.00	6,048,068.00	-1,378,068.00	129.5%	870,000.00	1,538,191.00	-668,191.00	176.8%
Medicines/ Stationary/ Contingencies	3,800,000.00	4,371,588.00	-571,588.00	115.0%	450,000.00	1,029,942.00	-579,942.00	228.9%
Equipments/Vehicles, etc	900,000.00	269,517.00	630,483.00	29.9%	600,000.00	0.00	600,000.00	0.0%
Training	1,200,000.00	535,792.00	664,208.00	44.6%	500,000.00	0.00	500,000.00	0.0%
IEC	1,000,000.00	273,560.00	726,440.00	27.4%	200,000.00	0.00	200,000.00	0.0%
Total	**11,570,000.00**	**11,498,525.00**	**71,475.00**	**99.4%**	**2,620,000.00**	**2,568,133.00**	**51,867.00**	**98.0%**

- A total fund of Rs 1,15,70,000.00 had been sanctioned for Delhi under the DMHP in the 9th Five Year Plan of which 99.4% had been utilized. And in the 10th Plan, 98% of the total allocation (Rs 26,20,000.00) that came as first installment in the FY 2007-08 has so far been utilized.

- The analysis clearly shows that, in the 9th plan period, there has been over spending on the staff's salary and in buying the medicines/ stationary/ contingencies by 29.5% and 15% respectively.

- Whereas, in the case of equipments/ vehicles etc and IEC, less than 30% of the allocated amount were spent. In the case training the amount spent was less than 50% of the allocated amount

- Similar trend was being observed for the 10th plan period. Out of the first installment received for the 10th plan period, 98% was spent on staff salary and medicines/ stationary/ contingencies. There has so far been no

utilization of the allocated funds which are meant for training, use of IEC and purchasing of equipments, vehicles, etc.

- The above spending pattern clearly indicates to the fact that major thrust of the DMHP has been to man the "institution" in the form of maintaining the salary of the mental health workers involved in DMHP and assuring the availability of medicines. The main goal of the DMHP with respect to spreading awareness among the community has been relegated to the lesser priority.

- Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, was not assigned the much needed priority. This is also visible from the non utilization of funds for training under the 10th plan. The Nodal officer for DMHP districts in Delhi also confirmed that training had not been conducted in the 10th plan due to lack of adequate funds.

- It was also highlighted by the nodal officer that the higher allocation for salary component leads to the high turnover of the trained psychologist who can only ensure the proper training, diagnosis and treatment.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 62 beneficiaries who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1. Composition of DMHP team

In Delhi, a team of members consisting of one Psychiatrist, one Psychologist, one Psychiatric Social Worker, one Statistician cum clerk, four Staff Nurses, one Nursing Orderly, one helper *" safai karmachari"* and one driver were part of the earlier team recruited under DMHP in the 9th plan. In the 10th Plan out of those four staff nurses only one is retained. Currently, the team consists of one Psychiatrist, one Clinical Psychologist, one Staff Nurse, one social worker, one clerk/data entry person and one attendant. In addition to this, they have taken need base voluntary assistance from the

staff/students of IHBHAS. This team goes to Chattarpur (South district) for the outreach clinic on Monday and Thursday and to Jehangirpuri (North West) on Wednesday and Friday.

2.2 Training

Training is a mandatory part of DMHP for first three years after initiation. In the earlier phase (i.e. 9th plan period) of DMHP till 2003 attempts were made to train General Physician and Paramedical staff of the hospital and Chattarpur Dispensary. In addition to this, doctors, health workers, non medical staff like ICDS workers, teachers and selected NGO members form other parts of Delhi, who were working in various health and other related institutions were also given training. The training was not localized or concentrated to the selected dispensaries under the DMHP programme for the 9th and 10th plan period. These trainings were mostly given by using the NIMHANS training modules and also keeping in mind the local requirement.

As per IHBAS officials the major hindrances they experienced related to training were the frequent changes in the dispensary and hospital staff in selected DMHP dispensaries. As the training was organized only for the first three years of the plan period, the health workers joined after the training period were not given any further training.

IHBAS could not start the training schedule in 10th plan because the fund for the plan period came in the year 2007. Major proportion of this fund was utilized for maintaining the existing staff. IHBAS is still planning to start the training programme under the 10th after receiving the subsequent installments. According to the Nodal Officer at IHBHAS preparations are being made for the training to be conducted after the receipt of the next round of funds under the 10th plan and IHBHAS is developing training modules for the same as well.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1. Heath System viewpoint

The DMHP out reach clinic/OPD is running two days in a week in Chattarpur and Jehangirpuri. On these days, there is a regular in flow of patients and their relatives. Average no of patients in Chattarpur was observed around 15-20 per day where as in Jehangirpuri the count is higher, around 50-60 per day. Out of them around 10% were found to be new patients.

As explained earlier, training was conducted in the initial year of 9th plan period. Therefore, the programme lacked the capacity building mechanism (CBM) in the selected dispensaries and the diagnosis was only possible through the IBHAS team visiting these clinics on the schedule days. (Chattarpur – Mondays and Thursdays; Jahangirpuri – Wednesday and Fridays). On other days, since the permanent staff in the hospital are not equipped or supposed to treat the patients therefore they are advised to visit only on the schedule days.

On those scheduled days of the outreach clinic the patients are registered by the nursing orderly or clerk and the psychiatrist examine them and prescribes medicines. Medicines are dispensed by the staff nurse who also explains the schedule of medicines to be administered. The role of clinical psychologist, who is a part of DMHP team is to interact with the patient and the family member about the disease and the care that needs to be given.

The DMHP team also started home visits for the drop out cases till the year 2005. However, this was discontinued in the later years due to the lack of staff. In the 9th plan the number of nurses who were assigned this work reduced only to one in the 10th plan as per the direction of MOHFW.

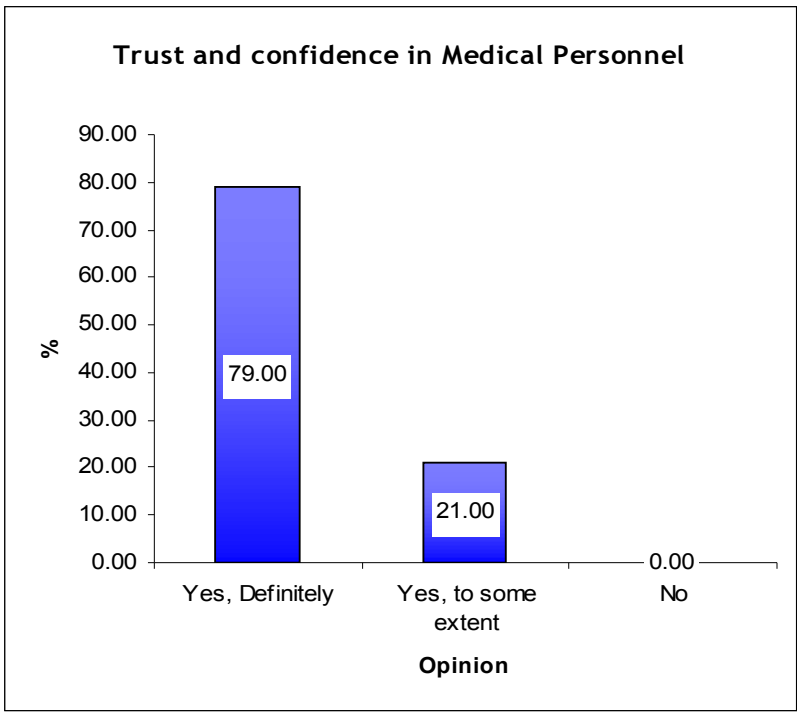
2.3.2. The beneficiaries view point

The ICMR, a division of Planman Consulting's field team also interviewed the beneficiaries from both Chattarpur and Jehangirpuri to understand their knowledge of the illness diagnosed and satisfaction on treatment that they were receiving. Altogether 60 beneficiaries were interviewed. Around 52% of the patients contacted were referred to these dispensaries by other doctors or hospitals. Their perceptions on various parameters are given below:

2.3.2.1. Perception about the Doctor

Around 4 out of every 5 beneficiaries interviewed (79%) reported that they had trust in the doctors. However, around 45% of the patients/ beneficiaries had met different doctors during their visits to the dispensaries.

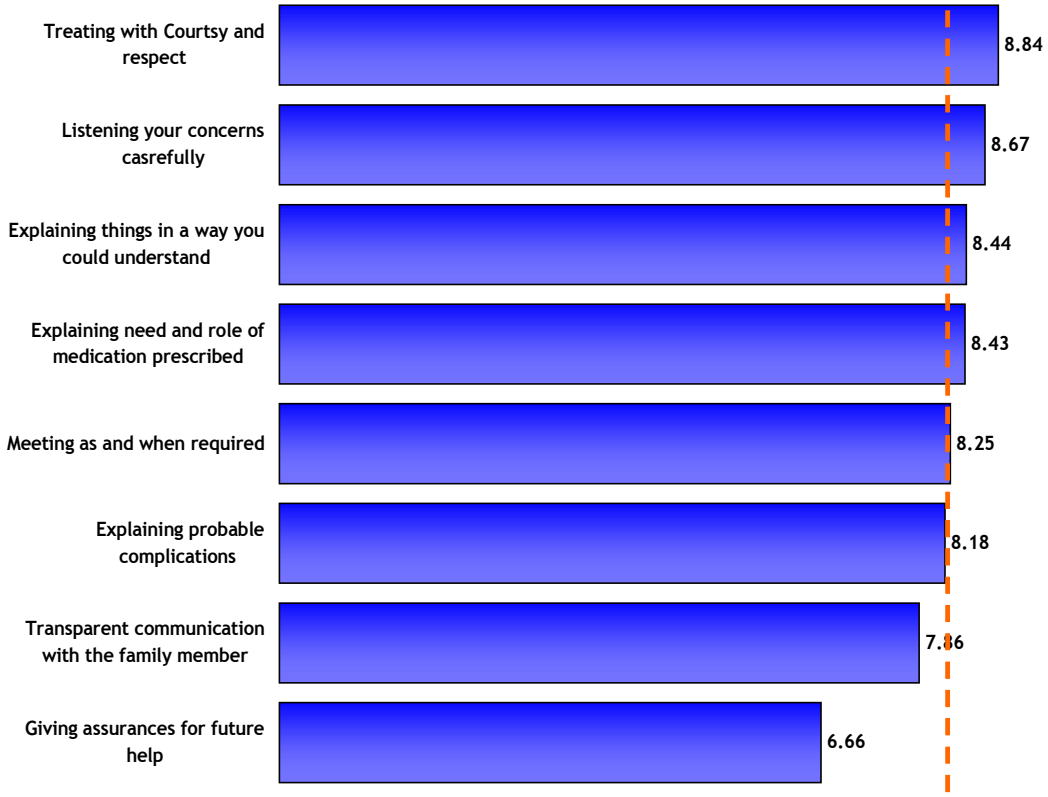
Fig 1.Trust and Confidence in Medical Personnel



The graph below shows that the satisfaction levels on the following aspects were above the composite mean: listening carefully to the concerns, treating with courtesy and respect, explaining things in a way that the patients could understand and explaining

need and role of medication prescribed. The aspect explaining probable complications however received an average response .The other aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the doctors on the aspects such as listened to their concerns carefully, treated them with courtesy, have explained the things in a way that the patients could understand and have explained need and role of medicines. However, the beneficiaries had below average satisfaction on the aspects such as "giving assurance for future help", and "transparent communication with family members".

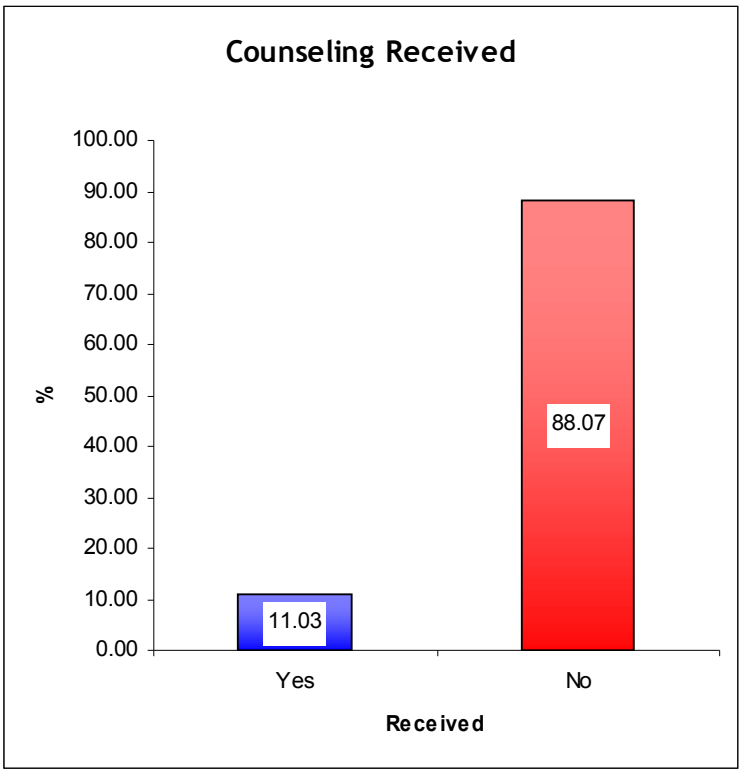
Fig.2 Satisfaction on interaction with the Medical Personnel



2.3.2.2. Counseling Received

The patients were also asked whether they had received any counseling during their treatment. Nearly 9 out of 10 (88%) of the patients/ beneficiaries contacted said that they had not received any counseling or met with a counselor during their treatment.

Fig 3. Counseling Received by the beneficiaries



2.3.2.3. Overall treatment

Most of the patients/ beneficiaries had ranked high (8 on a scale of 1- 10) on the satisfaction achieved from the treatment process. This shows that whoever is receiving the treatment was satisfied with the whole process of treatment being given by the doctors/ psychiatrist.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

In Delhi, the inventory of drugs is maintained at the level of the implementing body, IHBAS. As per the DMHP health officials most of the drugs are taken from the common drug pool of IHBHAS and the funds for the same are deducted by IHBHAS from the DMHP funds that they receive. Due to this most of the drugs are available with the DMHP team. The DMHP team, responsible for executing the plan, carries the entire lot of drugs to each of the outreach clinic areas namely, Chattarpur and Jehangirpuri, on the schedule days of visiting to these selected dispensaries under the DMHP plan. It should be noted that these drugs are not maintained with dispensaries' drug distribution outlets for distribution to patients. Drugs are only distributed to the patients/ beneficiaries only on the scheduled days when the DMHP team visits these dispensaries. The reasons for not maintaining the availability of drugs on all the working days, as per the DMHP implementing officials pertained to technical difficulties such as difficulties in maintaining the inventory register, tracking drug usage, inability of regular non DMHP staff to explain the side effects of the drugs etc.

2.4.2. The beneficiaries view point

2.4.2.1. Drugs availability

Most of the beneficiaries / patients (88.7%), who were interviewed at Chattarpur and Jehangirpuri dispensaries, confirmed the receipt of drugs. More than 67% also confirmed that they were clearly explained the purpose of medication they were being given. Some of the beneficiaries who were interviewed in Chattarpur, however, said that they were also advised by the doctors to buy some of the drugs from the market as those were not available with them.

2.5. Awareness about the mental illness

In order to gauge the awareness level about the mental illness and the DMHP programme, the field team under the guidance of senior researchers interacted with the health officials responsible for implementing the programme and also with the members of community living in and around the health institutions where the programme is being executed. The perception gathered by the research team is given below:

2.5.1. Health System viewpoint

As per the implementing agency the campaigns organized by the DMHP team at regular intervals in the community surrounding Chattarpur and Jehangirpuri areas have created significant awareness among the community. This marked growth in awareness level is also reflected in the turn out of patients to the hospitals/ dispensaries for seeking for help and treatment. As per the Status Report of IBHAS, the number of patients in Chattarpur dispensaries increased from 43 (new and old) in Oct-Dec 2000 to 6,290 in Oct-Dec 2005. In Jehagirpuri, this number increased from 1,185 in Oct-Dec 1999 to 13,391 in Oct-Dec 2005. For Chattarpur these figures further increased to 6,423 in Oct-Dec 2006. However, there was marked slowdown in the patients to 4,123 in 2007 and then further to 1846 in May 2008.

2.5.2. Community perception regarding awareness

2.5.2.1.Information on DMHP and mental health

Awareness about the mental illness among the community members were recorded through door to door survey and also discussion with common people through FGD at very informal level. Most of the people had shown their awareness about the illness through word of mouth and audio visual banners. For example more than half the respondents reported that they heard about the illness though the print and audio visual media. More than 1 out of 4 respondents stated that the doctor at the District hospital told them about mental illness. However, only 10% reported that they also came to know through the publicity campaign in the area by the health workers. They confirmed of street plays and other IEC materials like pamphlets for awareness of mental illness distributed some time back. This was reported more in the areas

surrounding Chattarpur dispensary, where DMHP is being implemented by IHBAS through its clinic outreach programme.

2.5.2.2. Awareness about symptoms and perception of mental health

As far as symptoms of mental illness is concerned, the awareness in the community was found to be varied. Most of them cited about spells of depression and fits as the common symptoms. It was also observed by the field team that community perception on black magic as a cause of mental illness still persists; however, more than half agreed that these can also be cured through medicines and treatment at the hospital. However, around 46% also opined that these could be cured through giving shock treatment to the patients. Treatment by occult practitioners was also reported by more than half the community level respondents.

3. Additional initiatives taken by IBHAS under DMHP

- **Meta Outreach Clinics**

  IBHAS also took some additional initiatives in implementing the DMHP programme in Delhi and the Meta outreach clinics programme was one of those initiatives. This refers to the outreach services to various institutions such as relief homes and the missionaries of charities which were located in surroundings the two outreach clinic areas. The DMHP team started visiting these institutions such as old age homes to impart training for the health workers and also treating patients who require psychiatric intervention.

- **Programme for the Homeless at Jama Masjid in collaboration with an NGO Ashray Adhikar Abhiyan**

  This extension was made in Delhi as survey revealed that high degrees of social as well as psychiatric problems have been reported in the homeless population in Delhi. Hence IBHAS decided that the DMHP team should visit Jama Masjid area to provide medical support. The homeless population in need of psychiatric help is gathered by the NGO Ashray Adhikar Abhiyan on Monday and Tuesday evenings when the DMHP team visits Jama Masjid. The team provides medical intervention and also provides medicines.

4. Implementation Problems

Training

- Training did not yield results due to frequent changes in the general health staff in hospitals and dispensaries
- Training under the 10th plan could not be conducted in Delhi due to unavailability of the 2nd fund installment, though 1st installment utilization certificate has not sent by them (Ministry record).

Staff

- Tracking drop outs was reduced due to reduction of staff in the 10th plan
- The clinical psychologist is present but very few beneficiaries say they have received counseling.

Awareness

- Awareness levels seem to be high but the number of patients being registered have reduced considerably

Suggestions/Recommendations

- Need for monitoring cell to supervise the activities under DMHP
- Stress training of all health functionaries
- Organizational skill training for DMHP staff
- Proper guidelines should be there at the District for initiating DMHP

District Mental Health Programme (DMHP)

Snapshot from Haryana

DMHP Programme was scheduled to be initiated in Haryana under the 9th plan, in District Kurukshetra but officially it started in the year 1999 as the funds under the programme came only in 1999. Post Graduate Institute of Medical Sciences, Rohtak was selected as the Nodal centre for implementing this programme. According to the Nodal Center, the programme was being run only at the District Hospital, Lok Naik Jai Prakash Hospital. In Kurukshetra, as per the nodal officer, the doctors at the CHC or the PHC were not trained under DMHP. Thus, all the patients who came to the CHC or PHC were sent to the District Hospital for diagnosis and treatment. This District Hospital is also covering almost all the areas of Haryana. Patients come from other districts also like –Yamunanagar, Panipat, Ambala etc.

1. Allocation and Utilisation of Funds.

	9th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	3,470,000.00	3,299,456.00	170,544.00	95.1%
Medicines/Stationary/Contingencies	2,800,000.00	901,073.00	1,898,927.00	32.2%
Equipments/Vehicles, etc	900,000.00	743,063.00	156,937.00	82.6%
Training	1,200,000.00	788,422.50	411,577.50	65.7%
IEC	800,000.00	81,261.00	718,739.00	10.2%
Total	**9,170,000.00**	**5,813,275.50**	**3,356,724.50**	**63.4%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 91,70,000.00 was allocated through five installments for the district of Kurukshetra under the DMHP in the 9th Five Year Plan of which 63.4% had been utilized till 2007-08. The first installment was received in the year 1998-99 and the other four installments were granted in the next four consecutive years till 2002-03.

- About 95% of the funds have so far been spent for paying the salary of the DMHP staff.

- In the case of purchasing of equipments/vehicles, around 80% of the allocated amount was spent.

- Whereas for buying the medicines, stationeries and other contingencies, the proportion of funds that had been utilized was about 30%.

- On the other hand, IEC, which is the component that is supposed to have a far reaching impact on the community's awareness is under utilized as the utilization rate is only 10.2%.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects, views were taken from the Health Staff working under DMHP or those who had received training under the programme, 61 beneficiaries who were receiving treatment under the programme and 30 members of the general community from villages around the District Hospital where the programme was being run.

2.1. Composition of DMHP team

In Kurukshetra the DMHP programme is being run by only 4 staff members. There is a Psychiatrist who is a permanent salaried staff of the hospital and others are temporary and have been hired under DMHP. There is one clinical psychologist, one record keeper and one lady as peon. There is one driver who has been appointed under DMHP but he usually works in the Nodal Center, PGIMS Rohtak (the team does not have a vehicle at their disposal). The DMHP staff opined that the lack of adequate staff was creating problems for the execution of DMHP. They advertised for new recruitment quite a number of times, but no fresh recruitment was held. Due to the absence of a staff nurse in the team, the clinical psychologist has to maintain the drug inventory as well. Moreover all the temporary staff members have not received their salary for the last five months therefore they are loosing the urge to work further in the future.

2.2. Training

Training is an integral part of DMHP. In 1999 when DMHP started its operation, trainings were held at the District hospital in Kurukshetra. This corroborates with the budget utilization breakup shown above which shows that funds for training have been utilized. However the doctors and other health staff who had attended this training had already left or had been transferred therefore information could be obtained regarding training from any of the officials present at the time of survey and investigation. All the health staff interviewed reported that they had not attended any training programme. The nodal officer opined that no training programmes have been held in Kurukshetra from past 4-5 years so the current staff at the CHC and PHC has received no training.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two parts. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiaries about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

The OPD in Kurukshetra district hospital opens 6 days in a week. On an average around 30-35 patients per day visit at the OPD. Of these around 40% are new patients. Each of the new patients first meet the psychologist whose responsibility is to prepare the profile of the patients, and thereafter the diagnosis is made by the Psychiatrist. For further treatment and follow-ups a separate profile of each patient is maintained by the record keeper, mentioning the history and details of the patient. Apart from this counseling is also done on the specific days - normally on Wednesday and Thursday. Due to the absence of the staff nurse, psychiatrist also explains the purpose of medicine which is dispensed by the record keeper. The medicine record is maintained by the clinical psychologist. Reasons for shortage of medicine was pointed out by psychologist as the period between requisition for drugs and their actual receipt is very lengthy. Due to the shortage of medicines in stock the beneficiaries were suggested to buy medicines from the nearby Chemist shops. The DMHP officials pointed out this to be a major reason for drop outs. Patients lack enough money to buy the medicines therefore cannot continue the treatment on a regular basis.

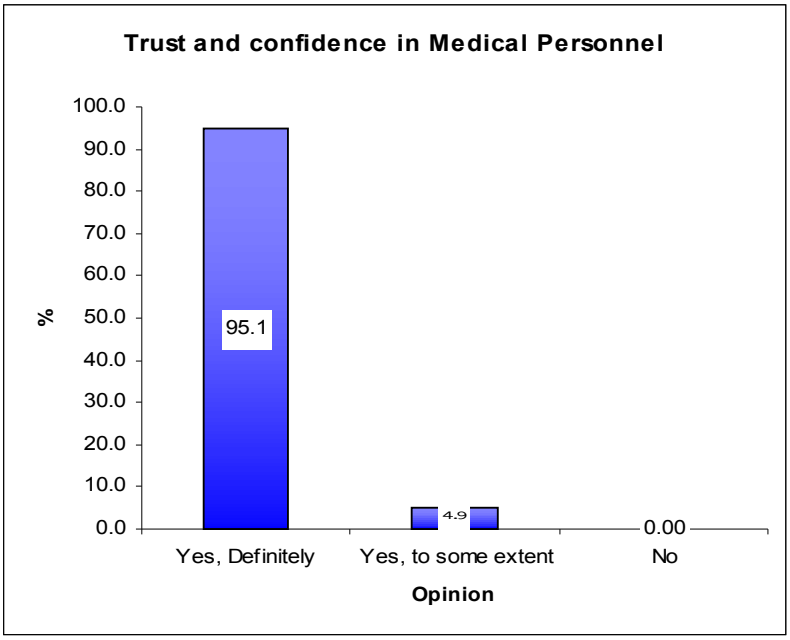
2.3.2 The beneficiaries view point

The beneficiaries were interviewed by the ICMR Planman Consulting team from both Kurukshetra Hospital and nearby villages like "pipli", etc. On being questioned about their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Since the staff at the CHCs or PHCs is not trained to provide psychiatric intervention, 98% of the beneficiaries said they had come to the District Hospital and the Psychiatrist was their first point of contact.

2.3.2.1 Perception about the Doctor

Most of the beneficiaries interviewed said that the trust on the doctor was on an average high. Almost all 95% of the beneficiaries interviewed opined that they had complete trust in the medical personnel whom they had met. Only 5% said that they had some amount of trust on the doctor they had consulted. All the beneficiaries, who were contacted during the survey, also reported that they had met the same doctor on each visit to the hospital and they were satisfied with the treatment received at the hospital.

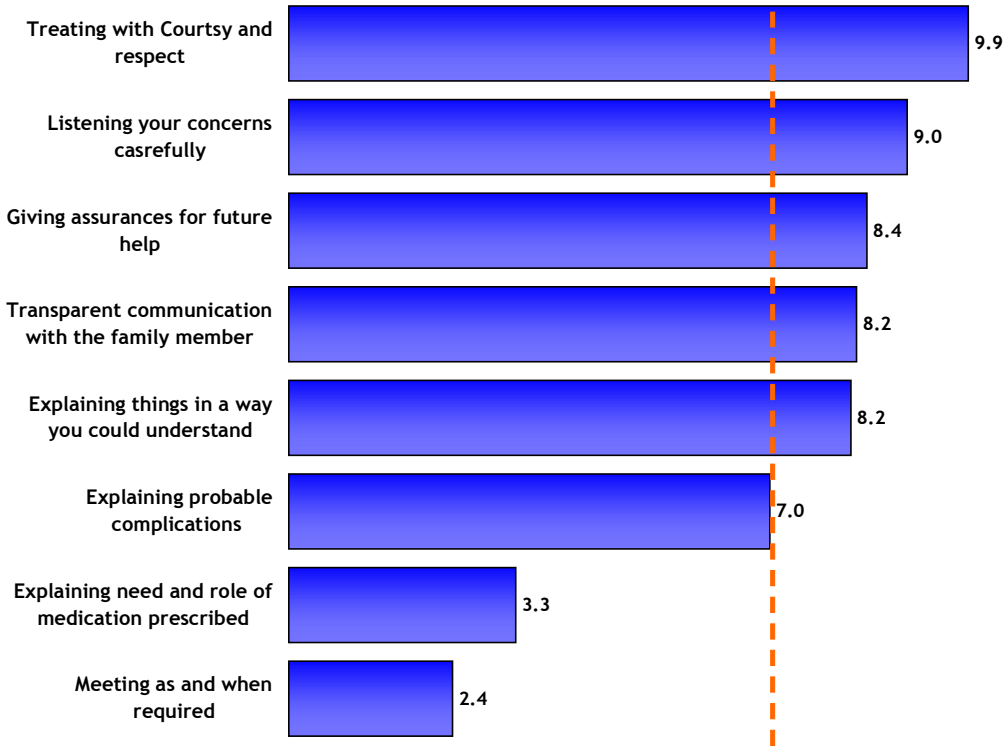
Fig.1 Trust and Confidence in Medical Personnel



The graph shows that the satisfaction levels on the following aspects were above the composite mean: listening carefully to the concerns, treating with courtesy and

respect, giving assurance for future help, transparent communication with family members and explaining things in a way that the patients could understand. Average response was estimated on the aspect of explaining probable complications. The rest of the aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the doctors on the aspects such as listened to their concerns carefully, treated them with courtesy, have explained the things in a way that the patients could understand and have explained probable complications. However, the beneficiaries had below average satisfaction on the aspects such as "meeting the doctors as and when required", and "explanations on the need and role of medications prescribed".

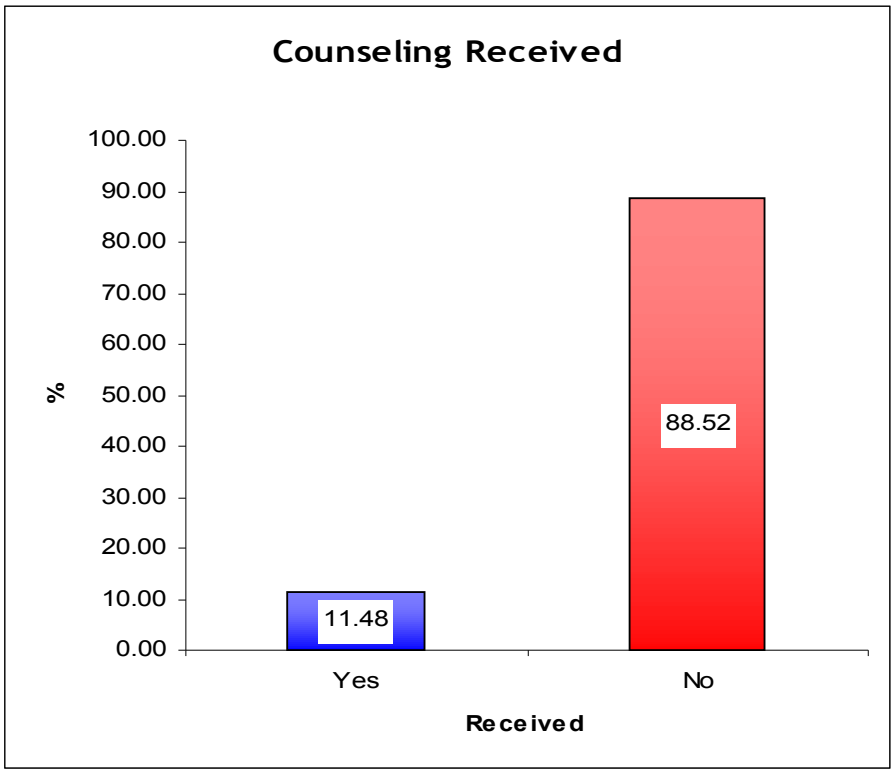
Fig.2 Satisfaction on interaction with the Medical Personnel



2.3.2.2 Counseling Received

Counseling is considered as an important component of treatment of mentally ill person. However, only one out of ten beneficiaries contacted during the survey confirmed that they had received counseling during their treatment. This figure points that counseling is done by the Clinical psychologist (only a few mentally ill patients required counseling) under DMHP.

Fig.3 Counseling Received



2.3.2.3 Overall treatment

The satisfaction with the treatment was found be slightly above the average as most of the beneficiaries contacted had given a rating of 7 on scale of 1 to 10 (1 being not satisfied and 10 being absolutely satisfied). However, around 20% had also rated the satisfaction level as 5 out of 10).

2.4. Availability of Drugs

2.4.1 Health System viewpoint

The drugs inventory for DMHP is being maintained by the implementing authority i.e. Nodal Office, PGIMS, Rohtak. The staff of District hospital, Kurukshetra sends the requisition for the drugs to the Nodal office at PGIMS, Rohtak. The nodal office in turn approves the requisition and issues the order for purchase of medicine to the DMHP implementing team. The team has arrangement with the dealer/ distributors who supplies the drugs on credit basis and accordingly raises the bills. The bill is again sent to the Nodal office which makes the payment after necessary documentation. Normally it takes 2-3 months for completing the process and by the time money is received by the DMHP team, another requisition for the medicines are sent to the nodal office. This whole process causes delay in the procurement of medicines and often patients have to buy medicines from the market.

2.4.2 The beneficiaries view point-

2.4.2.1 Drugs availability

The irregularity in the drugs was also confirmed by the beneficiaries interviewed during the survey. The analysis shows that only 3 out of the 10 beneficiaries confirmed that they had received drugs at the hospital. Most of them (90.2%) however reported that they were explained the purpose of the medication given only to some extent.

2.5. Awareness about Mental Illness

In order to gauge the awareness level about the mental illness and the DMHP programme, the field team under the guidance of senior researchers interacted with the health officials responsible for implementing the programme and also with the members of community leaving in and around the health institutions where the programme is being executed. The perception gathered by the research team is given below:

2.5.1 Health System viewpoint

As per the District level health officials the awareness that has been spread in Kurukshetra is not through campaigns or health camps, but only through the word of mouth. The health staff opined that they did not have any facilities for organizing awareness campaigns. Neither there any funds allocated to them nor did they have a vehicle to go to the nearby villages. Recently however, a meeting was held between the doctors of Kurukshetra hospital and the doctors of the Rohtak Medical College and they had organized a rally to spread awareness on mental health. This is the only activity that has been done so far to spread awareness. According to the health staffs, who were interviewed during the survey, since there is lack of awareness, people still have misconception regarding the mental diseases therefore they hesitate in discussing their problems even with their family members.

2.5.2 Community perception regarding awareness

2.5.2.1. Information on mental health

1out of every 4 community members, who were contacted during the survey(25%), reported that they had attended awareness programme organized by the DMHP team in their area. I out of every 5 respondents also agreed that the Doctor at the District Hospital informed them about mental illness.15% of them also reported that either the doctors at the CHCs or the ANMs at their village had informed them about mental illness.

2.5.2.2. Awareness about symptoms and perception of mental health

As far as awareness about various symptoms of mental illness are concerned, most of the respondents could indicate about spells of depression and fits. However, their perception on black magic as a cause of mental illness still persists as this was mentioned by nearly 4 out of 5 respondents. Regarding cure of mental of illness, three fourth agreed that such cases need to be treated at a hospital, 65% recommended counseling and half the respondents reported that medicines are also an option for treating the patients.

Treatment by occult practitioners was however reported by 65% of the respondents as well.

3. Key Implementation Problems

Training

- Lack of training for the past 3-4 years have made the CHC and PHC staff non functional for providing basic mental health care or diagnosis

Awareness

- Awareness programmes have not been held due to improper management of funds and lack of proper coordination.

Availability of Drugs

- The time lag between requisition and actual receipt of medicines has hampered the programme and led to drop out cases due to irregular flow of drugs.

Suggestions/Recommendations

- Supervision and strict monitoring of DMHP activities
- Better mechanism to initiate and operationalize DMHP required
- State Health society should be more active
- Training of DMHP to include organization of IEC activities, some modules should help such activity.
- Need for planning training programme for program management.
- Better drug procurement mechanism needed, bulk purchase should reduce cost.

Snapshot from Uttar Pradesh:

In Uttar Pradesh, two districts, namely, Kanpur and Rae Bareli, were covered for the purpose of evaluating the implementation of District Mental Health Programme (DMHP). In Kanpur district of Uttar Pradesh, DMHP was operational under the 9th five year plan whereas Rae Bareli was included under DMHP under the 10th five year plan. This report will therefore highlight the consolidated perception gained from both these districts under various parameters defined below.

The District Mental Health Programme (DMHP) started in Uttar Pradesh in February 1997 under the 9th five year plan and was implemented in the district of Kanpur. For Kanpur and Raebareli both, the Department of Psychiatry, C.S.M. Medical University was the institution responsible for implementation of the programme. In Kanpur district the DMHP is still running in UHM Hospital (District Hospital). Besides, UHM Hospital DMHP is also running in 4 CHCs (Sarsul, Bidhnoo, Ghatampur and Bilhaur) and 3 PHCs (Shivrajpur, Chaubeypur and Bheetargaon). Last installment was received by Kanpur in the year 2000-01. The programme in Kanpur district is being continued by utilizing the unutilized funds since May 1998 till now.

In the 10th five year plan RaeBareli district was also included under the DMHP programme. However, actual fund for the programme was made available beforehand on January 2005 and the project started during May 2005. There are 6 CHCs, and 13 PHCs under Rae Bareli District Hospital. However, besides the District Hospital the DMHP programme was operational only in two CHCs, namely Lalganj and Maharajpur. The Nodal Office implementing DMHP had applied for the release of 2nd and 3rd installment for continuation of the programme. So far they have received only two installments. Recently Nodal office has planned to start the DMHP programme in Vachhrawa CHC also.

1. Allocation and Utilisation of Funds

1.1 Allocation and Utilisation of Funds in Kanpur

9th Five Year Plan				
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	2,318,412.44	1,996,843.00	321,569.44	86.1%
Medicines/Stationary/Contingencies	1,867,184.06	598,783.07	1,268,400.99	32.1%
Equipments/Vehicles, etc	900,000.00	0.00	900,000.00	0.0%
Training	1,177,915.75	30,000.00	1,147,915.75	2.5%
IEC	577,915.75	0.00	577,915.75	0.0%
Total	**6,841,428.00**	**2,625,626.07**	**4,215,801.93**	**38.4%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 68,41,428 had been sanctioned for Kanpur under the DMHP in the 9th Five Year Plan of which 38.4 % had been utilized in the same plan period. No fund has been received after 2000-01 and the programme is still continuing in the district by utilizing available remaining balance.

- The table above clearly shows that, in the 9th plan period, 32.1% of schedule expenses has been utilized in buying medicines/ stationary/ contingencies.

- During the plan period, there had been a spending of about 86% in paying for the staff's salary.

- From above, the pattern of fund utilization shows irregularity on the part of the administration. Because very little money has been spent on training (2.5%) while on IEC nothing has yet been spent. This shows how one of the basic objectives of the DMHP to create awareness among the community has been ignored. Also, the training component of the programme which is very important for ensuring proper diagnosis and treatment has not been given its due priority.

1.2 Allocation and Utilisation of Funds in Raebareli

10th Five Year Plan				
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	870,000.00	1,931,581.00	-1,061,581.00	222.0%
Medicines/Stationary/Contingencies	450,000.00	222,339.00	227,661.00	49.4%
Equipments	600,000.00	149,047.50	450,952.50	24.8%
Training	500,000.00	82,435.00	417,565.00	16.5%
IEC	200,000.00	12,093.50	187,906.50	6.0%
Total	**2,620,000.00**	**2,397,496.00**	**222,504.00**	**91.5%**

- Total Rs. 2620000 was sanctioned by the Government of India in the year 2004 for the implementation of District Mental Health Programme (DMHP).
- After that no money was sanctioned by them for this purpose.
- The above spending pattern clearly shows that the expenditure which was incurred for the staff salary was more than 200% of the total money sanctioned for this purpose.
- Opposite thing was observed in case of purchasing Medicine/ Stationary/ Contingencies. Overall expenditure incurred for this purpose was less than 50% of the money allocated for this purpose.
- Similar thing happened for in buying equipment where total expenditure for this purpose was about 25% of the total money allocated.
- Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, was dealt with lesser priority which is clear from the fact that only 16.5 % of the allocated fund had been utilized.
- Even in case of expenditure on IEC, which is the component that is supposed to have a far reaching impact on the community's awareness is also under utilized as the utilization rate is only 6%.

This analysis clearly indicates the fact that in the 10th plan period major thrust of DMHP of this district has been to maintain the salary of the mental health workers involved in DMHP. Purchase of medicines, equipments has been dealt with lesser priority. Even training and awareness building, the two most important components of the DMHP, which could ensure the proper diagnosis and treatment, were not assigned the priority. The components of training and awareness building were not given priority as salary for maintenance of workers was thought to be of prime importance.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 60 beneficiaries from Kanpur and 50 beneficiaries from Rae Bareli who were receiving treatment under the programme and 30 members each of the general community from areas where the programme was being run.

2.1 Composition of DMHP team

Under the DMHP programme in Kanpur one psychiatrist and one clinical psychologist were appointed on yearly contractual basis. Present staff position of psychiatric unit in UHM Hospital under DMHP consists of one psychiatrist, one clinical psychologist, one psychiatric social worker and one record keeper. Staff (psychiatric) Nurse and Nursing Orderly was provided by rotation by UHM Hospital. Psychiatrist, staff nurse and driver are getting salary from State government while the others get their salary from DMHP fund.

The staff structure appointed under DMHP in Rae Bareli also follows the same pattern. In Rae Bareli under DMHP one psychiatrist, one clinical psychologist, one psychiatric social worker, one psychiatric nurse, one record keeper and one nursing orderly were appointed on yearly contractual basis since May 2005.

2.2 Training

Training is a mandatory part of DMHP for the first three years after initiation. Under the 9th plan period of DMHP in the Kanpur, eleven training programmes were conducted. In these training programmes district doctors, PHC/CHC doctors, Staff Nurses, ANM and other health workers were trained.

In addition to this, training sessions were also held in some schools, colleges, NGOs and local community for detection of psychiatric illness including mentally retarded cases

in societies as well as educational institutes. Besides training IEC leaflets and booklets were also circulated.

In Raebareli DMHP, training programmes were held for both Medical Officers and Primary Health Care workers under the supervision of senior staff of C.S.M Medical University, Lucknow and Nodal Officer, DMHP Raebareli for two days in 2005. However a mentionable point is that presently in both the CHCs where the programme is operational, the present staffs are untrained.

2.3 Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sub-sections. One sub-section captures the viewpoint of the DMHP team. The other sub-section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level. Here also perception from both the districts has been taken to give a consolidated perception.

2.3.1 Heath System viewpoint

The Psychiatric Wing OPD runs three days in a week in District Hospital, Kanpur. On these days, there is a regular in-flow of patients. Average number of patients visiting Kanpur District Hospital was 70 per day (OPD register, Kanpur). In CHCs the DMHP OPD is opened for 2 days in a week and the average number of mentally ill patients treated in the OPD is 20 per day.

In Kanpur it was observed by the field team of ICMR that the DMHP team arrives at the District Hospital only at 10 a.m, while the OPD hour is supposed to start at 8 a.m. The team members are stationed at the District Hospital and come from nearby areas so this delay in regular duty hours in inadmissible. The ICMR team further observed that the duration for which the DMHP team visits the CHC during outreach work is only one and a half hour which is too insufficient. Therefore most of the patients have to return back without any diagnosis or treatment.

In Rae Bareli, the Psychiatric Wing OPD runs six days in a week in District Hospital, Rae Bareli. The average number of mentally ill patients treated in OPD has increased from 2 per day before initiation of the programme to 50 per day. Out of which

approximately 59% were new patients (OPD Register, Rae Bareli). In CHCs the general OPD operates 6 days a week and average number of mentally ill patients coming to the OPD is 5 per day. In Raebareli district hospital there is no separate psychiatric wing and only a room has been allotted for diagnosis and treatment.

2.3.2 The beneficiaries view point

The beneficiaries who were interviewed from both Kanpur and Raebareli were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Out of the 60 beneficiaries interviewed in Kanpur district, only 12 % was referral cases (those who had been referred from a lower Medical institution to a higher one) whereas out of the 50 beneficiaries interviewed in Raebareli district, 34 % were referral cases.

2.3.2.1 Perception about the Doctor

In Kanpur, all the beneficiaries said that they had trust in the doctor whom they had met. In Rae Bareli district 36% of the beneficiaries have full trust on their doctor, while around 3 out of 5 respondents said that have some amount of trust on the doctor whom they had met. Only 2% of them said that they did not have trust and confidence in the medical personnel they had met. In both the districts Kanpur and Rae Bareli all of the beneficiaries said that they met same doctors during each visit to the hospital, but their overall satisfaction level with the doctor/psychiatrist was on the higher end.

Fig 1 .Trust and Confidence in Medical Personnel (for Kanpur)

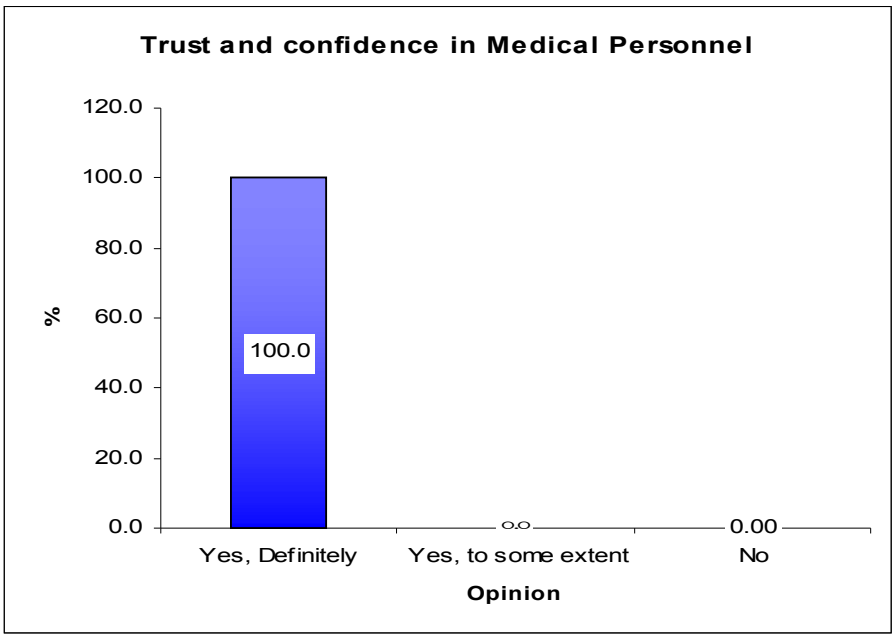


Fig 2.Trust and Confidence in Medical Personnel (for Raebareli)

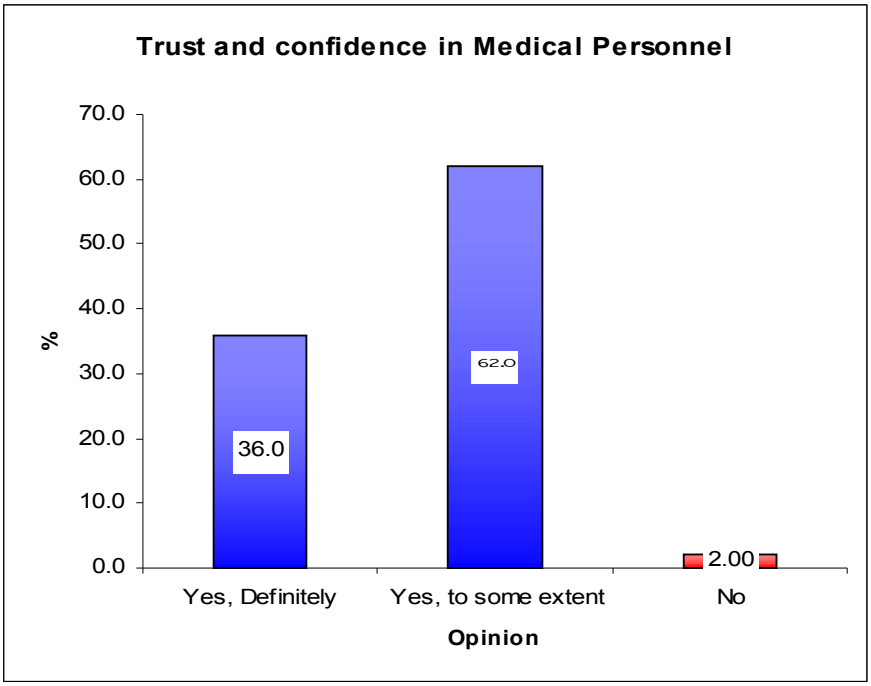
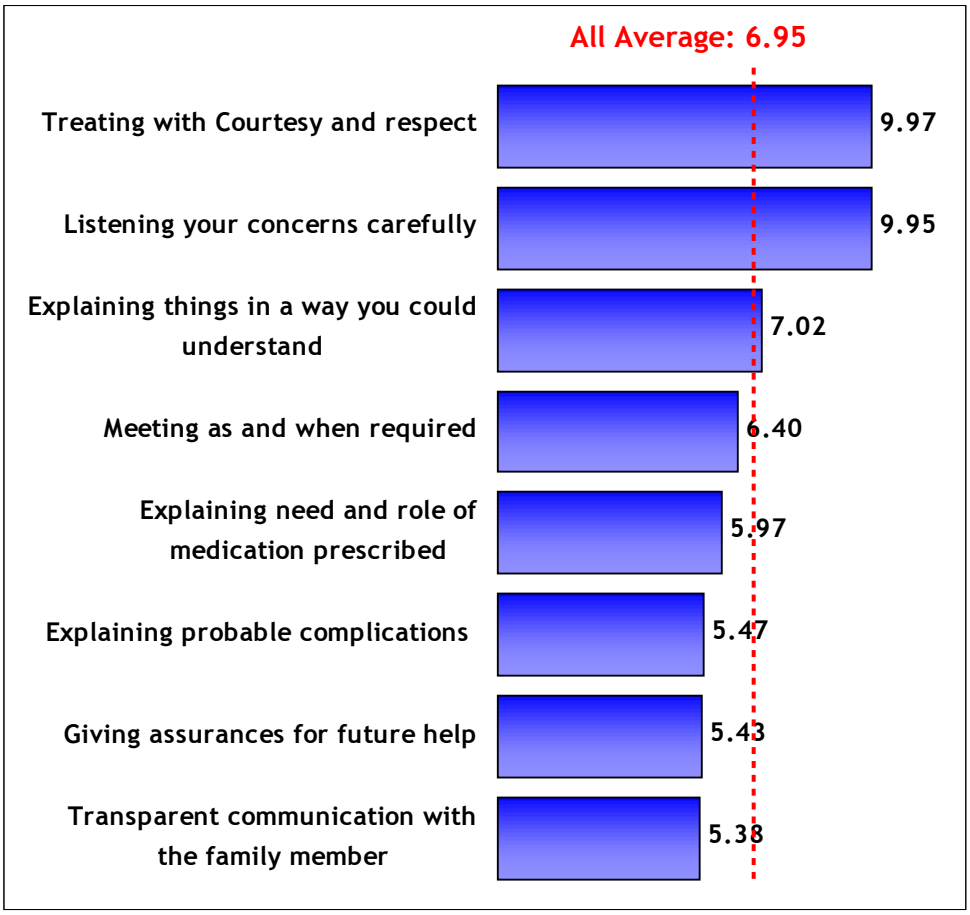
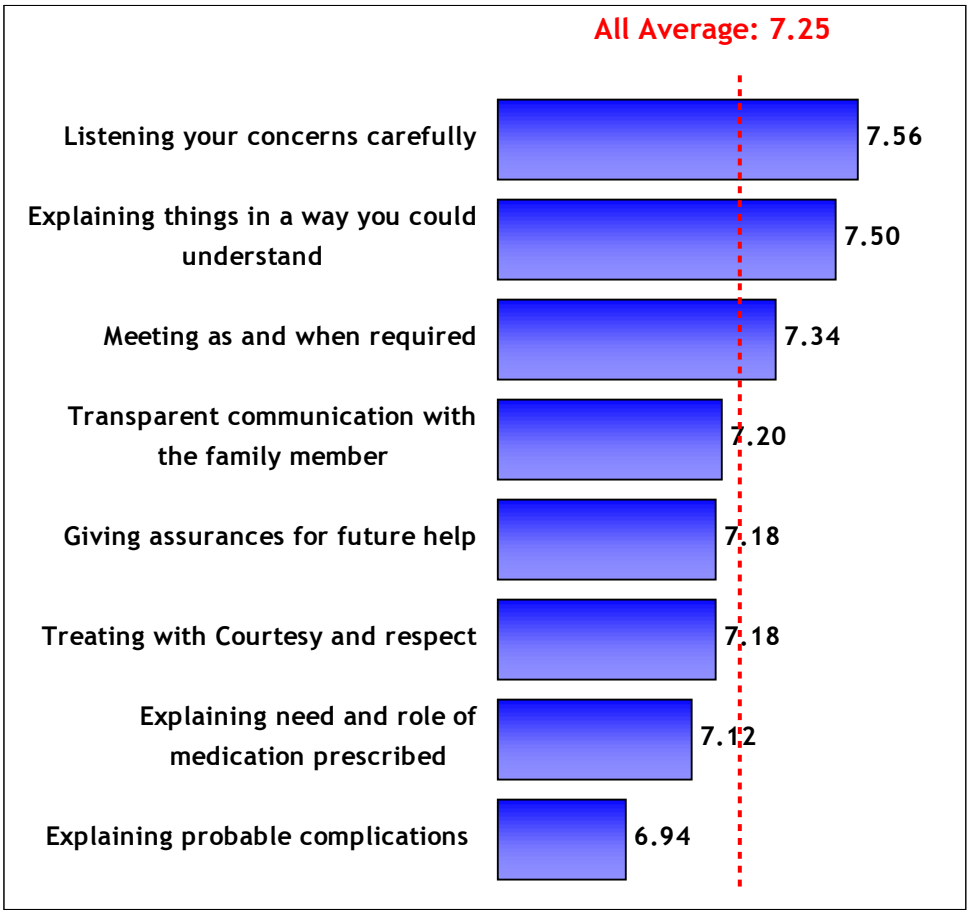


Fig.3. Level of satisfaction on various aspects of interaction with the doctor (Kanpur)



The above graph shows that the satisfaction level of the beneficiaries in Kanpur, on the following aspects are below the 'All Average': transparent communication with the family member, giving assurance for future help, explaining probable complications, explaining need and role of medication prescribed and meeting as when required. The rest of the aspects are above the 'All Average'. This reflects that the beneficiaries who had been interviewed are satisfied with the medical personnel on the grounds that the medical personnel have explained things in a way that the beneficiaries could understand. They listened to their concerns carefully and have treated the beneficiaries with courtesy and respect.

Fig.4. Level of satisfaction on various aspects of interaction with the doctor (Raebareli)



The above graph shows that the satisfaction level of the beneficiaries in Rae Bareli, on the following aspects are below the 'All Average': explaining probable complications, explaining need and role of medication prescribed, treating the beneficiaries with courtesy and respect, giving assurance for future help and transparent communication with the family member. The rest of the aspects are above the 'All Average'. This reflects that the beneficiaries who had been interviewed are satisfied with the medical personnel on the grounds that they can meet the doctor as when required, medical personnel have explained things in a way that the beneficiaries could understand and have listened to their concerns carefully.

2.3.2.2 Counseling Received

In Kanpur out of the 60 beneficiaries who were interviewed all of them said that they had not received any counseling during their visit to the hospital. Similarly, in Rae Bareli, 83.67% of the beneficiaries confirmed they had not received any counseling during their visit to the hospital while only 16.33% of the beneficiaries confirmed that they had received counseling during their visit to the hospital. This shows that the higher percentage of the beneficiaries interviewed had not received counseling during their visit to the medical institution.

Fig.5. Beneficiaries perception on the counseling received during treatment (Kanpur)

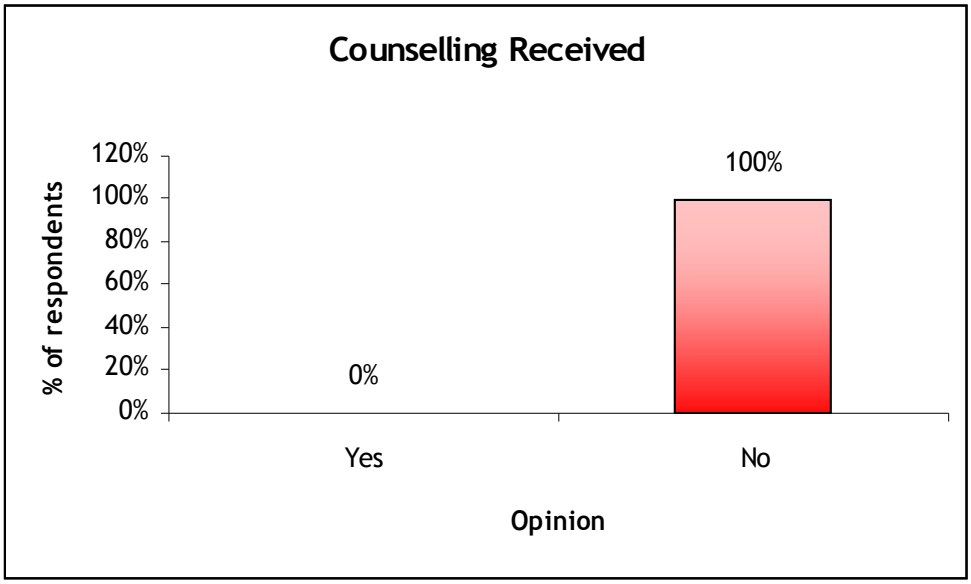
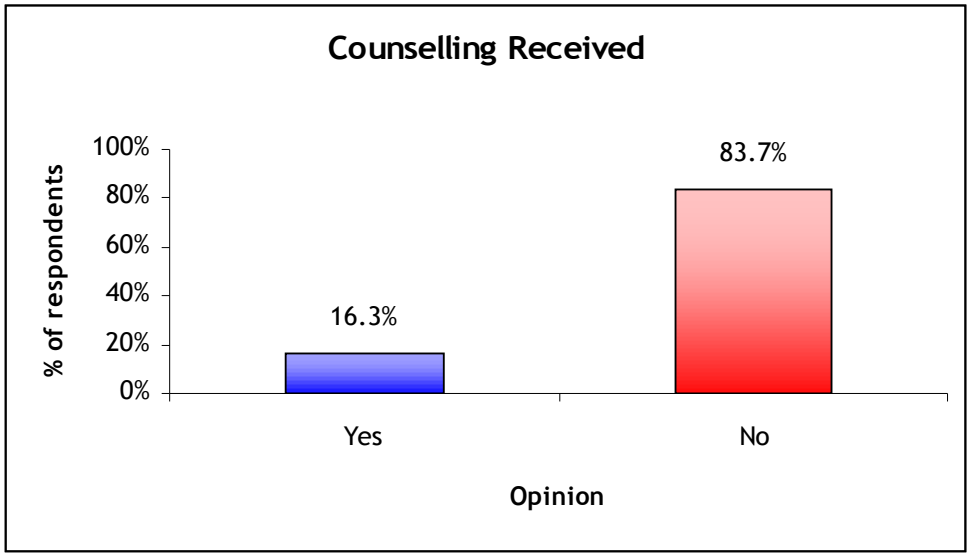


Fig.6. Beneficiaries perception on the counseling received during treatment (Rae Bareli)



2.3.2.3 Overall treatment

Beneficiaries in Kanpur district have given a lower rating of satisfaction on the overall treatment that they had received, all the beneficiaries had given a rating of 5 or 6 on a scale of satisfaction from one to ten (one being not satisfied and ten being absolutely satisfied). This shows that the beneficiaries in Kanpur are not very much satisfied with the treatment that they had received.

However, beneficiaries in Rae Bareli district were satisfied with the overall treatment that they had received as most of them had given a rating of 6 to 8 on being asked to rate the treatment level on a scale of satisfaction from one to ten (one being not satisfied and ten being absolutely satisfied). This confirms that the people who had received treatment are happy with the treatment, approach and support of the health staff.

2.4 Availability of Drugs

2.4.1 Health System viewpoint

In Kanpur the inventory of drugs in the District Hospital is maintained by the record keeper. The drugs are distributed in the District Hospital on the OPD days. In the CHCs and the PHCs, drugs are distributed only when the DMHP team visits there. On the other days drugs are not distributed and patients are sent back and asked to come on the OPD days. All the Kanpur health staff members interviewed informed that the drugs supply was either sufficient or quite sufficient .

Similarly in Rae Bareli drugs are distributed from District Hospital itself. Here DMHP OPD runs 3 days a week. In the CHCs drugs are available when district team visits the CHC. However, only 2 out of 5 respondents informed that drugs availability is sufficient. Following are the drugs available in the District Hospital of Rae Bareli.

- Cap Fluoxetine (20 mg)
- Tab Alprazolam (0.25 mg)
- Tab Haloperidol (5 mg)
- Tab Carbamazapine (200 mg)
- Tab Impramine (25 mg)
- Tab Phenytoin Sodium (100 mg)
- Tab Nitrazepam (5 mg)
- Tab Sodium Valporate (200 mg)
- Tab Lorazepam (2 mg)
- Inj. Lorazepam (2 ml)
- Tab Sodium Gardinol (60 mg)
- Inj. Haloperidol (1 ml0
- Tab Amitryptaline Hcl (25 mg)
- Tab Lithium Carbonate (300 mg)
- Inj Promethazine (2 ml)
- Tab Trifluoperazine (5 mg)

2.4.2 The beneficiaries view point-

Out of 60 beneficiaries interviewed in Kanpur 92 % said that they had received drugs at the hospital where they had gone for treatment. 40% respondents receiving medicines said that the purpose of medication was not explained to them at all. However an almost equal percentage 38% of them also said that the purpose of the medication was clearly explained to them.

Similarly out of 50 beneficiaries interviewed in Rae Bareli, 82% said that they had received drugs at the hospital. Only 1 out of 4 respondents receiving medicines said that the purpose of medication was explained to them clearly. A sizeable number of them (70%) said that the purpose of the medication was not explained to them at all.

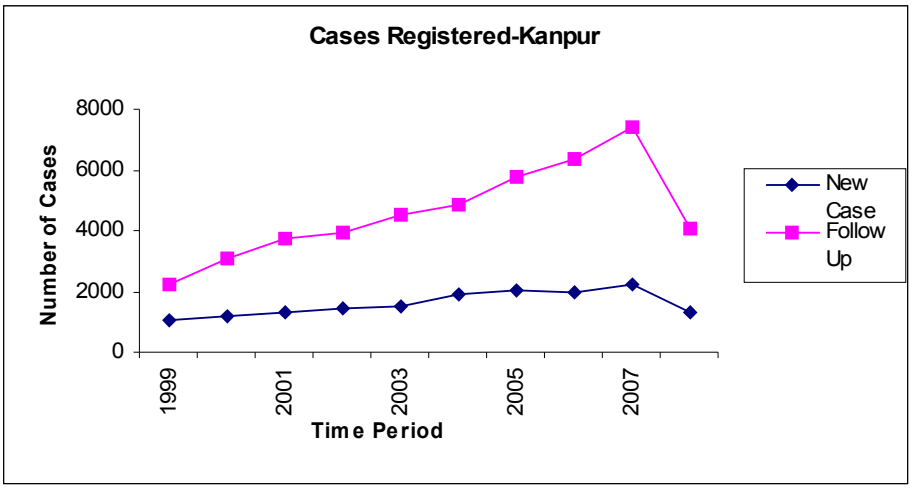
The above statistics clearly shows that percentages of beneficiaries who have received medicines under DMHP are quite high. It suggests that the availability of medicines in both Kanpur and Raebareli were somewhat sufficient to support the higher percentage of patients who had turned up for treatment in the hospitals under DMHP.

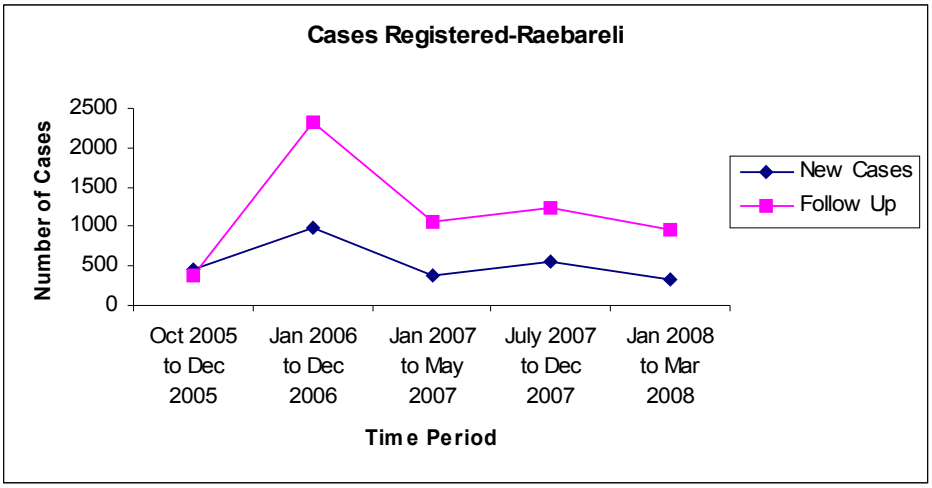
2.5 Awareness about mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1 Health System viewpoint

As per the implementing agency various campaigns have been organized by the DMHP team at regular intervals in the community in Kanpur and Rae Bareli district to create significant awareness among the community. In Kanpur Multi Specialty Camp and awareness programme for relatives of patients were held to make them aware of the causes and curability of the disease. School mental health programme was also conducted to make students and teachers aware of mental illness and the DMHP programme. Pamphlets and display boards have been distributed in both the districts to create awareness within the community of both the districts. There has been a marked decline in the number of registered cases of mental illness in 2008 in both the districts. This is depicted in the graphs below.





2.5.2 Community perception regarding awareness

2.5.2.1 Information on DMHP and mental health

Awareness about the mental illness among the community members were recorded through door to door survey and also by discussion with common people at very informal level. In Rae Bareli the awareness programmes have not been able to create much awareness in the area. Half the community members reported that they came to know about mental illness through the media (audio visual and print media) and 37% through discussion reported that it was through discussion with a health worker.

In Kanpur Nearly 2 out of 5 respondents however reported attending awareness camps and receiving information through IEC materials. 1 out of every 4respondents also reported that other health workers informed them about mental illness.

2.5.2.2 Awareness about symptoms and perception of mental health

As far as symptoms of mental illness is concerned, the awareness in the community was found be limited. Most of them in Raebareli cited sadness, depression, fear and nervousness as common symptoms of mental illness. It was also observed by the field team that community perception on black magic as a cause of mental illness strongly persists; however 70% of the respondents also agreed that these can also be cured at a hospital. More than half the community members also reported the use of medicines for treatment. In Kanpur no awareness could be created in the community, so the work done by the DMHP team on awareness was a failure. Health staff suggested lack of funds was the main cause behind insufficient awareness camps. Regarding the curability while three forth of those interviewed in Kanpur recommended treatment in the hospital can cure mental illness half of them also suggested shock treatment. 44% also recommended visiting an occult practitioner for treatment.

Implementation problems

Staff Salary

- The expenditure pattern of the funds allocated under DMHP in both the districts reveal that a major proportion of the fund has been utilized in the salary component. Whereas very little fund has been utilized for important aspects like training, IEC material etc.

Awareness Camp

- Even though the health officials have reported that the awareness camp had been organized in the survey districts, the community members reveal that no such camp had been held and community's awareness regarding mental illness is very low.

Suggestions/Recommendations

- Need for operational guidelines for DMHP
- Need for operational guidelines for training and program implementation
- Training in program management required for DMHP team
- Dedicated monitoring system /team to be deputed
- Training and IEC to be given equal weightage as treatment

District Mental Health Programme (DMHP)

Snapshot from Rajasthan

In the state of Rajasthan, DMHP was supposed to be initiated in the District of Sikar under the 9th Plan period (1997-2002). However, due to non transfer of funds from the Nodal Office, DMHP officially started only in 1998 at the Shri Kalyan District Hospital, Sikar. Psychiatric Centre, Jaipur was the Nodal Centre implementing the programme. The District Hospital where the programme was initiated did not have a separate psychiatric wing. Therefore, the programme was being run from a room allocated to the psychiatrist by the district hospital.

The programme officially completed its tenure in 2004. The nodal officer at Jaipur said that they had received the last installment under DMHP in 2002. Till 2003 the programme was successfully implemented at the District level and also the PHC's and CHC's under the district with the balance from funds received in 2002. However, after 2003 the programme started suffering due to lack of funds and unavailability of medicines, after which it was discontinued.

Presently, however two psychiatrists are still working at the Shri Kalyan District Hospital, Sikar. They are salaried staff under the state government now. Today the facility of free medicines is only being given to the people who are below the poverty line. The DMHP programme has not been taken over by the state government but the psychiatrist was retained at the District Hospital as a permanent employee. The psychiatrist now takes care of the cases of mental illness that come to the District Hospital. However there is a general level of dissatisfaction among the patients due to non availability of drugs after DMHP ended.

1. Allocation and Utilisation of Funds

	9th Five Year Plan

Expense Categories	Scheduled Expenses	Actual Expenses	Balance	% of utilization
Staff Salary	3,768,438	4,572,847.00	-804,409.50	121.3%
Medicines/Stationary/Contingencies	3,038,750	752,181.00	2,286,569.00	24.8%
Equipments/Vehicles, etc	900,000	856,715.00	43,285.00	95.2%
Training	1,200,000	962,904.00	237,096.00	80.2%
IEC	847,750	838,773.00	8,977.00	98.9%
Total	**10,997,000.00**	**7,983,420.00**	**3,013,580.00**	**72.6%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 1,09,97,000.00 had been sanctioned for Sikar under the DMHP in the 9th Five Year Plan of which around 73% had been utilized. As per the utilization certificate the remaining unutilized amount is at present with the state government.

- The analysis shows that, in the 9th plan period, there has been a utilization of 95% while spending on equipments and vehicle. But in case of spending on medicines and stationeries, less than 25% of the allocated fund got utilized.

- An excess of 21.3% of the allocated amount under Salary has been spent.

- 80% of the entire funds allocated for training and almost 99% of the amount scheduled for IEC have been utilized

- A significant analysis that is also visible is that the main goal of the DMHP with respect to treating the mentally ill patients and spreading awareness among the community has been relegated with appropriate priority.

- Another significant component worth mentioning is that the Nodal office had received Rs 12,00,000 in April 2002 but no breakup of the utilization for 2002-2003 was available at the Nodal Office.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 32 beneficiaries who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1. Composition of DMHP team

The DMHP team should have a psychiatrist, a clinical psychologist, a health worker, a psychiatric nurse and a counselor. In Sikar District Hospital during the tenure of DMHP only one psychiatrist was associated with the programme. Four staff nurses working in the general ward of the district hospital were also assisting in the programme. These nurses mainly assisted in taking care of the mentally ill in-patients who were admitted at the district hospital. All these staff working for DMHP at the District hospital are permanent salaried government employees.

Even after DMHP officially ended in 2004, two psychiatrists are still working at the district hospital. They attend to the patients who come to the district hospital. The other health staff from the general hospital also assists these psychiatrists in the treatment of the mentally ill patients who are admitted to the hospital.

2.2. Training

Training is an important component of DMHP. Training under DMHP should happen in the first 3 years after the initiation of the programme. In Sikar however, training was held only in the year 1998. Initially the general doctors of the district hospital received training at the Jaipur, Nodal office. This training was conducted for 15 days. These doctors then organized small training sessions for the medical officers and general health staff at the CHC and PHC level. These trainings were also accompanied by a pre and post training evaluation of the personnel.

The District health officials stated that this initial period of training ensured the permeation of DMHP to the CHC and PHC level as well. However since training had

happened only in the initial phase of the programme around 65% of the respondents had said that they had attended the training programme.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two parts. One part captures the viewpoint of the DMHP team. The other part tries to capture the viewpoint of the beneficiaries about the diagnosis and treatment they received and their satisfaction level.

2.3.1. Heath System viewpoint

During the tenure of DMHP the OPD in Sikar District Hospital was operational on all seven days of the week. The average number of patients turning up per day was found to be 15-20 (OPD register at the time DMHP). Additionally the DMHP team from the District hospital also visited the CHCs once a week and once in a fortnight to the PHCs for OPD.

After DMHP ceased to operate, the psychiatrists only attend to cases who directly come to the District Hospital. The DMHP officials reported that after 2004 the number of patients has reduced. They stated that earlier free medicines were available so patients used to turn up regularly. Nowadays the drop out rate is higher due to unavailability of free medication.

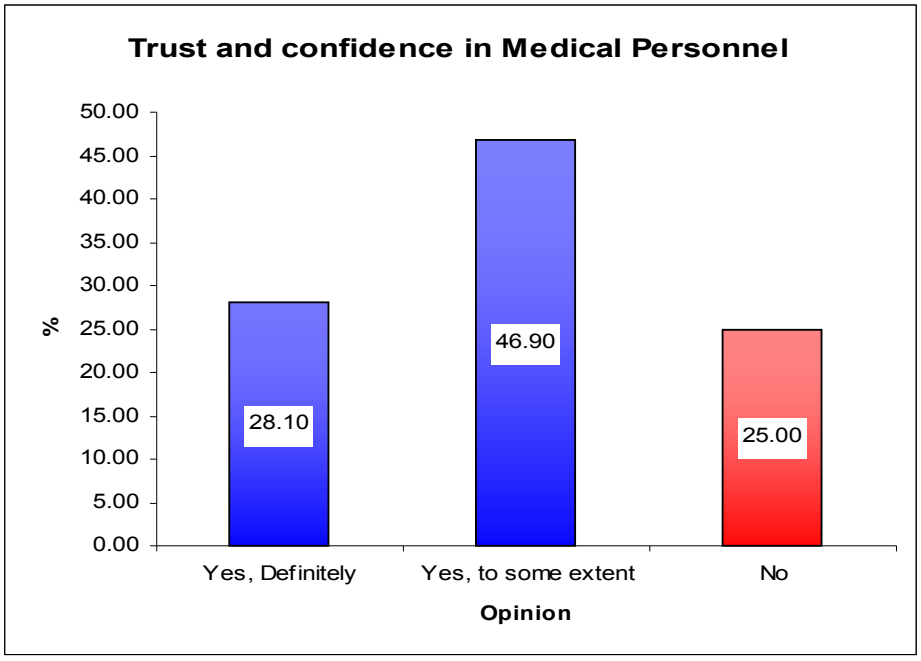
2.3.2. The beneficiaries view point

The ICMR, Planman Consulting field team also interviewed the beneficiaries from areas surrounding the District Hospital at Sikar and villages around a CHC and a PHC as well to understand their knowledge of the illness diagnosed and satisfaction on treatment that they received. Altogether 32 beneficiaries were interviewed. Out of them more than 50% of the beneficiaries informed that they go to the District hospital in Sikar for their treatment, 28% of the beneficiaries also reported that they had visited the CHC while 16% said they went to the PHC as their first point of contact. The perception of all these beneficiaries on various parameters is given below:

2.3.2.1. Perception about the Doctor

The figure below depicts that almost half, 47% beneficiaries reported that they had trust and confidence on the doctor to some extent .Only 3 out of every 10 respondents reported that they had full trust and confidence on the doctor who is treating them. This shows that most of the beneficiaries had only limited amount of trust and confidence on the medical personnel that they had met for the treatment. Moreover one out of every four respondents also stated that they had no trust on the doctor they had met.

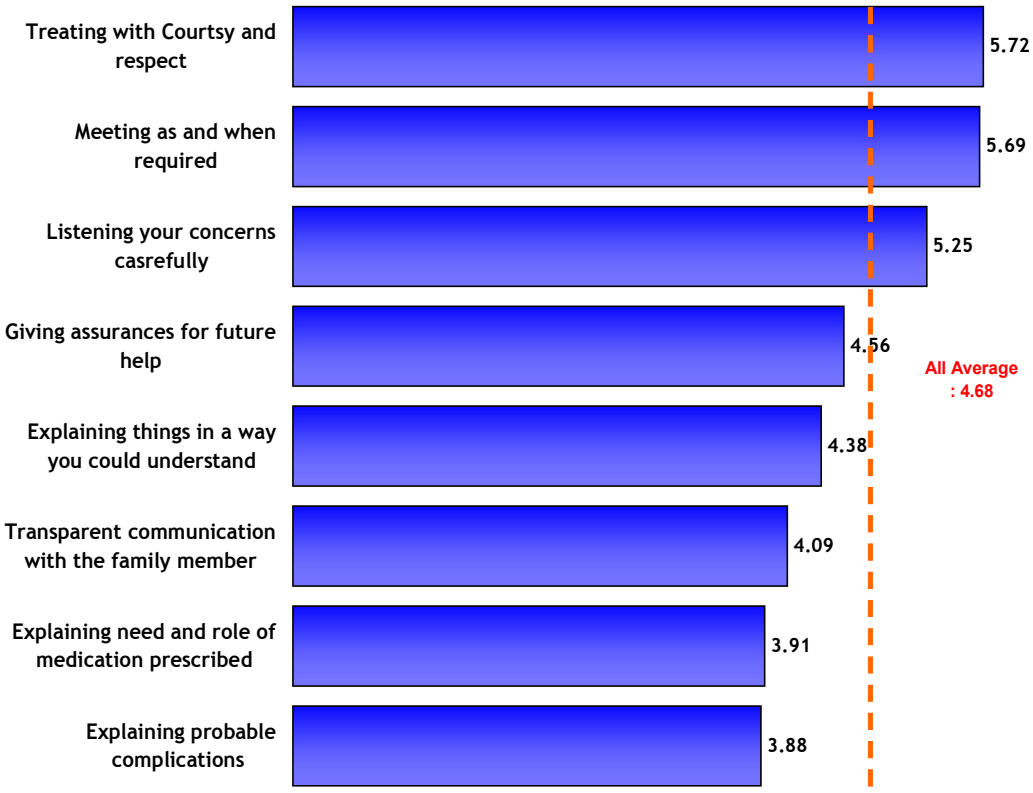
Fig.1: Trust and confidence in Medical Personnel



Detailed satisfaction level of the beneficiaries of Sikar with the psychiatrist based on certain parameters of satisfaction is shown by the figure below (fig.2). Out of these "meeting as when required" and "listening to concerns carefully" were found to be above the average level. Transparent communication with family members and explaining probable complications and need and role for medication were rated below

the average value. The beneficiaries are most satisfied that doctors treated them with courtesy and respect and met them when required. They are however least satisfied by the way the doctor explains the probable complications to them.

Fig. 2: Average Level of Satisfaction

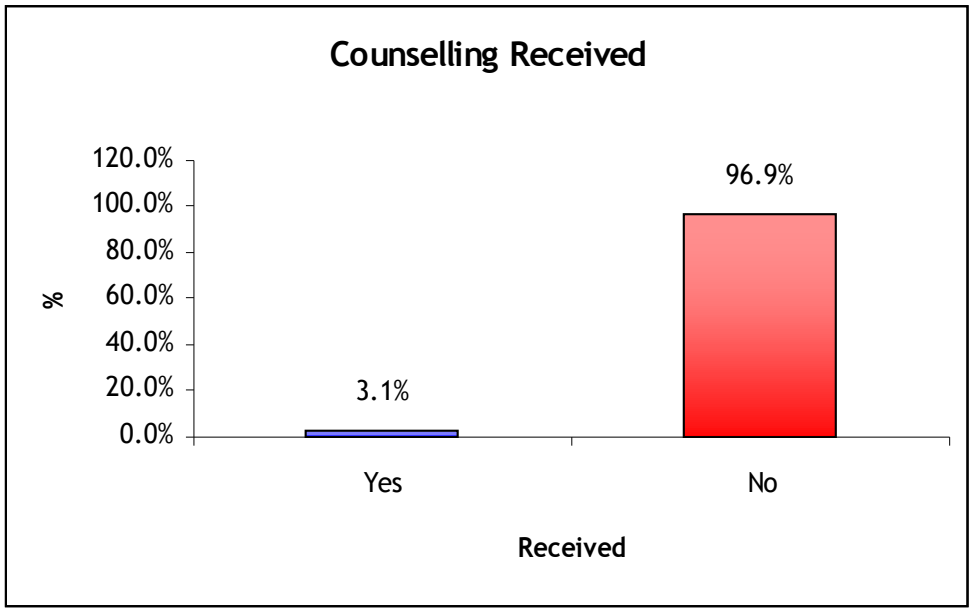


2.3.2.2. Counseling Received

Most of the beneficiaries (96.88%) denied having received any counseling during their visit in the hospital. This confirms that in the absence of a psychologist the psychiatrist

at the District hospital was finding it difficult to perform the dual role of a physician and counselor.

Fig. 3: Counseling Received



2.3.2.3. Overall treatment

There was a average level of satisfaction found among the beneficiaries of Sikar with respect to the overall treatment received.1 out of every 5 beneficiaries interviewed gave a rating between 5-7 on a scale of satisfaction from one to ten (one being not satisfied and ten being absolutely satisfied). Majority of the patients and their family members however confirmed that they could see improvement in their condition after receiving treatment from the doctors and health institutions they visited.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

The inventory of the drugs was being maintained by the Psychiatrist Centre, Jaipur. During the tenure of DMHP there was a regular supply of medicines from Jaipur. The psychiatrist at the district hospital who had worked under DMHP stated that medicines were also given to the beneficiaries at diagnostic camps organized at the PHC and CHC level. After 2004 the supply of medicines to Sikar district hospital was discontinued. Only the below poverty line patients were still supplied with medicines but this was not under the DMHP scheme.

2.4.2. The beneficiaries view point

The beneficiaries interviewed from the villages around the PHC and CHC and surrounding the district hospital of Sikar also confirmed that drugs were available before 2004. Most of the beneficiaries contacted confirmed that they were provided medicines by the medical personnel before 2004. However only one out of every five beneficiaries interviewed reported that they were given some explanation on the purpose of medication given. Around 72% reported that they had not been explained the purpose of medication.

2.5. Awareness about Mental Illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community's perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

The District level health officials said that there had been no awareness camps held as funds had not been allotted from Jaipur Nodal office. The psychiatrist at the district hospital opined that no funds had been allotted for the awareness campaigns for the past 6-8 years. The awareness at the community level was spread during the diagnostic camps held at the PHC and CHC (where leaflets and pamphlets on mental health were distributed) and through word of mouth.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Awareness about mental illness among the community members were recorded through door to door survey in the district of Sikar, Rajasthan and also discussion with common people at very informal level. Most of the community members contacted during the survey were of the opinion that no health awareness camp had been held in their village at all. Only 4% reported attending a health camp. 1 out of 4 community members responded that they had come to know about the mental illness from their neighborhood through word of mouth and print media. One out of every four community member interviewed also said that the doctors of the PHC and other health workers had told them about symptoms of mental illness.

2.5.2.2. Awareness about symptoms and perception of mental health

The common symptoms of mental illness identified by the community members were depression, lack of sleep and fits. Some of the respondents also believed evil spirits is the main reason behind mental illness. A mixed response was found regarding the curability of mental illness as well. 73% of the respondents opined that epilepsy is curable. Moreover, half the people interviewed said that Neurosis and Psychosis is curable but only 23% people think that mentally retarded people can be cured. Regarding the procedures of cure, while more than 3 out of 5 respondents recommend medicines and treatment at a hospital, 65% also recommend visiting an occult practitioner. More than half the community members also pointed out that shock treatment is a procedure to cure mental illness.

Suggestions/Recommendations:

- There is difficulty in flow of funds at the District which needs to improve
- Funds should be sent to the District Health System under the mechanism of NRHM for better utilization.

District Mental Health Programme (DMHP)

Snapshot from West Bengal

DMHP programme was initiated in West Bengal under the 9th Plan period only in Bankura. It was further extended to three other districts of West Bengal (Jalpaiguri, East Midnapur and South 24 Parganas) in the 10th plan. For evaluating the overall implementation of DMHP in the State of West Bengal, two districts, Bankura (9th plan) and Jalpaiguri (10th plan) were selected.This report therefore captures the situation in both these districts.

Bankura at a Glance:

DMHP was initiated in Bankura in the year 1999 after the transfer of funds from the Central Government. As there is no district hospital in Bankura, DMHP was implemented by the Psychiatric department of Bankura Sammelani Medical College (BSM). As per the nodal officer, as there is no District Hospital the structure being followed in Bankura was little different. Under the Medical College implementing DMHP, several rural hospitals run their service facilities. In Bankura, DMHP was being run through satellite clinics at these rural hospitals. The nodal officer stated DMHP had started three satellite clinics in the areas Bishnupur, Amarkanan and Chatna within Bankura. Doctors and psychiatrist of BSM College went to those satellite clinics once in a week. Officially the tenure of DMHP for the 9th plan has ended for the district. However, it was informed that a satellite clinic at Bishnupur is still being run once in a month by the Psychiatric department of BSM College.

Jalpaiguri at a Glance:

DMHP was initiated in Jalpaiguri under the 10th plan in the year 2003. The programme was being implemented by the Psychiatric department of North Bengal Medical College. The head of the department psychiatry, North Bengal Medical College was the nodal officer supervising the programme. In Jalpaiguri, the district hospital has not yet received any money under DMHP. The health staff at Jalpaiguri District hospital said that no money has been released from the Nodal Office. The Nodal Officer had met the team and intimated them about the programme and asked to make preparations. However no money has been released as yet. Under this District Hospital several Rural

Hospitals run their service facilities followed by the BPHCs (Block Primary Health Centres) and ANMs respectively. Boards and hoardings creating awareness on mental illness have been displayed at these centers but no other activity has been initiated. The psychiatrists stationed at the district hospital opined that there is an inflow of patients because of the presence of a psychiatric department at the district hospital. The Nodal Officer further reported that only 16 Lakhs had been received in 2007 which was used for IEC activities, Medicines and some instruments. The medicines and instruments are still at the Nodal Office in North Bengal Medical College as there is no DMHP staff in Jalpaiguri. The rest of the fund was also allocated to the Nodal Office but is still unutilized

1. Allocation and Utilization of Funds-Bankura

	9th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	1,928,888.89	589,640.00	1,339,248.89	30.6%
Medicines/Stationary/Contingencies	1,549,637.68	3,198,729.0	-1,649,091.32	206.4%
Equipments/Vehicles, etc	900,000.00	1,824,508.0	-924,508.00	202.7%
Training	1,093,236.71	107,400.00	985,836.71	9.8%
IEC	493,236.71	269,441.0	223,795.71	54.6%
Total	**5,965,000.00**	**5,989,718.00**	**-24,718.00**	**100.4%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A fund of Rs 59,65,000.00 had been so far been allocated for the district of Bankura under the DMHP in the 9th Five Year Plan on which there had been a marginal over-utilization of 0.4%. As reported by the nodal office, the first installment was received in the FY 2000-01 and the last grant being received in the year 2005-06.
- The analysis clearly shows that, under the 9th plan period, there had been a huge over spending of around 100% for the purpose of buying of medicines/stationeries and also on equipments and vehicles.

- On the other hand, for the payment of staff salary, there had been an utilization of only 30% of the allocated amount.

- Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, was dealt with very less priority which is clear from the fact that below 10% of the allocation had been utilized.

- IEC, which is the component that is supposed to have a far reaching impact on the community's awareness, is also under utilized as the utilization rate is slightly above 50%.

- The analysis points to the fact that more emphasis has been given on the physical infrastructural set up. As revealed by the nodal office for DMHP in Bankura, the over spending in case of equipments and vehicles were mainly due to few successive years spending on vehicles, fuels, AC machines, etc.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the 10 Health Staffs working under DMHP or those who had received training under the programme, 52 beneficiaries who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run from the each of Bankura and Jalpaiguri of West Bengal.

2.1. Composition of DMHP team

In Bankura, DMHP team consisted of one Psychiatrist, one Psychologist, one Psychiatric Social Worker and Staff Nurses. The team was supervised by the Head of Psychiatric department, Bankura Sammelani Medical College.

In Jalpaiguri district, North Bengal Medical College was given the responsibility of conducting the programme. No additional team has been formed for this purpose at Jalpaiguri as yet due to non transfer of funds. However, two psychiatrists present at the psychiatric department of the District Hospital are treating patients from the district. They are however permanent salaried staff of the state government and not working under DMHP. The Nodal Officer had reported that the process of staff recruitment began around August 2007. However due to official delays from the state

government the appointment letters of selected DMHP staff has arrived only in December 2008. Therefore the program will be initiated after December 2008 only.

2.2. Training

Training is a mandatory part of DMHP for first three years after initiation. In the Bankura district training team is composed of coordinator, one instructor, two doctors and one nurse.

The staffs were given two days training at the earlier stage of the programme and except one all other trained staff have been transferred from Bankura because of which the rural Hospital where the satellite clinic is being run in Bankura is suffering from the less number of trained staff. This absence of training is directly affecting the quality of diagnosis and treatment being that the patients receive in Bankura.

In case of Jalpaiguri the responsible authority did not conduct any training session. They did not even form a team for the purpose of training. The reason given for this as cited above also was the non transfer of funds to the district hospital. The District health officials said that the nodal officer had only conducted an initiation meeting but no funds had been transferred thereafter for any activity.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two parts. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level. The consolidated views from both Bankura and Jalpaiguri districts are discussed below.

2.3.1. Health System viewpoint Bankura:

In Bankura during the tenure of the programme three satellite clinics were conducted in three different rural hospitals. It was run by the Psychiatric department of BSM College. These satellite clinics do not however maintain a record of the patients registered or treated. However the records are maintained at the Nodal institution, Bankura Sammelani Medical College Hospital. As per these records and the Psychiatrists opinion an average of 10 patients visit the hospital every day. According to the psychiatrist who was working under DMHP, to make DMHP successful it should be

spread all over the district. However lack of training has been a major hindrance in the success of the programme. As stated earlier, the existing staff in Bankura who are running the DMHP have not been trained under DMHP. The staff at the rural hospital similarly had received no training and the earlier trained staff had been transferred. Hence in the absence of capacity building the satellite clinics were not serving as efficient mechanisms for initial diagnosis and treatment of patients. As the staff at these rural clinics also confirmed that most patients were sent to the Bankura Sammelani Medical College Hospital for treatment.

2.3.2. The beneficiaries view point

ICMR, Planman consulting field team interviewed the beneficiaries from this district to understand their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Most of the beneficiaries (more than 95%) informed that they go to the Bankura Sammelani Medical College Hospital for their treatment as the first point of contact. This confirms the views of the health staff at the satellite clinics who said that due to lack of training, most patients were directly sent to the nodal office.

In Jalpaiguri, all the beneficiaries interviewed were from the District Hospital and its surrounding areas only. Since the programme had yet to be initiated here the beneficiaries interviewed do not fall under the programme. They are the regular patients who come to the psychiatrist at the Jalpaiguri District Hospital.

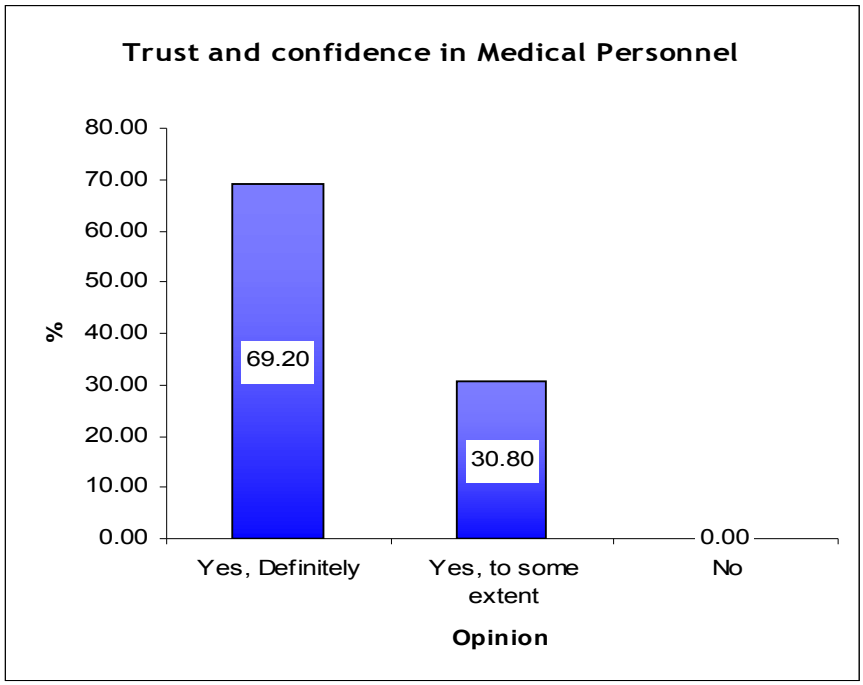
2.3.2.1. Perception about the Doctor

Bankura:

The beneficiaries who were interviewed at Bankura were mostly from the areas surrounding the Bankura Sammelani Medical College Hospital (BSM Hospital). This was done because the rural hospital staff said that they referred the patients to BSM College Hospital as they were not trained to treat them. Thus the perception gathered below directly pertains to the treatment received at the BSM College Hospital.

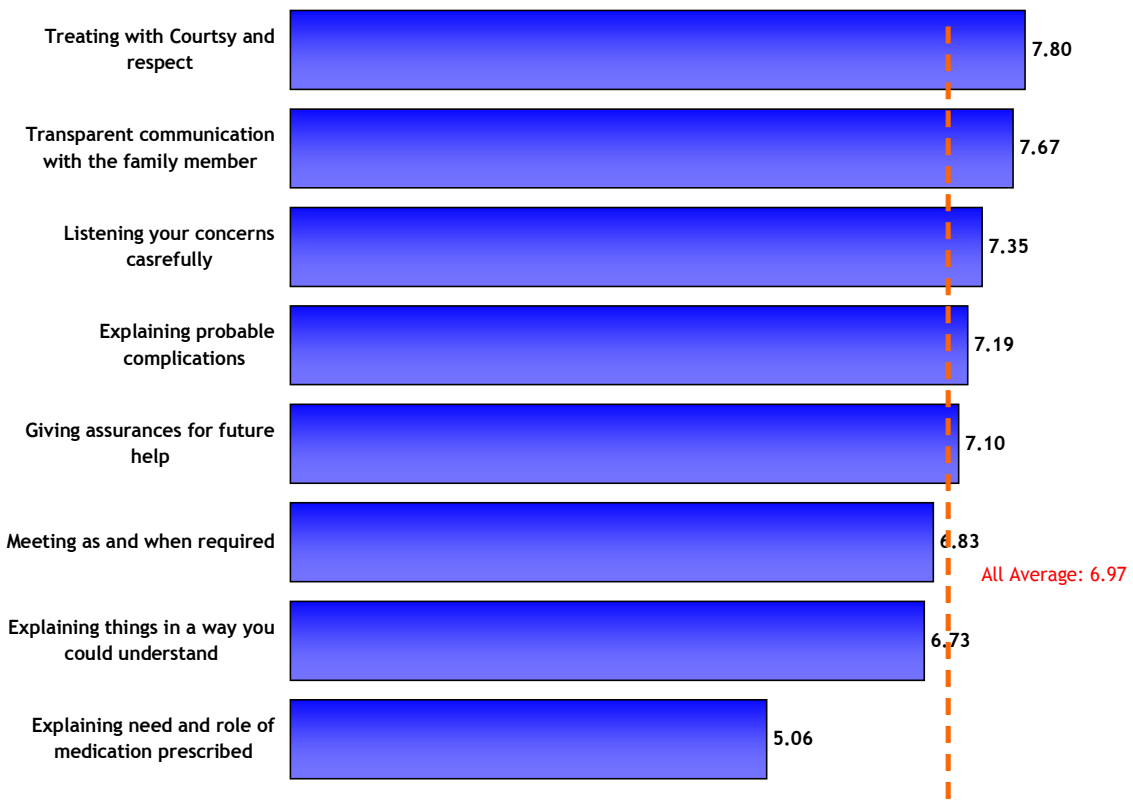
The patients interviewed had shown high level of trust and confidence on the doctors. As shown in the graph below almost 7 out of every 10 respondent (69%) reported that they had full trust and confidence on the doctor who is treating them. Moreover, 30% also reported that had trust and confidence on the doctor to some extent.

Fig 1 (Bankura). Trust and Confidence in Medical Personnel



All the beneficiaries interviewed said that they have trust and confidence in Doctors and Psychiatrist who treat them. This indicates that in spite of the lack of training at lower levels, the psychiatrist at the Nodal center has been able to instill trust in the patients.

Fig 2 (Bankura). Satisfaction level of beneficiaries



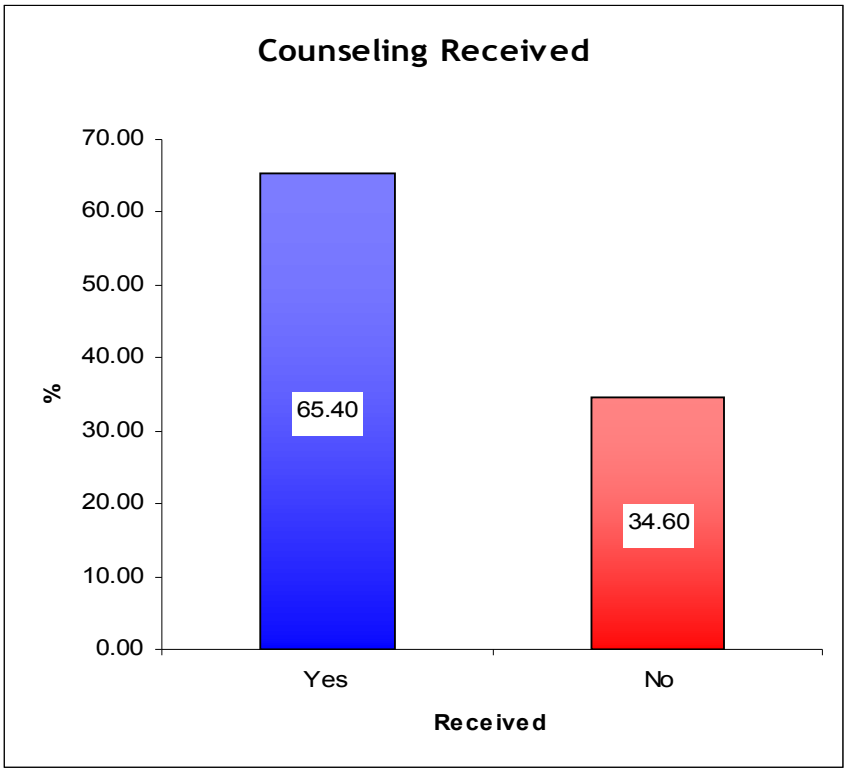
The above figure shows that on the scale of satisfaction rated by the beneficiaries, the categories treating with courtesy and respect, transparent communication, listening to the patients concerns and explaining probable complications were found to be above the average rating of 6.97. However the category explaining the purpose of medication received the lowest rating. From this it can be concluded that while the beneficiaries were satisfied by the way the psychiatrist treated them and explained the complications to their family. They were not so satisfied by the way the doctor explains the purpose of medication.

2.3.2.2. Counseling Received

In the Bankura DMHP team there is a psychologist who provided counseling to the patients. Around 65% of the beneficiaries reported to have attended this counseling session. Regarding the frequency of their attending this session it was found that most of them have attended this session less than 3 times and they have also found this session to be helpful in their treatment to some extent. The fact that more than half

of the beneficiaries had received counseling proves that the psychologist at the Bankura Nodal Center gave counseling to their patients.

Fig.3 (Bankura) Counseling Received by the beneficiaries



2.3.2.3. Overall treatment

In response to the perception regarding the overall care and treatment that the beneficiaries have received from the mental health services it was found that most of them are very satisfied in this respect. According to them the patient's mental health is also improving after the treatment. 33.33% beneficiaries had ranked 7 and 8 on the satisfaction achieved from the treatment process.

2.3.3. Jalpaiguri

2.3.3.1 Health System viewpoint

In Jalpaiguri, the programme had not been initiated only but regular OPD was being held at the district hospital. The psychiatrist at the District Hospital however claimed that the patients who came were not given any benefits under DMHP as the scheme

was yet to be initiated here. The average number of patients visiting the district hospital as per the psychiatrist numbered around 100 per day. He however could not specify how many of these new patients were as there was no such record maintained.

Average number of mentally ill patients treated in the district hospital is 100 per day. So the demand for setting up out door clinic in different areas of the district is very high.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

In Bankura and Jalpaiguri health officials are not satisfied with the availability of drugs. According to them supply of drugs are not adequate. In Bankura during the tenure of the programme the nodal officer faced a lack of adequate medicines because of shortage of medicines. In Jalpaiguri since the programme has not yet started, there are no medicines that are available at the District Hospital.

The nodal office confirmed that the following medicines were available in Bankura during DMHP.
Following drugs were available at the Bankura Medical College.

- Tab Chlorepromazine (CPZ) 100 mgs
- Tab Imipramine 75 mgs
- Tab Phenobarbitone 30 mgs
- Tab Diazepan
- Trihexiphenydyl

The patient had to purchase other prescribed medicines from the market for other drugs.

2.4.2. Beneficiary view point

2.4.2.1. Bankura

About 85% of beneficiaries said that they had received drugs at the hospital where they had gone for treatment. However most of them also said that they had received only some of the drugs and had to buy the rest from the market.

2.5. Awareness about Mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

In the Bankura district a team of DMHP under the supervision of the Psychiatric department of Bankura Medical College has created some level of awareness about the mental illness in this district. According to the health officials DMHP is successful in some particular parts of the district. But more initiative is needed to make it fully successful.

In the Jalpaiguri district no awareness activities had happened due to non transfer of funds. The health officials however said that boards depicting causes and symptoms of mental illness and its cure were displayed at the District Hospital and the rural hospitals. These boards had been sent from the Nodal Office in North Bengal.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health: Bankura

The community has responded that more than half of them have come to know about the mental illness from the health workers of some NGOs. However, one out of every 5 of them (22%) got the information from the doctors of PHC. All of the respondents reported 'regarding the last mental awareness camp' that awareness camp was held only once and could not recall when it was held.

2.5.2.2. Awareness about symptoms and perception of mental health: Bankura

The perception of the community regarding mental health was also collected by interviewing them. It was found that most of the people are aware about this problem and they think that mental illness is nothing but a disease. Most of the people are happy with the govt. initiative taken for the betterment of the mentally ill people. As far as symptoms of mental illness is concerned, the awareness in the community was found be varied. Most of them cited about spells of depression, fits, excessive anxiety as the common symptoms. According to 7 out of 10 members of the community treatment at the hospital may be a way to cure the mental illness. More than half the people from the community also pointed out medicines and counseling as the most appropriate ways of curing mental illness. However a similar proportion of the community also recommended shock treatment as a method of curing mental illness.

Suggestions/Recommendations:

- The DMHP team requires training in organizational activity
- Need for monitoring at the District level
- Need for co ordination between the Nodal Institution and District Health System
- The fund should be directly transferred to the District Health System for effective usage.

District Mental Health Programme (DMHP)

Snapshot from Assam

In Assam, two districts were covered for the purpose of evaluating the implementation of DMHP - Nagaon and Tinsukaia. In Nagaon district in central Assam, DMHP was operational under the 9th Plan and in Tinsukia the operation started in the 10th plan. This report will therefore highlight the consolidated perception gained from both these districts under various parameters defined below.

The District Mental Health Programme (DMHP) started in Assam in June 1997 under the 9th five year plan and was implemented in two districts of Nagaon and Goalpara (of these Nagaon as mentioned above was evaluated by the Planman team).In Nagaon, the Department of Psychiatry & Drug De addiction Centre, Gauhati Medical College was the institution responsible for implementation of the programme. In Nagaon the DMHP programme operated from the District Hospital and 6 CHC's and 11 Block PHC's (the numbers correspond to the situation during 1997-2002).The whole district health structure was subdivided into District Hospital, CHCs and block PHCs. Some of the CHCs have been upgraded to First Referral Units. However, after June 2002 The District Mental Health Programme had ceased to operate in Nagaon after completing its 5 year term and the unutilized fund was handed over to Joint Director of Health Services, Assam. The state Government, which was supposed to continue the programme in the 10th plan period, however, has not continued this further. Therefore DMHP is no longer operational in Nagaon.

In the 10th five year plan one more district of Assam (Tinsukia) was included under the DMHP programme and the approval for the same from the state government was obtained on 28th November 2003. The Department of Psychiatry & Drug De addiction Centre, Assam Medical College was the institution responsible for implementation of the programme in Tinsukia. As per the nodal institution the programme could only start in January 2006 due to delay caused by procedural formalities like fund transfer and processing. The delay was caused in the process of transfer of funds from the Nodal office along with the various procedural formalities issued to the District to begin DMHP. There are 4 CHCs and 4 PHCs under Tinsukia District Hospital. However, besides the District Hospital the DMHP programme was started in only one CHC, the

Doomdooma FRU, on 7th September 2006. The Nodal Officer, responsible for implementing DMHP said that services were not made available at the other CHC's and PHC's due to lack of funds. Further, due to non receipt on 2nd installment the DMHP has also been discontinued in Tinsukia district, since August 2008.

1. Allocation and Utilisation of Funds.

1.1 Allocation and Utilisation of Funds in Nagaon

	9th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	0.00	0.00	0.00	0.0%
Medicines/Stationary/Contingencies	650,000.00	628,380.00	21,620.00	96.7%
Equipments/Vehicles, etc	200,000.00	110,358.00	89,642.00	55.2%
Training	500,000.00	450,000.00	50,000.00	90.0%
IEC	200,000.00	149,355.00	50,645.00	74.7%
Total	**1,550,000.00**	**1,338,093.00**	**211,907.00**	**86.3%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- As was revealed by the nodal officer, component utilization of a fund of Rs 15,50,000.00 till date was available with the nodal centre for DMHP in the district of Nagaon. However, the total money received for the plan period was Rs

- The analysis clearly shows that, under the 9th plan period, there had been more than 90% utilization of the allocated funds under the heads of medicines/stationeries and contingencies and on training as well.

- About 75% of the allocated funds were utilized for IEC. On the other hand, a little more than half of their funds meant for purchasing the equipments, vehicles had so far been utilized.

- Training, which forms an integral component of the DMHP, which also ensures the proper diagnosis and treatment, was attached considerable priority with ninety percent of the allocation had so far been utilized.

Contrastingly, it came out from the nodal officer that there had been no allocation of the fund meant for staff salary.

- The utilization percentage on IEC at Nagaon shows that there still lies the scope of improvement in terms of enhancing the community's awareness.

Note: After repeated rounds of confirmation with the nodal officer in Guwahati for DMHP in Nagaon district by the ICMR Research team, the grant received was reported to be Rs 15.5 lakh only on which the above mentioned expenses were made. ICMR team has been unable to obtain any further grant receipt and the corresponding utilization details..

1.2 Allocation and Utilisation of Funds in Tinsukia

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	870,000.00	566,417.00	303,583.00	65.1%
Medicines/Stationary/Contingencies	450,000.00	618,965.90	-168,965.90	137.5%
Equipments	600,000.00	886,715.82	-286,715.82	147.8%
Training	500,000.00	387,247.00	112,753.00	77.4%
IEC	200,000.00	98,229.00	101,771.00	49.1%
Total	**2,620,000.00**	**2,557,574.72**	**62,425.28**	**97.6%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 26,20,000.00 as one installment had been sanctioned for the district of Tinsukia in 2006-07under the DMHP in the 10th Five Year Plan of which 97.6% had been utilized till 2007-08.

- The analysis clearly shows that, under the 10th plan period, there had been over spending of around 48% on the purchase of equipments and vehicles and an excess spending of 37.5% in buying the medicines/ stationary/ contingencies.

- Whereas, in the case of payments to staff, 65% of the allocated amount were spent.

- For the purpose of training, the proportion of funds that had been utilized was about 77%. In the case IEC the amount spent was 49% of the allocated amount.

The above spending pattern clearly indicates to the fact that the major thrust of the DMHP in Tinsukia had been to main the "institutional set up and building up of physical assets" in the form of buying equipments and vehicles. Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, was assigned considerable priority. However, the awareness level in terms of the use of IEC materials, the utilization rate is below 50%.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects, views were taken from the Health Staff working under DMHP and those who had received training under the programme, along with 60 beneficiaries each from the two districts who were receiving treatment under the programme and 30 members of the general community from each of the areas where the programme has been implemented or being implemented.

2.1 Staff Structure:

Under the DMHP programme in Nagaon one psychologist, one receptionist, one grade IV worker (peon) and one sweeper were appointed on contractual basis for the period of DMHP in Nagaon District Hospital. A Psychiatrist from Gauhati medical College used to visit Nagaon district hospital on a regular basis during the time of the programme. The people appointed under DMHP in Nagaon have not yet become permanent staff of the hospital and they are currently working on contractual basis in the District Hospital.

In order to implement the DMHP, the nodal office was set up in Assam Medical College Dibrugarh. For this purpose one office assistant, one peon and one accountant were appointed at the nodal office. The programme in Tinuskia was supervised by a Programme Officer - a Psychiatrist in Tinsukia District Hospital (who was not part of DMHP team). The programme was started from Doomdooma FRU, a CHC under the Tinsukia District Hospital. To run the programme in the CHC a psychiatrist along with one ward boy and one care taker were also appointed. A total of 3 staff at the Nodal office and 1 psychiatrist and 2 staff members were hired at the CHC.

2.2 Training

Training is a mandatory part of DMHP for the first three years after initiation. Under the 9th plan period of DMHP in the district of Nagaon, attempts were made by the psychiatrists of Gauhati Medical College and the district level team leaders to train the Medical Officers of the CHCs & the PHCs on mental illness and its care. Additionally the training was also extended to various Medical Officers of Tea Estates, private practitioners and Paramedical staff of the Civil Hospital.

Under the 10th plan period of DMHP in Tinsukia, training programmes were held for both Medical Officers and other health care workers by the team of medical personnel from Assam Medical College, Dibrugarh. Three training programmes were held in the period 2006-2007 for the medical officers at Assam Medical College and two training programmes were held for multipurpose primary health care workers & allied staffs. Pre and post training assessment of the training programme was also conducted. However due to non receipt of further monetary installments, no refreshers could be held. Thus the effect of these trainings was limited only to the one year period during which the training had been held. The exact duration of these training programmes or the total number of staff trained could not be ascertained from the nodal officer.

2.3 Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level. Here also perception from both the districts has been taken to give a consolidated perception.

2.3.1 Heath System viewpoint

The Psychiatric Wing OPD runs six days in a week in B.P Civil Hospital, Nagaon. On these days, there is a regular in-flow of patients. On an average 10-15 patients used to visit at B.P Civil hospital during the time DMHP was in operation. Out of which around 40% were new patients (OPD Register). However, after the discontinuation of DMHP after the 9th plan, the numbers of patients have declined in the last four years.

In L.G.B Civil Hospital, Tinsukia the Psychiatric Wing OPD runs for six days in a week. Here the average number of patients has been estimated to be 15-20 per day. During the programme period the psychiatric OPD of Doomdooma FRU also operates twice in a week for 8 hours. Initally this programme was run by a team of two psychiatrists from Assam Medical College. However after the appointment of a psychiatrist in Doomdooma FRU, the visit of psychiatrists from Assam Medical College have been reduced to once or twice in a month.

At the Doomdooma FRU, initially diagnosis and treatment used to take place on the scheduled days when DMHP team used to visit the area. Medicines were provided to the care taker of the FRU but the register was maintained by the officials from the Medical College Assam who used to visit this FRU. After the appointment of a psychiatrist in this FRU the register is being maintained at the FRU itself. No counselor has been appointed in Tinsukia district under DMHP programme. It was left to the Psychiatrist to explain the patient's families about the disease and the care that needs to be given. Since the Psychiatrist appointed at the Doomdooma FRU has also left the job, therefore, a care-taker has been employed on part-time at the general OPD. Therefore psychiatric cases at the FRU are no longer treated here. All the patients in need of the treatment directly approach the Tinsukia District Hospital or Assam Medical College.

2.3.2. The beneficiaries view point

The beneficiaries who were interviewed from both Tinsukia and Nagaon were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Of the 60 beneficiaries interviewed in both the districts, around 13% and 18% were referral cases (those who had been referred from a lower Medical institution to a higher one) in Nagaon and Tinsukia respectively.

2.3.2.1. Perception about the Doctor

All the beneficiaries in Nagaon agreed that they had trust in the doctor whom they had met for the treatment. In Tinsukia also nearly 9 out 10 had shown trust in the doctor. All of the beneficiaries at both the places agreed that they met the same doctors during each visit to the hospital and their overall satisfaction level with the doctor/psychiatrist was also found to be on the higher end.

Fig 1 .Trust and Confidence in Medical Personnel (for Nagaon)

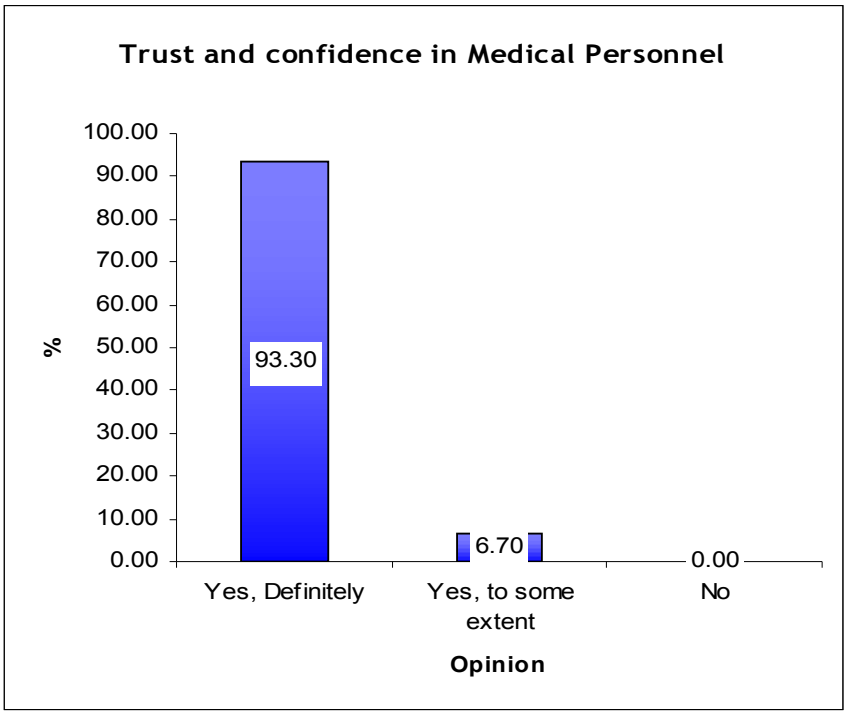
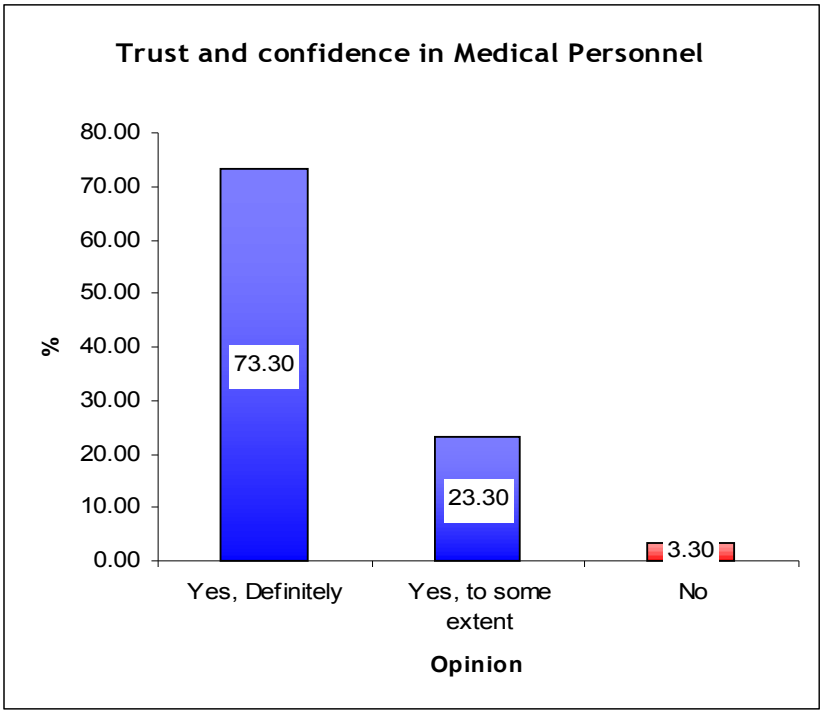


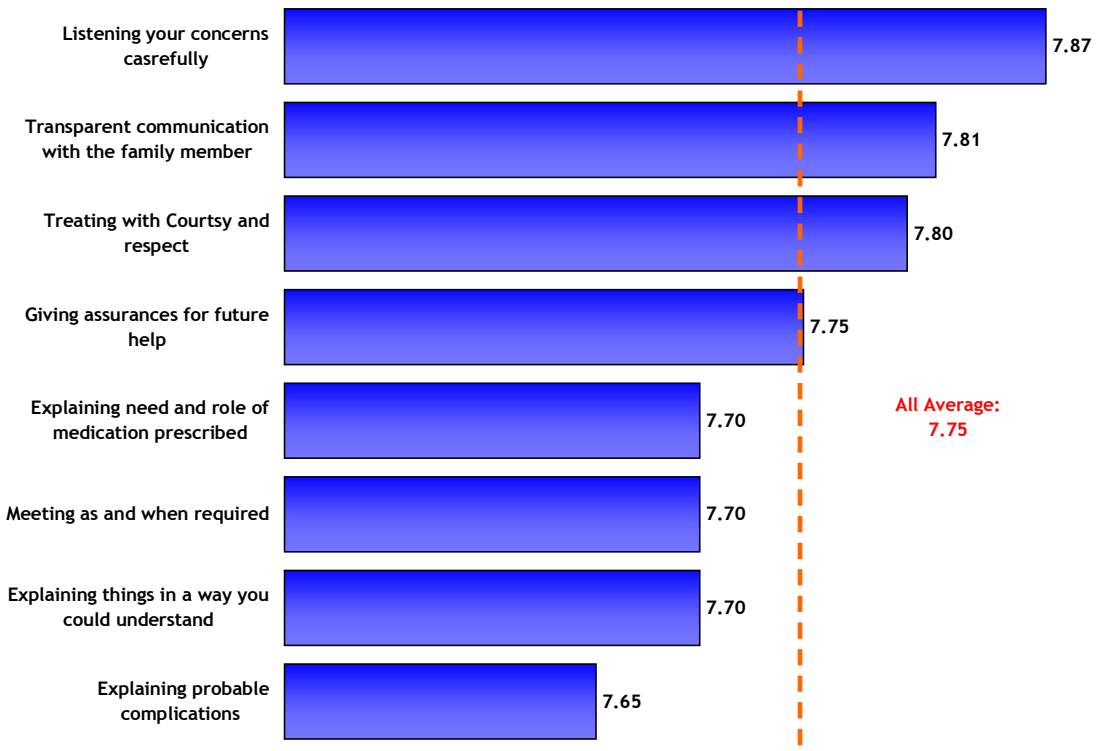
Fig 2.Trust and Confidence in Medical Personnel (for Tinsukia)



The graph below shows a detailed perception of the beneficiaries of Nagaon on certain parameters of satisfaction. From the graph we can conclude that the satisfaction levels

on the following aspects were above the composite mean: listening carefully to the concerns, treating with courtesy and respect and transparent communication with the family members. The aspect explaining giving assurances for future help however received an average response .The other aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed in Nagaon were fairly satisfied with the doctors on the aspects such as listened to their concerns carefully, treated them with courtesy and communicated about their condition with the family members as well. However, the beneficiaries had below average satisfaction on the aspects such as "explaining need and role of medication", "meeting as and when required" and explaining things in a way they could understand. The aspect "explaining probable complications" received the lowest rating which proves that patients were least satisfied with this aspect.

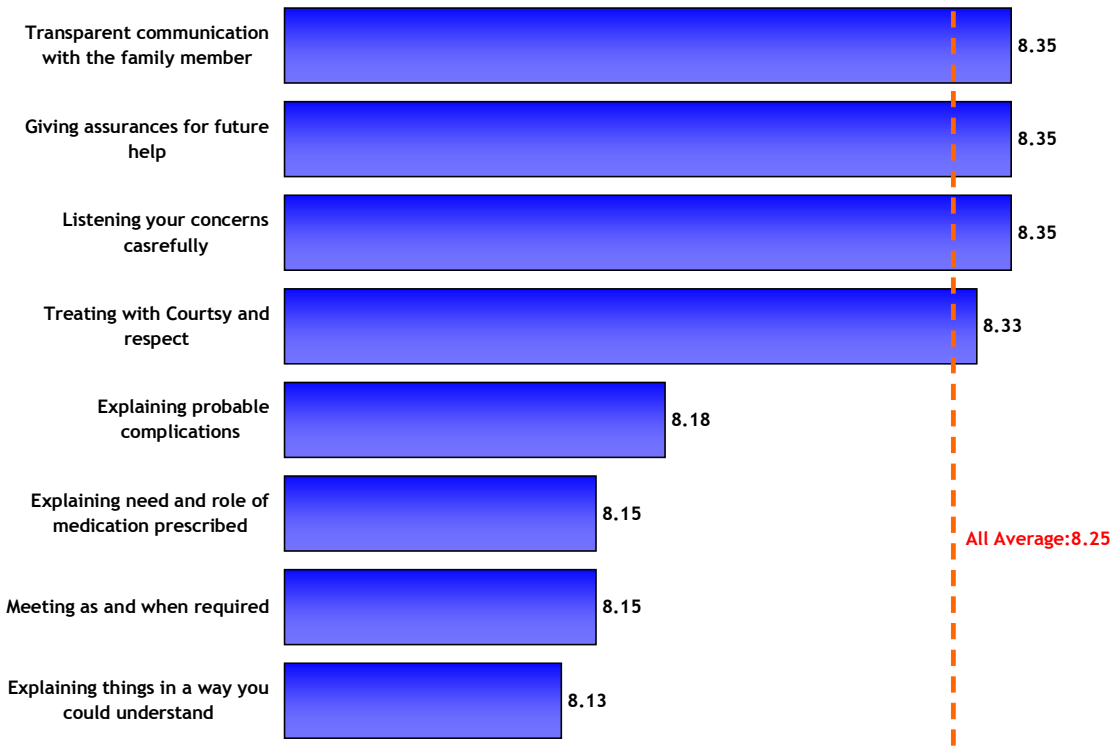
Fig.2 Satisfaction on interaction with the Medical Personnel -Nagaon



A detailed perception on certain parameters of satisfaction was also taken from of the beneficiaries of Tinsukia. The graph below depicts that the satisfaction levels of the beneficiaries of Tinsukia on the following aspects were above the composite mean:

listening carefully to the concerns, treating with courtesy and respect, giving assurance for future help and transparent communication with family members. The other aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the doctors on the aspects such as listened to their concerns carefully, treated them with courtesy, explaining about the illness to the family members and giving assurance for future help. However, the beneficiaries had below average satisfaction on the aspects such as "explaining need and role of medication" and "meeting as and when required" and "explaining things in a way you could understand".

Fig.2 Satisfaction on interaction with the Medical Personnel-Tinsukia



2.3.2.2. Counseling Received

As mentioned earlier a psychologist was employed at Nagaon. However, most of the beneficiaries in Nagoan, (97%) reported that they had not received any counseling or

met with a counselor during their visit to the hospital. In the case of Tinsukia, there was no psychologist employed and none of the patients confirmed that they received any counseling.

2.3.2.3. Overall treatment

Beneficiaries of both Tinsukia and Nagaon district were satisfied with the overall treatment that they had received as most of them had given a rating of 8 on being asked to rate the treatment level on a scale of satisfaction from one to ten (one being not satisfied and ten being absolutely satisfied).This confirms that the people who had received treatment are happy with the treatment received, approach and support of the health staff.

2.4. Availability of Drugs

The inventory of drugs in Nagaon district was maintained at the level of the District Hospital. Block PHCs (functioning as CHCs) and CHCs and FRUs also maintained their own inventory of drugs during the programme period. However, after the 9th plan period when the DMHP has been discontinued, there is no availability of drugs in any of the hospitals. Some basic drugs are available at the district hospital but drugs under DMHP programme have been discontinued.

The medicine record in Tinsukia district is maintained at Assam Medical College, Dibrugarh. Initially the drugs were taken by the DMHP team to the first referral unit in Doomdooma. Later on an inventory of basic drugs was maintained at the Doomdooma FRU itself. However after the discontinuation of the programme the registers and inventory has been taken back to Assam Medical College. Presently only one or two drugs are available in Assam Medical College.

2.4.1. The beneficiaries view point-

2.4.1.2. Drugs availability

Altogether 60 beneficiaries were interviewed at Nagaon. Over 9 out 10 (95%) confirmed that they had received drugs at the hospital where they had gone for treatment. Around 3 out of every 5 beneficiary interviewed (62 %) also confirmed that the purpose of medication was clearly explained to them.

Similarly 60 beneficiaries were also interviewed in Tinsukia, where nearly 4 out of 5 (78.3%) confirmed about receiving the drugs at the hospital. 43% of those interviewed confirmed that the purpose of medication was also clearly explained to them while 35% said the purpose of medication was explained to some extent.

2.5. Awareness about mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

As per the nodal officer implementing the programme orientation training sessions were held in various parts of Nagaon district to orient the school and college teachers for detection of mental illness in societies and educational institutions. The training was given using IEC leaflets & booklets. A section of the society was also evaluated on mental health by administering questionnaires regarding their perception and attitude as part of the training .

In Tinsukia also campaigning programmes were held by the DMHP team amongst the local leaders, elderly people of the village and the school teachers in order to create awareness on mental illness and for the removal of the stigmas attached to it. Information and awareness programmes using the IEC materials were also organised in Tinsukia town and Sadiya town. Such programmes attempted to increase the awareness level of the general community including students, teachers and community leaders (like, *Sarpanch* etc.).

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

In order the gauge the awareness level about the mental illness among the community members ICMR, Planman Consulting field team recorded the perception of community members through door to door survey and also held discussion with common people through FGD at a very informal level. In Nagaon, around 2 out of 5 respondents of the community reported that they got the information on mental illness from the doctor at the District Hospital. Nearly 3 out of 10 respondents also reported having received information from the sub center. In Tinsukia, around 1 out of 4 respondents reported to have received information on mental illness from the Doctor at the PHC and other health workers. 16% of the community members also reported to have attended Health awareness camps on mental illness.

2.5.2.2. Awareness about symptoms and perception of mental health

As far as symptoms of mental illness is concerned, the awareness in the community was found be limited. Most of them cited symptoms like excessive drug abuse and fits and lack of sleep (which most people in Nagaon cited as a symptom) as the common symptoms. It was also observed by the field team that community perception on black magic as a cause of mental illness strongly persists; however they agreed that these can also be cured through medical treatment. Regarding the curability while 72% interviewed in Tinsukia recommended treatment at the hospital, 32% also recommended visiting an occult practitioner. In Nagaon similarly a duality exists, while 72% recommended treatment at a hospital and more than half also recommended medicines and counselling as a curative, half of the respondents also recommended shock treatment. Moreover 44% of the respondents in Nagaon also recommended visiting an occult practitioner for cure.

3. Implementation Problems

- Non-receipt of fund for second installment.
- Repeated bandhs hampering the delivery of services.
- Lack of trained personnel.

- Sensitization to the paramedical staff to a great extent is to be done, which is however possible with the receipt of next installment which is overdue.

Suggestions/Recommendations:

- Lack of guidelines to Nodal Officer for implementing the programme
- Lack of operational guidelines and organizational training for the team.

Snapshot from Orissa

District Mental Health Programme (DMHP) was initiated in Orissa only in the 10th Plan period. During this plan period total 8 districts were selected for this purpose. ICMR research team had selected district Puri for evaluation study. In this district DMHP was initiated on 3.8.2005. The programme was implemented from the District Head Quarter Hospital. As there was no psychiatrist at the initiation phase, it was run by other departmental staff.

Finally Asst. Surgeon of the surgery division took over the charge of DMHP clinic. After his resignation as an in-charge on 31.05.2008, Medicine Specialist took up his place. But the post of Psychiatrist is still vacant. Also, the District Head Quarter hospital does not have any separate psychiatrist wing. Therefore the programme was being run from one room which was allotted by the district hospital for District Mental Health Programme. The OPD remains open six days in a week.

According to the CDMO of District Headquarter Hospital of Puri, DMHP is not running successfully in Puri. The main cause for this is the absence of a psychiatrist. As per DMHP guidelines, a trained psychiatrist is a must for running this programme. However, low salary package fails to attract the trained Psychiatrists to join DMHP. Besides, Orissa is deficient in trained Psychiatrist as every year only two psychiatrist seats are allotted for postgraduate students in S.C.B Medical College. So there are very few Psychiatrists in Orissa. It has also created a problem in running the DMHP.

1. Allocation and Utilization of Funds

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	870,000.00	714,509.00	155,491.00	82.1%
Medicines/Stationary/ Contingencies	450,000.00	349,790.50	100,209.50	77.7%
Equipments/Vehicles, etc	600,000.00	296,213.00	303,787.00	49.4%
Training	500,000.00	0.00	500,000.00	0.0%
IEC	200,000.00	0.00	200,000.00	0.0%
Total	**2,620,000.00**	**1,360,512.50**	**1,259,487.50**	**51.9%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A fund of Rs 26,20,000.00 had been sanctioned as the first installment for the district of Puri in 2005-06 under the DMHP during the 10th Five Year Plan of which about 52% had been utilized.

- The budget analysis shows that, of the money received for the payment of staff's salary, 82.1% have so far been utilized and in buying the medicines/ stationary/ contingencies the percentage of utilization has been around 78%.

- About 50% of the allocations made under the first installment for buying of equipments/vehicles have so far been utilized.

- The above spending pattern clearly indicates to the fact that major thrust of the DMHP in the district of Puri has been to main the "institutional set up" in the form of maintaining the salary of the mental health workers involved in DMHP, assuring the availability of medicines and building up of physical assets in terms of buying equipments, vehicles, etc. The main goal of the DMHP with respect to treating the mentally ill patients and spreading awareness among the community has been

relegated to the lesser priority. Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, has not been assigned any priority and as a result there have been no utilization of the funds.

- Additionally, it also came out that so far no money out of the allocated funds has been spent on IEC materials. This indicates the low level of community's awareness. However, district health officials have reported to have distributed leaflets among the community members in order to spread awareness. But it can be seen from the table above that the fund for distributing leaflets was not taken from the amount that was sanctioned for the IEC material under DMHP.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 55 beneficiaries who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1 Composition of DMHP team

At the time of inauguration of DMHP 9 posts were created - One Psychiatrist, One Clinical Psychologist, One Psychiatrist Social Worker, One Clerk, Four Nurses, and One Record keeper cum clerk. All except the post of the psychiatrist were functional under DMHP programme in Puri. These people were supposed to provide DMHP service in Puri District Head Quarter Hospital. The Asst. Surgeon of District Headquarter Hospital, Puri, was finally appointed as the in-charge of the programme from 25.08.2007. As stated earlier that medicine specialist of the District Headquarter Hospital has taken the charge from May 2008. The post of psychiatrist is still vacant. According to the personnel who had worked under DMHP, no one is wiling to come to the hospital as a psychiatrist specialist, because of the low salary structure.

2.2. Training

Training is the most essential component for the successful implementation of DMHP. As per the DMHP guidelines training is mandatory for the first three years after initiation of the programme. However, the lack of a proper trainer (psychiatrist), proper guideline and a job chart obstructed the training programme under DMHP in Puri. Consequently, no training was imparted to any health officials under DMHP.

2.3 Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sub-sections. One sub-section captures the viewpoint of the DMHP team. The other sub-section highlighted the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1. Heath System viewpoint

DMHP training programme is not running satisfactorily in Puri. After the resignation of Assistant Surgeon, who was appointed as a Psychiatrist for DMHP in Puri District Headquarter Hospital, the Psychiatrist post is still vacant. Medicine Specialist is now continuing as in charge of the Psychiatrist specialist. The other two important staff members are clinical Psychologist and Psychiatric Social Worker are running the DMHP operation in the district. In the OPD, the patients are diagnosed by clinical Psychologist and the medicine is prescribed by the Medicine specialist. Regarding referral cases, maximum patients are referred to the Cuttack medical college for further treatment.

2.3.2 The beneficiaries view point

55 beneficiaries were interviewed by the ICMR Planman Consulting team from areas surrounding the District Hospital. The beneficiaries were inquired about the illness diagnosed and satisfaction level regarding the treatment that they were receiving. More than half the beneficiaries said that they had visited the doctor at the district hospital as their first point of contact. Around 28% also reported to have visited the doctor at CHC as their first point of contact.

<u>2.3.2.1 Perception about the Doctor</u>

Out of the beneficiaries interviewed around 90% said that after the resignation of the Psychiatrist, they meet the same clinical psychologist, during their visit to the district hospital. However, around 10% also reported to have met different doctors during each visit. Regarding the trust and confidence level in the medical personnel to whom the beneficiaries had gone for treatment, more than half responded that they definitely trust the doctor, around 42% reported that they trust their doctor to some extent and only a meager proportion of 1.8% revealed that they do not have confidence in their doctor.

Fig.1 Trust and Confidence in Medical Personnel

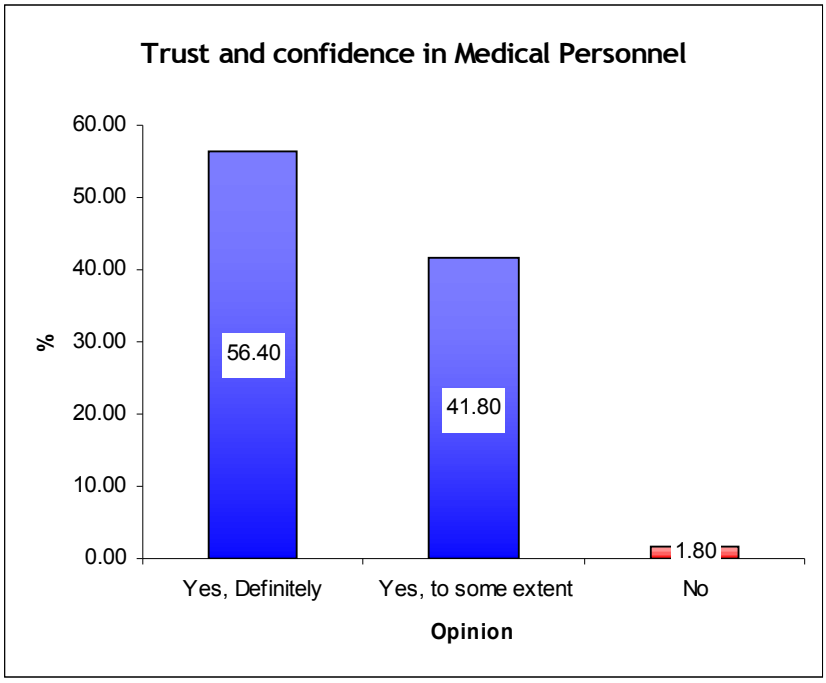
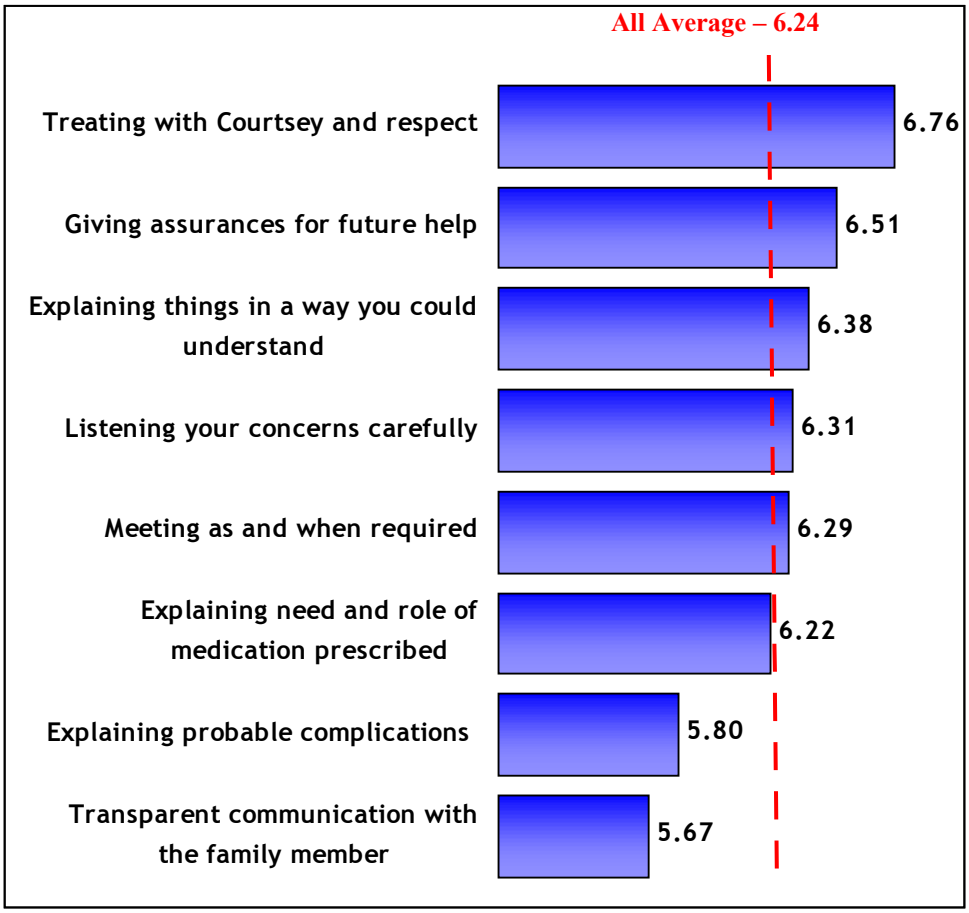


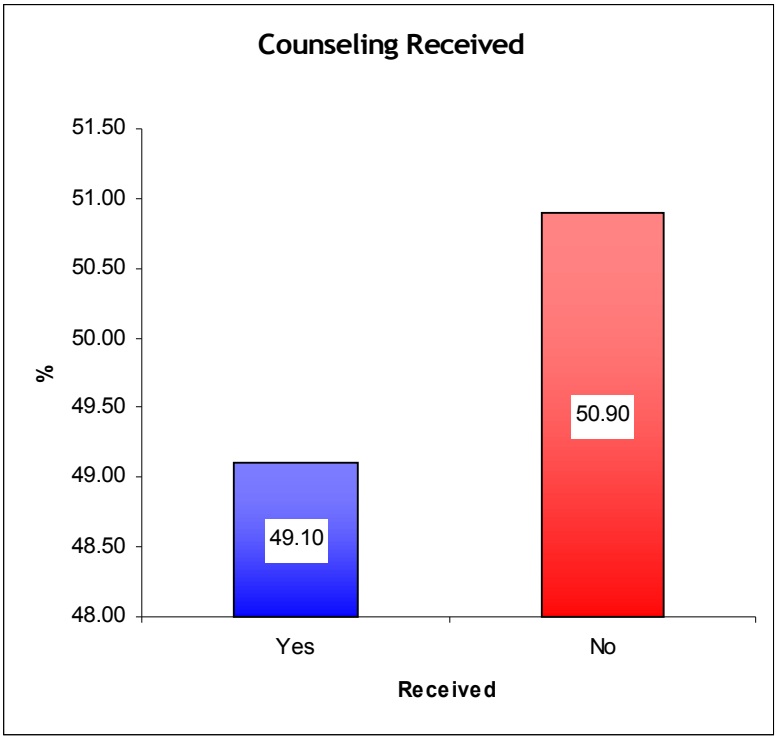
Fig.2 Satisfaction on interaction with the Medical Personnel



The above figure shows that the satisfaction levels on the following aspects are above the 'all average': meeting the psychiatrist as and when required, listening carefully the concerns, explaining things in a way that the patients could understand, assuring future help and treating with courtesy and respect. The rest of the aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed are fairly satisfied with the medical personnel they have met on the grounds that they can meet the doctors as and when required, doctors have listened to their concerns carefully, have explained the things in a way that the patients could understand, assured future help and have treated them with courtesy. However, the beneficiaries are not very satisfied on the grounds that the doctors do not communicate transparently with the family members and explain probable complications. They have also not been explained the need and role of medicines prescribed.

2.3.2.2 Counseling Received

The beneficiaries were also asked whether they had attended any counseling session during their treatment. Around 50% reported that they have attended these sessions while a little more than half the respondents reported that they have never attended the counseling sessions from the hospital. Among those who have received counseling, around 67% find these sessions to be extremely helpful while 33% reported them to be helpful to some extent.



2.3.2.3. Overall treatment

On being questioned about the satisfaction level of the overall treatment that they had received, most of the beneficiaries have given ratings between 5 to 8 on a scale of satisfaction from one to ten(one being not satisfied and ten being absolutely satisfied). The satisfaction level of the beneficiaries can be considered to be average but not on the higher side.

2.4. Availability of Drugs

2.4.1 Health System viewpoint

The drug register is maintained by the Puri District Headquarter Hospital jointly with DMHP team. Drugs are only available in the District Headquarter Hospital. The respondents at the District hospital however reported that there has been shortage of medicines. Only 2 out of 5 respondents reported that there was a regular inflow of drugs. However all the respondents stated that medicines that were being made available were sufficient. Following are the only few medicines available here.

- Tab Haloperidal (5 mg)
- Tab Procyclidine (2.5 mg)
- Tab Procyclidine (5 mg)
- Tab Respevidon (1 mg)
- Tab Olnazepine (10 mg)

2.4.2. The beneficiaries view point

2.4.2.1 Drugs availability

Out of the beneficiaries interviewed, 91% of them said that they received medicines from the hospital where they had gone for treatment. Out of the beneficiaries who had received medicines 60% said that the purpose of the medication were explained to them to some extent and 40% of them said that the purpose of the medication had been clearly explained to them.

2.5. Awareness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1 Health System viewpoint

No awareness programme had been organized by the DMHP team in Puri. The reason cited for this is the absence of Psychiatrist, lack of proper guideline and a job chart. All this has led to the failure of organizing an awareness camp in Puri under DMHP. However they have reported to have distributed leaflets for making people aware of Mental Illness.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

In Puri, 3 out of every 10 respondent stated that they had heard about mental illness from the doctors at the PHC. One of every 5 respondent also opined that they had been informed about mental illness by the Doctor at the District Hospital while 1 out of 10 respondents reported to have received information from the Doctor at the CHC and other health workers.

2.5.2.2. Awareness about symptoms and perception of mental health

The interview of the community members reveals that there is awareness of mental illness in the community. The symptoms of mental illness cited by the community were varied; the community members have recognized most of the symptoms of mental illness. However lack of sleep, feeling sad and depressed, excessive anxiety and fear and nervousness are the symptoms that were recognized by most of the respondents.

Regarding the community perception about the curability of mental illness, it was observed 7 out of 10 recommended treatment at the hospitals. More than half the community members also opined that mental illness can be cured with the help of medicines and counseling while. However 2 out of 5 respondents also recommended shock treatment and visit to the occult practitioner for treatment. A similar proportion of the community members opined that mentally ill people are harmful and should be avoided. About 43.3% of the members also believe that very well educated and intelligent people can develop mental illness and about 40% of the respondents hold the view that the family member should recognize the change in the behaviour of the people and discuss it with their doctor for early diagnosis.

3.Implementation Problems

Staff

- Absence of a trained Psychiatrist is a main problem in implementation of DMHP programme.

Training

- No training was given to the health staff. As per DMHP guidelines training should be given by a trained psychiatrist. But absence of trained Psychiatrist acted as a stumbling block in imparting training.

Awareness Camp

- No awareness camp was organized under DMHP to spread awareness among the community.

Recommendation/Suggestion

- Lack of guidelines to the Nodal Officer for effective implementation of the programme
- Salary of psychiatrist should be increased and recruit and train MO in mental health.
- Training in organizational activities for the team
- Operational Guidelines and responsibilities to be given to the Nodal Officer

District Mental Health Programme (DMHP)

Snapshot from Madhya Pradesh

Initially District Durg was selected for DMHP in the year 1996-97 (9th Plan), when it was part of Madhya Pradesh, with its Nodal office at Gwalior Mansik Arogyashala (GMA, Gwalior. However these districts become the part of Chattisgarh after its creation in the year 2000. Therefore, as an alternate district Shivpuri in Madhya Pradesh was selected for running the District Mental Health Programme.

DMHP was initiated in Shivpuri in the year 2001 and it completed its tenure on 22nd April 08. The Shivpuri Jila Chikitsalaya was the district hospital where the programme was implemented. However the district hospital did not have any Psychiatric wing. Therefore the programme was being run from one room which was allotted by the district hospital for District Mental Health Programme. The OPD was opened for only one day in a week i.e. every Tuesday.

1. Allocation and Utilisation of Funds.

	9th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	1,154,484.84	3,326,638.00	-2,172,153.16	288.1%
Medicines/Stationary/Contingencies	919,268.93	373,625.00	545,643.93	40.6%
Equipments/Vehicles, etc	900,000.00	432,967.00	467,033.00	48.1%
Training	784,053.02	14,332.00	769,721.02	1.8%
IEC	313,621.21	27,832.00	285,789.21	8.9%
Total	**4,071,428.00**	**4,175,394.00**	**-103,966.00**	**102.6%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 40,71,428.00 was received by the district of Shivpuri during the time period of 1998-99 to 2004-05 under the DMHP in the 9th Five Year Plan of which more than the total allocation had been utilized till 2008.

- The analysis clearly shows that, under the 9th plan period, there had been over spending of 188.1% on account of payment made for the staff's salary.

- In the case of expenses incurred for purchasing equipments/vehicles, 48% of the allocated amount had so far been utilized. In the case medicines, stationeries and contingencies, the utilization had been about 40% of the allocated amount.

- The above spending pattern clearly indicates to the fact that the major thrust of the DMHP in Shivpuri had been to main the "institutional set up" in terms of paying the staffs their salary and buying equipments and vehicles. Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, was not assigned the priority which is clear from the fact that only 1.8% of the allocation had so far been utilized and in spending for IEC materials, the utilization rate is only 8.9%.

- The low utilization on training and IEC also points to the fact that the community out-reach or the awareness which are also some of the goals of this programme are in a lackadaisical stage in the district of Shivpuri.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme along with 60 beneficiaries who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1. Composition of DMHP team

In order to implement the DMHP in Shivpuri, a psychiatrist was appointed at the District Hospital along with nursing and other staff members. However, this was very short term situation as the psychiatrist, unhappy with the salary structure, left his job within few months. Later on the programme is being run through Gwalior Mansik Arogyashala (GMA), Gwalior by a team consisting of eight members, which include one Clinical Psychologist, one trained social worker, four male nurses, one Statistician cum Clerk and one driver. The team had the prime responsibility to provide service in Shivpuri District Hospital. This team used to visit Shivpuri district hospital only once in a week.

The programme was initially supervised by a Psychologist at GMA as a Nodal Officer for Shivpuri. But in January 2007 the psychologist who was supervising the programme as a

nodal officer also left the DMHP team and later the programme was being supervised by a Gynecologist from GMA. This resulted in unhappiness among other DMHP staff members responsible for implementing the programme.

The DMHP in Shivpuri had already completed its plan period and at present is no longer in operation due to lack of fund. All the appointments made under this programme were on contractual basis; therefore the services of all the personnel had been terminated.

2.2. Training

Training is an essential component of DMHP. In Shivpuri only one training session had been organized during the entire tenure of DMHP. The district health officials said that the training was organized on 7th and 8th of December 2004. No other training sessions for any other health staffs were held in Shivpuri. All the staff interviewed during the evaluation study confirmed to have received training under the DMHP programme.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

The DMHP OPD was operational for one day in a week when the team from GMA used visit at Shivpuri District Hospital, usually Tuesdays and for only two hours. On the other days the patients were sent back and asked to come only on the days when psychiatrist OPD was on operation ie Tuesdays. On the OPD days the patients were diagnosed by the Clinical Psychologist and medicines were distributed by the four nurses. The health staff said that there used to be huge inflow of patients on the OPD days, but most of the patients went home without any treatment as the duration of OPD hours was very less and irregular as well. The nurse orderly further told that the OPD room changed every week, so the patients had to waste much of their time looking for the OPD room.

Further the staff also said that there was no arrangement for the patients to sit while waiting for their turn, therefore, they used to sit on the ground. Since there was no Psychiatric wing in Shivpuri District Hospital, the mental patients who needed hospitalization were sent to GMA for their treatment.

Currently, there is no OPD running in Shivpuri district hospital as DMHP is no more operational here. Due to this the patients have suffered the most, because their treatment had been stopped abruptly. The health staff of the hospital opined that they also have suffered due to the stoppage of the programme. As their appointment was on contractual basis, their services had been terminated.

2.3.2. The beneficiaries view point

The ICMR Planman Consulting team also interviewed 60 beneficiaries from areas surrounding the District Hospital where the OPD was being run. The beneficiaries were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Around 75 % of the beneficiaries said that they had visited the doctor at the district hospital as their first point of contact. This was probably because the DMHP programme in Shivpuri was implemented primarily through the weekly OPD at the district hospital. There were no cases of referral as such.

2.3.2.1. Perception about the Doctor

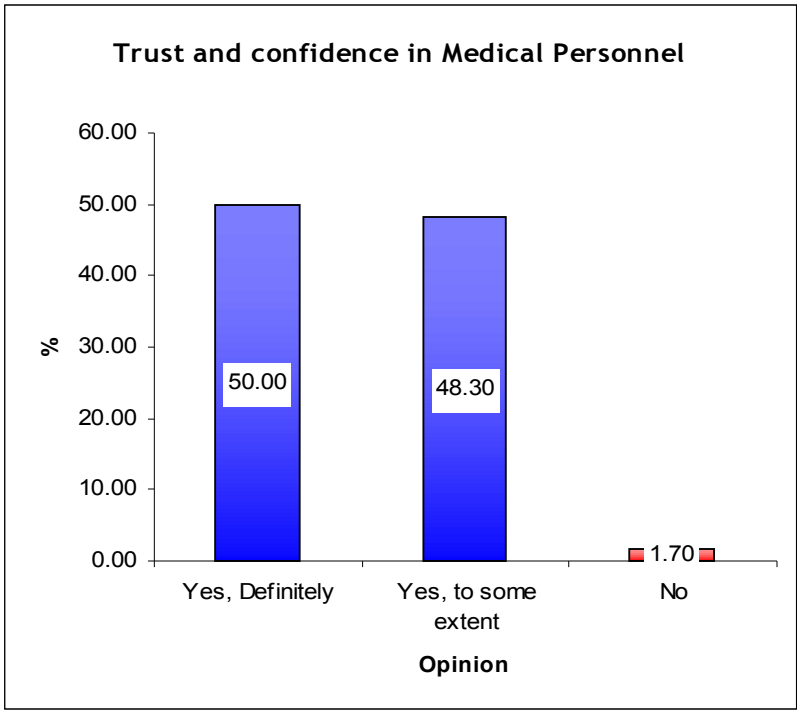
The beneficiaries who had received treatment under DMHP said that every week the doctors and OPD room used to change which was a big problem for them. The doctor who had come for the previous week OPD used to prescribe one course of medicines which was changed by the other doctor who visited the OPD in the next week. The team which visited the Shivpuri district hospital were not punctual, so the patients did not know exactly when to come. Thus often the patients had to return without visiting the doctor.

Out of the beneficiaries interviewed 88% of them said that they met different doctors during their each visit to the District hospital therefore only 12% had confirmed that they met the same doctor during each visit. However, surprisingly all of the

beneficiaries said that they have trust and confidence level in the medical personnel to whom they had met for their treatment.

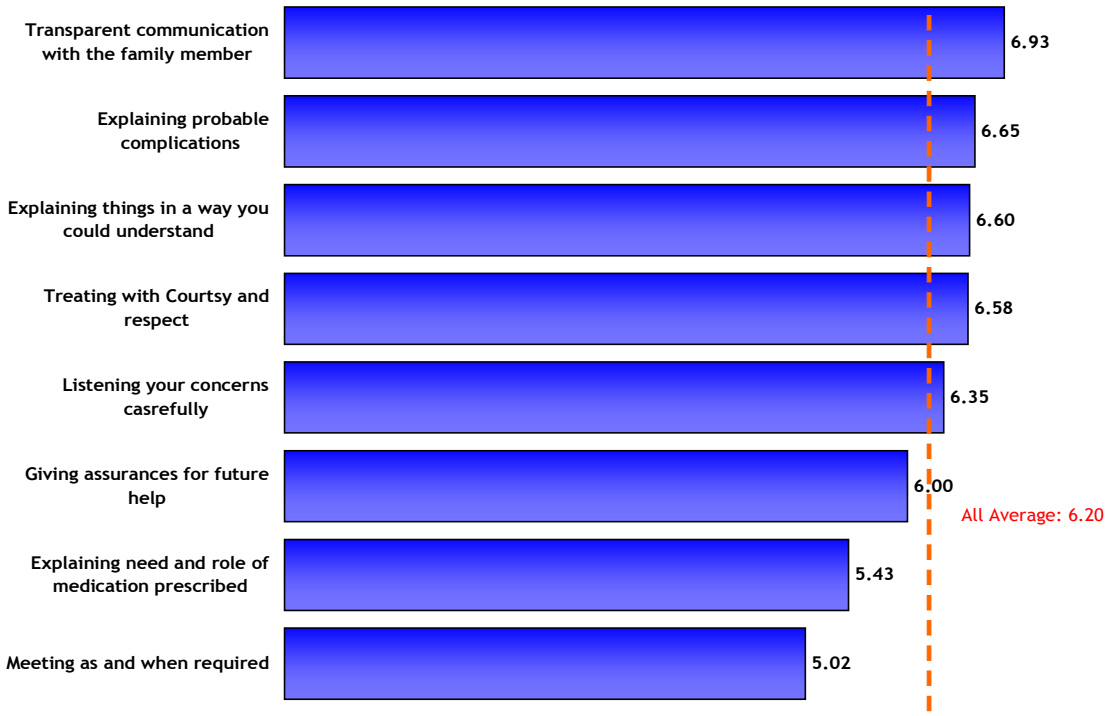
At present there is no treatment happening in the district hospital as the services of DMHP team had been terminated after April 2008. The patients also complained that they have suffered a lot because their treatments have been stopped in between and they did not know what to do.

Fig.1 Trust and Confidence in Medical Personnel



The above graph shows that around half of the total beneficiaries interviewed (50%) said that they had high degree of trust and confidence on the medical personnel they had met during their treatment. Rest 48% had the trust and confidence level to some extent. This shows that most of the beneficiaries had an average level of trust and confidence on the medical personnel that they had met for the treatment.

Fig.2 Satisfaction on interaction with the Medical Personnel



The above graph shows that the satisfaction levels on the following aspects were above the composite mean: listening carefully the concerns, treating with courtesy and respect, explaining things in a way that the patients could understand and explaining probable complications. The rest of the aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the medical personnel they have met on the grounds that the doctors have listened to their concerns carefully, have treated them with courtesy, have explained the things in a way that the patients could understand and have explained probable complications. However, the beneficiaries had below average satisfaction on the aspects such as “meeting the doctors as and when required”, “doctors explanations on the need and role of medications prescribed and “giving assurance for future help”

2.3.2.2. Counseling Received

In Shivpuri district, on being asked whether they had received counseling, the beneficiaries told that none of them have received counseling under DMHP. This puts a question mark on the utility of having a Clinical Psychologist in the DMHP team.

2.3.2.3. Overall treatment

On being questioned about the satisfaction level of the overall treatment that they had received, most of the beneficiaries have given ratings between 6 to 8 on a scale of satisfaction from one to ten(one being not satisfied and ten being absolutely satisfied). The satisfaction level of the beneficiaries can be considered to be average but not on the higher side.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

The drugs register was being maintained at the Shivpuri district hospital jointly by all the DMHP team members. The health staff of Shivpuri district hospital told that the drugs were stored in the room allotted by the district hospital for the District Mental Health Programme. The medicines were distributed only on the OPD days when the DMHP team from GMA visited the district hospital. The other six days medicines were given by the staff orderly only to those who were on regular medicine course. As the nurse orderly who worked in Shivpuri permanently did not have the capacity to deal with complications, the patients with any complications were asked to come on the OPD day. The inflow of medicines was reported to be regular during the tenure of the programme and the supply of medicines was also found to be adequate. As the programme is not running anymore in Shivpuri, therefore, at present no medicines are being distributed at the District Hospital.

2.4.2. The beneficiaries view point-

2.4.2.1.Drugs availability

Almost all (97%) the beneficiaries interviewed confirmed that they received medicines from the hospital when they had gone for treatment. Nearly 7 out of 10 (68%) also confirmed that the purpose of the medication were explained to them to some extent. Where as nearly 3 out of 10 respondents (27 %) revealed that the purpose of the

medication was clearly explained to them. Only 5 % stated that the purpose of medication was not at all explained to them.

2.5. Awareness regarding Mental Illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

In Shivpuri, a total of 12 camps were held for creating awareness about mental illness. As per the Camp OPD Register, 5 camps were held at the CHC, PHC level and 7 camps were held around the village areas. The awareness was created with the help of distributing leaflets, pamphlets, brochures, putting up hoardings and banners. These camps were organized by the DMHP team from GMA. The camps were held inside a school or any other area around a CHC or PHC by putting up a tent where they gave some information about the symptoms of mental illness to the community members. This orientation through camps were given so that there is early detection of mental illness in the society and also for removal of stigma attached to mental illness in the community. Diagnostic camps were also held at these awareness meetings. Patients diagnosed in these camps were sent to the district hospital for further treatment. However, allocation and expense table shows that only 8% of the amount allocated for the IEC was utilized. Therefore it leaved a lost of scope for further raising the awareness among the community.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Half the community members interviewed (50 %) confirmed that they had come to know about Mental illness trough IEC materials and other sources of media. 3 out of 10 respondents reported that the doctor at the District Hospital informed them about mental illness while 13% confirmed that other health workers had informed them about mental illness. Only 4.5% confirmed that awareness camps had been held in this area.

2.5.2.2. Awareness about symptoms and perception of mental health

The opinion of the community members who were interviewed shows that there is fair degree of awareness in the community. The symptoms of mental illness cited by the community were varied; the community members have recognized most of the symptoms of mental illness. Lack of sleep, feeling sad and depression were some of the symptoms which was recognized by the higher percentage of the community members interviewed during the survey. Around 3 out of 10 (28%) of the community members interacted opined that mental illness is caused due to evil spirit or black magic.

Regarding the community perception about the curability of mental illness, it was observed that nearly 7 out of 10 members interviewed recommended treatment at the hospital. Moreover more than half the community members opined that mental illness can be cured with the help of medicines. More than 2 out of 5 respondents also recommended visiting an occult practitioner for cure. However, almost all of them had agreed that mentally ill people need help and care from their family members. All of the community members interviewed have had agreed that government has taken many initiatives to identify and treat mentally ill people.

DISTRICT MENTAL HEALTH PROGRAMME (DMHP)

Snapshot from Chhattisgarh

District Mental Health Programme (DMHP) was scheduled to start in Chhattisgarh under the 10th Plan period but it began only in the year 2006 that too only in one District, Dhamtari. The government of India had chosen two medical colleges in the state of Chhattisgarh as nodal agencies for implementing DMHP - Jawahar Lal Medical College or Dr.Bhim Rao Ambedkar hospital in Raipur and Chhattisgarh Medical College in

Bilaspur. Under Jawahar Medical College there were four district hospitals namely Dhamtari, Baster, Jagdalpur and Durg whereas under Chhattisgarh Medical College there were Bilaspur and Raipur hospital.

Before moving to Dhamtari the reason for non initiation of the programme in Bilaspur was captured by the evaluation team. According to the Nodal officer procedural delays had prevented the programme from being initiated in Bilaspur. According to Head of psychiatry wing, Bilaspur, 'Bilaspur Medical College' was earlier attached with Gurughasidas University and it was controlled by the Vice Chancellor. But from last 6 months it became an autonomous body under the Directorate of Medical Education. Initially the funds under DMHP however had been transferred to the Vice Chancellor, Gurughasidas University. Transferring this fund back to the Directorate of Medical Education has taken a lengthy two year period from 2006-2008. The funds have only been transferred three months back (i.e. August 2008). The Dean has also joined recently so the programme is yet to be initiated in Bilaspur.

In Dhamtari also the programme could only begin in 2006. According to the Nodal Officer of Chhattisgarh, the main cause for delay in initiating the programme for Dhamtari was the lack of manpower (Psychiatrist) in Chhattisgarh. He said that as per the guidelines of DMHP, for running this programme there must be a trained psychiatrist. However, there is no post graduate course in Psychiatry being offered in any Medical College of Chhattisgarh or even Madhya Pradesh. Moreover the trained psychiatrists were not willing to join DMHP because of low remuneration and due to the contractual nature of the job which caused the delay in programme initiation. The programme could be initiated in 2006 only after a psychiatrist was found for Dhamtari District Hospital.

1. Allocation and Utilization of Funds.

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	870,000.00	870,000.00	0.00	100.0%
Medicines/Stationary/Contingencies	450,000.00	227,312.50	222,687.50	50.5%
Equipments/Vehicles, etc	600,000.00	244,373.00	355,627.00	40.7%

Training	500,000.00	0.00	500,000.00	0.0%
IEC	200,000.00	0.00	200,000.00	0.0%
Total	**2,620,000**	**1,341,685.50**	**1,278,314.50**	**51.2%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 26,20,000.00 had been sanctioned to the district of Dhamtari under the DMHP in the 10th Five Year Plan of which 51.2% had been utilized till 2007-08.

- The analysis clearly shows that the entire money allotted for paying the staff salary has been exhausted.

- On purchasing of medicines/stationeries/contingencies about 50% of the allocation has yet been used. While it is around 40% in case of buying of equipments and vehicles.

- The above spending pattern clearly indicates to the fact that the primary focus of the DMHP in Dhamtari has been to main the **"institutional set up and building up of physical assets"** in the form of buying equipments and vehicles and retaining of the staffs. But, **"training"** and **"community's awareness"**, the two most important component of the DMHP, which could ensure the proper diagnosis and treatment and lowering of social stigma and myths, was not assigned the necessary priority. And this is evidently clear from the fact that so far no amount has been utilized either for training and or in the use of IEC materials.

2. Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 43 beneficiaries from Dhamtari (due to the low registration rate there) and from the nodal center in Raipur who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1 Composition of DMHP team

At the time of its initiation in December 2006 the DMHP team has consisted of 5 people. One Psychiatrist, One Clinical Psychologist, One Psychiatrist Social Worker, One Clerk and One Nurse who were appointed in 2006 itself. All the staff was appointed on a contractual basis for a period of one year.

The psychiatrist appointed at the district hospital however quit in September 2007 after which there has been no replacement. During his tenure also, the psychiatrist used to visit only once in a week which was later extended to 4 days by the CMO's intervention. However, when the psychiatrist was in position, the number of mentally ill patients in the hospital had increased. At present the clinical psychologist Psychiatric social worker and the clerk are the only three staff members running this programme.

Tabular format showing staff presence:

Staff	2006 (Year of initiation)	2008 (time of evaluation)
Psychiatrist	1	0
Clinical Psychologist	1	1
Psychiatric social worker	1	1
Clerk	1	1
Nurse	1	0
Total	5	3

2.2. Training

Training is a mandatory part of DMHP for the first three years after its initiation. However interaction with the health staff revealed that in Dhamtari no such training has been imparted to the staff. The Nodal officer opined that as per DMHP guidelines training should be given by senior psychiatrist like MD or DPM. However insufficient funds did not permit the hiring of senior psychiatrists to train staff members of DMHP or general physicians in Dhamtari. Thus there has been no training programme conducted under DMHP since its inception in 2006.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture

the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1. Heath System viewpoint

The DMHP OPD is running six days in a week at the district hospital of Dhamtari. Earlier during the presence of the Psychiatrist there was a regular in flow of patients and their relatives around 50-60 per month (as per OPD register). Out of them around 10% were found to be new patients.

In the absence of the Psychiatrist, two other staff members, Clinical Psychologist and Psychiatric Social Worker, are diagnosing cases of mental illness and providing treatment to the patients. It was observed and also reported that the Clinical Psychologist has taken up the role of a Psychiatrist while the social worker maintain records and provides counseling. Cases which both these staff find critical and difficult to diagnose are referred to Raipur Medical College. In fact, the Nodal officer who sits at the Raipur medical college also has a regular inflow of patients besides these referral cases.

In Dhamtari there is no facility of inpatients. For this purpose they refer critical cases to Raipur Medical College. In Raipur, there is a state run scheme called Ayusmati for BPL families (card holders) and it is specifically for women. Under this scheme state gives Rs.1,000/- to them for purchase of medicine (one time admission in state run hospitals).The in-patients in Raipur Medical College and hospital get this benefit under this scheme also.

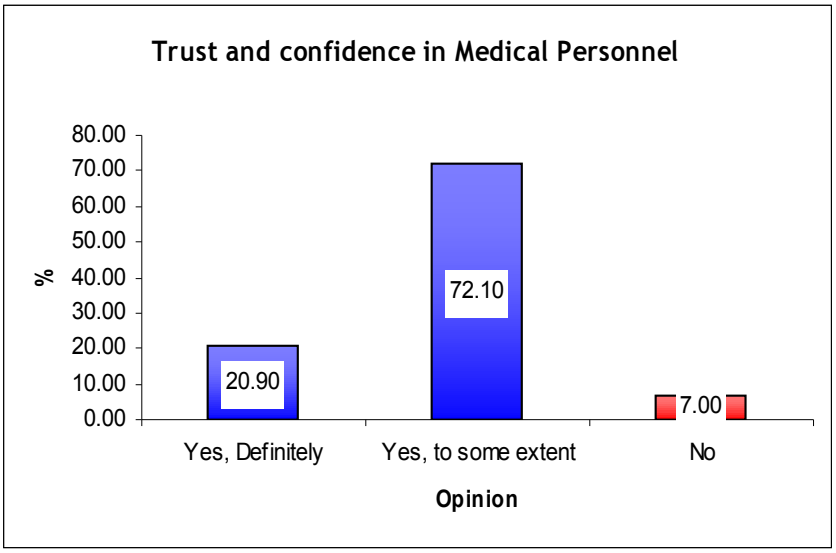
2.3.2. The beneficiaries view point

The ICMR, Planman Consulting field team also interviewed the beneficiaries from both Dhamtari and the Nodal Office i.e. Raipur medical college to understand their knowledge of the illness diagnosed and satisfaction on treatment that they were receiving. Altogether 43 beneficiaries were interviewed. Their perceptions on various parameters are given below:

2.3.2.1. Perception about the Doctor

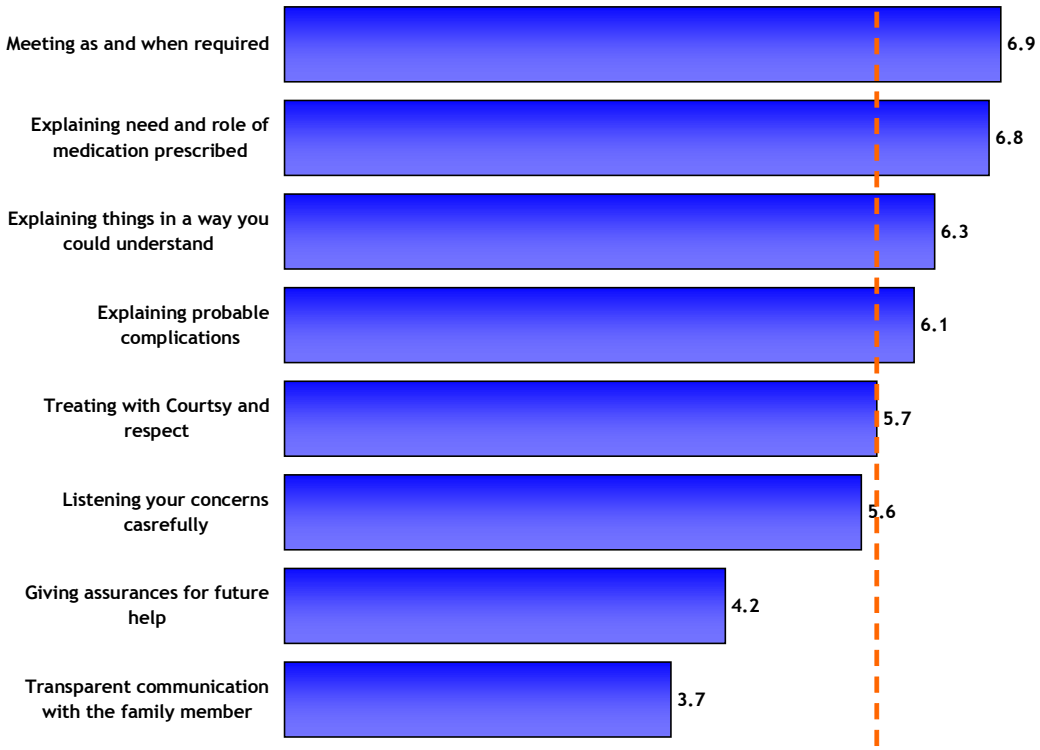
The patients interviewed had shown average trust and confidence on the doctors. As shown in the graph below, 1 out of 5 (20%) reported that they had full trust and confidence on the doctor who is treating them. However, 72% reported that had trust and confidence on the doctor to some extent.

Fig 1.Trust and Confidence in Medical Personnel



The beneficiaries in Dhamtari have also given a rating between 6-8 (on a scale of 1-10 where 1 is least satisfactory and 10 most satisfactory) reflecting higher trust on the doctor who treated them. As mentioned before, in Dhamtari, it is the clinical psychologist who is referred to as the doctor here. The graph below reflects the satisfaction level of the beneficiaries with the psychiatrist based on certain other aspects of their satisfaction parameter. Of these most patients said that that they are given enough time to discuss their condition in detail. However, they are least satisfied by the way the doctor explains the probable complications in the diagnosis.

Fig.2 Satisfaction on interaction with the Medical Personnel

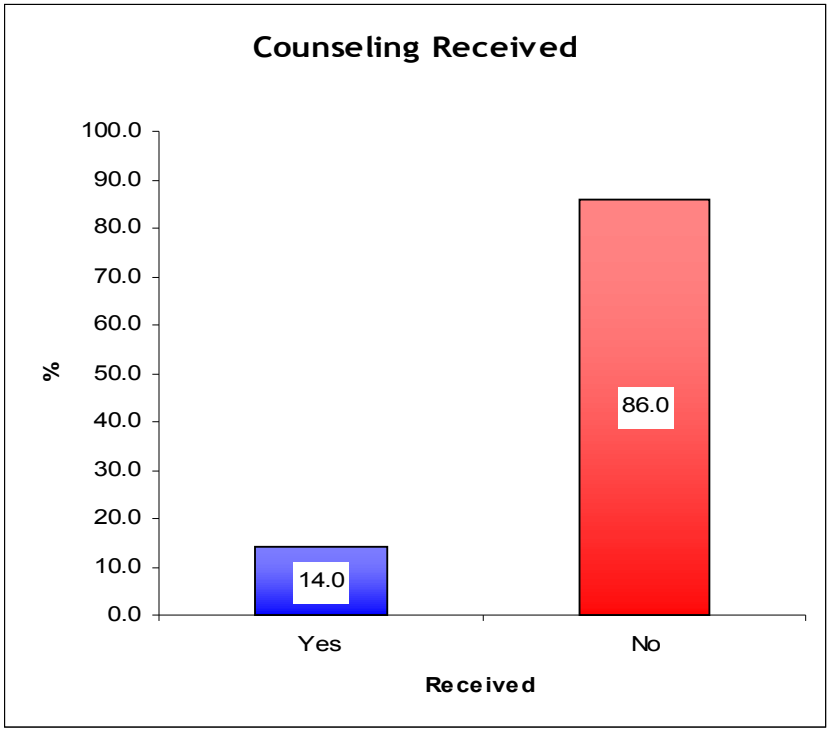


In the above graph we can see from among the various aspects of satisfaction parameter, we have arrived at a composite average of 5.66. While in some aspects like explaining need and role of medication prescribed, explaining probable complications and giving assurances for future help, satisfaction parameter falls short of the composite average, in most of the other aspects it is way above the composite average. Specifically in the cases like listening patient's concerns carefully, meeting them as and when the requirement arises and explaining the way the patient or the family members can understand, respondents seem to be fairly satisfied.

2.3.2.2. Counseling Received

As discussed earlier, the beneficiaries/ patients are treated by clinical psychologist; majority of the patients (86%) reported that they have not received any counseling. Therefore, it shows that when medical personnel perform the dual role of psychiatrist as well as psychologist, performance of the profession is bound to go down.

Fig 3. Counseling Received by the beneficiaries



2.3.2.3. Overall treatment

There was general level of satisfaction found among the beneficiaries with regard to overall treatment they had received as most of the patients had confirmed that they very satisfied. Majority of the patients and their family members also confirmed that they could see improvement in their condition after receiving treatment from the doctors and health institutions they visited.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

In December 2006, when DMHP had started in Dhamtari, the health staff opined that most of the drugs were available at the centre. However at present only two medicines are available, namely, Tab Jolyon MD 5 mg and Tab Jolyon MD 10 mg. The patients are advised to purchase all the other prescribed medicines from the market. According to the district health officials the unavailability of medicines has affected the beneficiary turnout rate and increased the drop out rates. The medicine register is maintained at the District level jointly by the staff running DMHP there. Shortage of medicines had

already been conveyed to the nodal officer. The Nodal Officer cited the lack of funds for the irregular medicinal flow to the district, where the programme is being executed. The budget utilization shown above however indicates that there has been overspending under the head of medicines. However even after spending above the scheduled expenditure, the nodal officer cited lack of funds as the reason for irregular medicinal flow.

2.4.2. The beneficiaries view point

More than half the beneficiaries who were interviewed by the survey team also confirmed that most of the medicines prescribed had to be purchased from the market. However, nearly 2 out 5 (35%) beneficiaries contacted confirmed that they were provided the medicines by the medical personnel. More than three fourth of the beneficiaries reported that the purpose of medication given was not explained to them.

2.5. Awareness about mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

Very limited awareness programmes have been held so far in the areas in and around Dhamtari, and that too at District level, not at the PHC or CHC level. Awareness level is very less among the local people which are clearly reflected in the patient turnout rates. In Dhamtari the patient turnout rates were observed to be very low with 25 being the highest number of patients in a day. The limited awareness is reflected in the drop out rates as well. As the health officials opined that psychiatry problems need long time to recover but beneficiaries lack time and patience to continue the treatment. Some patients who don't get relief in the first instance stop taking medicines while others, after finding slight improvement in their condition presume that they don't need further medication and stop using the medicines. This increases the chances of relapse and when these patients face acute problem they sometime again start coming to the doctor for treatment. This cycle is predominant among the

patients or their family members who are less aware about the treatment procedures and the time and patience required for improvement.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Awareness about mental illness among the community members were recorded through door to door survey in the areas around Dhamtari District Hospital and also discussion with common people through FGD at very informal level. Around3 out of every 10 respondent stated that they had come to know about mental illness through IEC materials and other media sources. Some (18%) also said that the Doctor at the District hospital and the ANM in the village had told them about mental health treatment facilities available at the Dhamtari Hospital. However, majority of the community members who were contacted during the survey were of the opinion that no health awareness camp had been held in their village at all which co relates with the health officials viewpoint as well.

2.5.2.2. Awareness about symptoms and perception of mental health

Due to the absence of any health awareness camps and limited word of mouth spreading, awareness levels were very mixed regarding mental illness and its curability. The perception of the community regarding symptoms of mental illness was mostly limited to identifying fear and nervousness and depression spells as the common symptoms. It was also found that there was a mixed response regarding the perception on mental illness. Majority of the people consider mental illness as a disease and many also believed it to be work of evil spirit. However more than half the people contacted agreed that mental illness is curable through medicines and at a hospital. However 3 out of every 5 respondents recommended going to an occult practitioner for treatment as well.

3. Implementation Problems

- Lack of requisite manpower led to delay in initiation of the programme in the district. This was due to the low remuneration being offered.
- There is an irregular flow of medicines from the nodal office to the district hospital causing shortage of medicines in the district hospital of Dhamtari.
- Shortage of medicines coupled with lack of awareness in the community lead to increasing number of drop out cases.
- The programme is officially running in Dhamtari based on word of mouth awareness but without a psychiatrist and medicines.
- The clinical psychologist and psychiatric social worker along with a helper are the only staff running the programme in Dhamtari.

Suggestions/Recommendations:

- Improve procurement of drugs and Fund flow mechanism
- Operational guidelines for the Nodal Officer
- Better supervision and dedicated monitoring of the program
- Organizational training for the DMHP team

District Mental Health Programme (DMHP)

Snapshot from Gujarat:

The District Mental Health Programme (DMHP) was scheduled to begin in Gujarat in November 1998 under the 9th five year plan in the district of Navsari. Funds were made available for the project from July 1999 after which the programme was officially initiated.

The Department of Psychiatry, SSG Civil Hospital, Navsari was the institution responsible for implementation of this programme in the District with the Civil Surgeon

of the District as the Nodal Officer. Simultaneously a District Mental Health Society was formed to monitor and evaluate the programme since 27th April 2000. This consisted of the District Magistrate, Civil Surgeon and other renowned health officials of the state. In 2004 the programme completed its tenure of 5 years (albeit funds for only four installments had been transferred from the Central Government). After 2004, the Gujarat State government has taken up the project and is running it till now. This is one of the few cases where the state government has taken over DMHP after completion of its tenure. In Navsari the DMHP programme operated simultaneously from the District Hospital and 8 CHCs and 35 PHCs (the numbers correspond to the situation during 1999-2004).

1. Allocation and Utilisation of Funds.

	9th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	3,470,000.00	2,081,272.00	1,388,728.00	60.0%
Medicines/Stationary/Contingencies	2,800,000.00	562,514.65	2,237,485.35	20.1%
Equipments/Vehicles, etc	900,000.00	1,075,393.00	-175,393.00	119.5%
Training	1,200,000.00	492,768.00	707,232.00	41.1%
IEC	800,000.00	114,650.30	685,349.70	14.3%
Total	**9,170,000.00**	**4,326,597.95**	**4,843,402.05**	**47.2%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 91,70,000.00 was sanctioned through four installments for the district of Navsari under the DMHP in the 9th Five Year Plan of which 47.2% had been utilized till 2001-02. The first installment was received in the year 1998-99 and the other three installments were granted in the next consecutive years till 2001-02.

- In the district of Navsari, the monetary grant was jointly monitored both by the Central and the State Government where the State government was accountable for monitoring of the staff's salary. After 2001-02, the DMHP has been running on under the surveillance of the State Government.

- The analysis shows that, during the 9th plan period, 60% of the allocated fund for paying the staff's salary had been utilized.

- In the case of purchasing of equipments/vehicles, there had been an overspending of 19.5%.

- On the other hand, for buying the medicines, stationeries and other contingencies, the proportion of funds that had been utilized was only 20%.

- "Training of the DMHP Staffs" and "Increasing the community's awareness level", which are the two most important component of the DMHP, was dealt with relatively less priority. And it is evident from the fact that about 40% of the allocation had been utilized on training and on spending for IEC materials, the utilization rate is 14.3%.

2. Perception on Programme Implementation

To gather an overall perception on the implementation of the programme and its effects views were taken from the Health Staff working under DMHP or those who had received training under the programme, 60 beneficiaries each from the district who were receiving treatment under the programme and 30 members of the general community from areas where the programme was being run.

2.1 Staff Structure:

After the initiation of DMHP in Navsari, an entire Psychiatric department was set up at the District Hospital. This department appointed one psychiatrist, four staff nurses, one clerk, two sweepers and one driver. The position of clinical psychologist and psychiatric social worker however still remains vacant since the initiation of the programme. The district health officials opined that they had advertised for the post but they are still in the process of filling the vacancy. The position of the psychiatrist has also seen shifts after 1999. After 2004 all the employees working under DMHP have been absorbed as permanent salaried employees under the State Government.

2.2 Training

Training is a mandatory part of DMHP in the initial three years of the programme. Under the 9th plan period of DMHP in the district of Navsari, training was held by the Psychiatrists of SSG Civil Hospital. The training was given using IEC leaflets & booklets.

About 60% of medical officers of CHCs & PHCs had also received training from the psychiatrist to treat the mentally ill patients and prescribe initial medication to them. 40% of the health staff also said that they had received on job training from the psychiatrist at the Civil Hospital. The people who had received training however opined that the frequency of the trainings should be increased. Considering the fact that only a miniscule percent of the allotted money for training was used, still the response of the health staff on training seemed positive.

2.3 Diagnosis, Treatment and Referral

The section on diagnosis, treatment and referral has been dealt in two parts. One part captures the viewpoint of the DMHP team. The other part tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

The Psychiatric Wing OPD runs six days in a week in SSG Civil Hospital. On these days, there is a regular in-flow of patients. Average number of patients visiting the SSG Civil hospital during the time and after DMHP was 35-45 per day (OPD register Navsari). The OPD operating for diagnosis and treatment of mental illness at CHCs and PHCs also remains open for 6 days a week for an average period of 5 hours. There are also monthly visits by the Psychiatrist from SSG Civil Hospital to CHCs and once in three months to PHCs to train the medical officers and to explain the patient's families about the disease and the care that needs to be given.

2.3.2 The beneficiaries view point

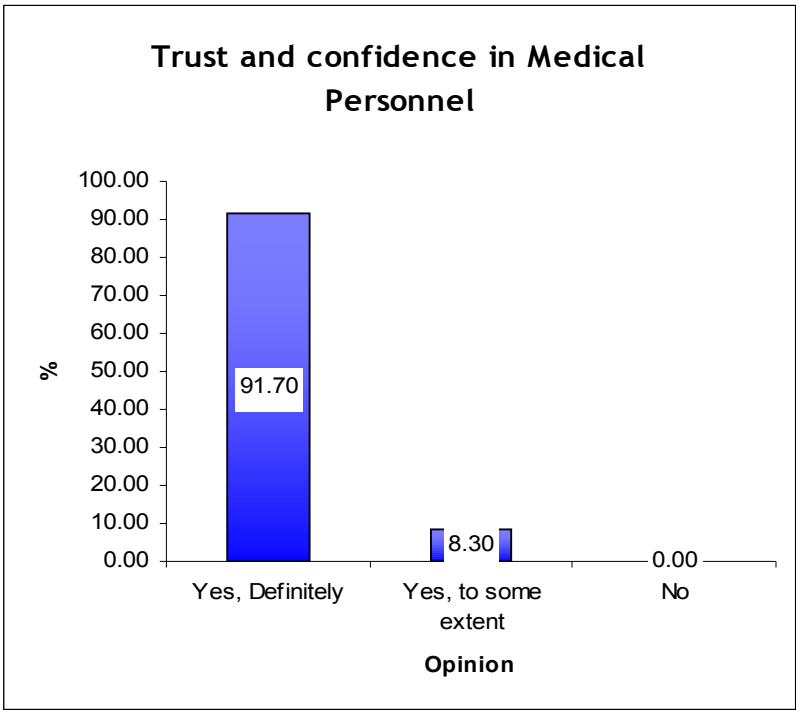
The ICMR, Planman Consulting field team also interviewed the beneficiaries from both the villages around PHC's and CHC's under Navsari District Hospital to understand their knowledge of the illness diagnosed and satisfaction on treatment that they were receiving. Of the 60 beneficiaries interviewed in the district, only 5% were referral cases (those who had been referred from a lower Medical institution to a higher one).

2.3.2.1 Perception about the Doctor

Around 92% of the beneficiaries in Navsari reported that they had complete trust in the doctor whom they had met. The rest 8% stated that they had trust to some extent. All

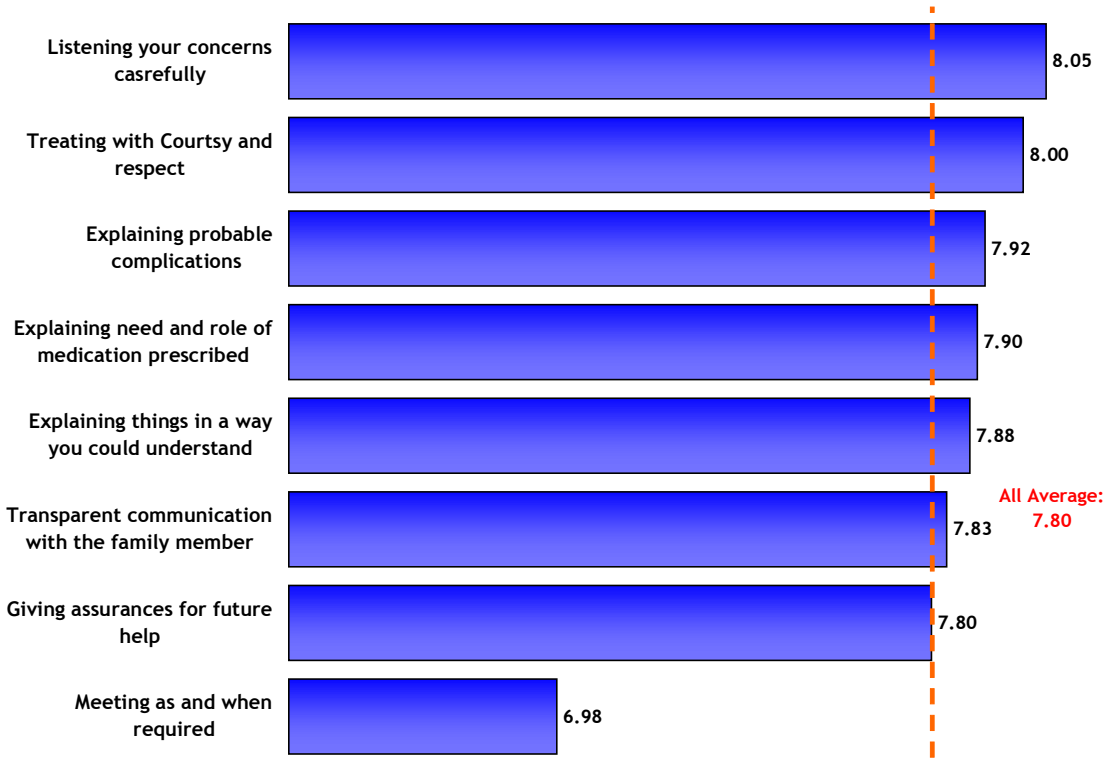
of the beneficiaries said that they met same doctor during each visit to the hospital but overall their satisfaction level with the doctor/psychiatrist was on the higher end.

Fig 1 .Trust and Confidence in Medical Personnel



The graph below reflects the level of trust achieved by beneficiaries on various aspects of interaction with the psychiatrist. Of these "listening to your concerns carefully", "treating with courtesy and respect", "explaining probable complications"," explaining need and role of medication prescribed"," explaining in a way that they could understand", "transparent communication with the family members", and are found to be above the average level of 7.00. Ranking on the parameter "meeting as when required" was rated below the average.

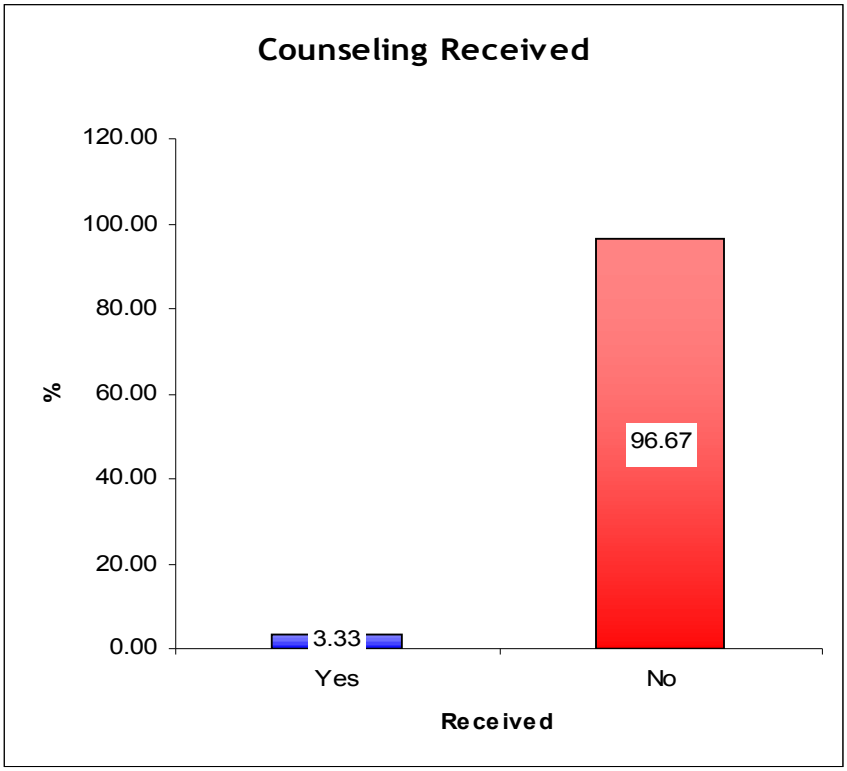
Fig. 2 Level of satisfaction on various aspects of interaction with the doctor



2.3.2.2. Counseling Received

About 97% of the beneficiaries said they had not received any counseling or met with a counselor during their visit to the hospital. This highlights the lacuna in treatment caused by the absence of a clinical psychologist or social worker on the team.

Fig 3. Counseling Received



2.3.2.3. Overall treatment

Beneficiaries of Navsari district are satisfied with the overall treatment that they had received as almost 90% of them had given a rating of 8 on being asked to rate the treatment level on a scale of satisfaction from one to ten(one being not satisfied and ten being absolutely satisfied).

2.4 Availability of Drugs

The inventory of drugs in Navsari district was maintained at the level of the District Hospital, CHCs and PHCs independently. Since the funds for DMHP used to come directly to the Psychiatric wing of the District Hospital, the procurement of medicines was faster. After the state government took up the programme the provision of medicines was done from the state fund. A three panel structure had been build by the state for the purchase of medicine. First was the provision at the Central medical store, second was a contract based procurement of medicines from specific contractors at a fixed rate. The third one was procuring from the open market through tenders. According to the State Mental Health Programme Officer there is no shortage of drugs

in any of the hospitals or medical units. Due to the distribution mechanism, generally there is no shortage of medicines in the entire district. Around 9 out of 10 health staff interviewed reported that medicines available were adequate.

2.4.1. The beneficiaries view point-

2.4.1.1. Drugs availability

In Navsari, 98% of the beneficiaries interviewed, said that they had received drugs at the hospital where they had gone for treatment. Most of the (about 92%) respondents receiving medicines said that the purpose of medication was also clearly explained to them. It should be additionally noted that some of the beneficiaries opined that they had received only some medicines and rest they had to buy from the local market.

2.5. Awareness about Mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

Orientation training sessions, awareness camps and school health programmes were held in various parts of Navsari district under this programme for the detection of psychiatric illness in the general community and educational institutions. The health staff opined that due higher awareness among the community (as a result of awareness camp) most of the mentally ill cases are brought to the doctors for medical help instead of going to the occult practitioners. In addition to this, camps, awareness sessions and school health programmes were held in order to orient the school & college teachers. NGOs were also made part of the awareness camps for detection of psychiatric illness including cases of mental retardation. Considering the fact that only a very small part of the budget allotted had been used for spreading awareness, the activities that were done seem to be numerous. Gujarat state government co operation in Navsari helped in conducting more widespread awareness programmes.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Awareness about the mental illness among the community members were recorded through door to door survey and also discussion with common people at very informal level. 2 out of 5 respondents had responded that awareness about the illness was created through discussion along with use of Information Education Communication material. Only Around 37% of the respondents also reported that awareness camps through street play and demonstrations had been held. This perception of the community corroborates the lower usage of allocated budget for spreading awareness. 13% of the respondents also reported that they had been informed about mental illness by the Doctor at the District Hospital.

2.5.2.2 Awareness about symptoms and perception of mental health

As far as symptoms of mental illness are concerned, a varied perception regarding awareness in the community was found. Most of them (around 77%) cited their conception that mental illness is contagious. Regarding curability around 3 out of 5 respondents recommended medicines counseling and treatment at the hospital. Another same proportion of the respondents recommended "shock treatment" as a method of cure. A notable contradiction in the viewpoint of respondents was visible with all of them emphasizing on the need of support and care of family members and community to mentally ill people and still around 76% of them reporting that they believe that mentally ill people cannot be treated at home.

3. Implementation Problems

- Interference of nodal officer in proper functioning of the programme.
- Lack of proper infrastructure at the CHC/ PHC level
- Absence of the Clinical Psychologist and Psychiatric Social Worker affects counselling of patients
- Navsari is district which affected by frequent epidemics of filaria, leptospiro, dengue, chikengunia and regular floods which keeps the health staff very busy.
- Frequent epidemics require additional staffs which also hampers the functioning of programmes like DMHP.

Recommendation:

- Improve co ordination between nodal office and district.

District Mental Health Programme (DMHP)

Snapshots from Maharashtra-Raigad

Maharashtra was one of the states taken up by the Ministry of Health and Family Welfare in the 9th Five Year Plan for implementation of DMHP. In Raigad district the programme was initiated on 16th March, 2000. Fund allocated for this district was given to the Civil Hospital which is located at Alibag, the district town of Raigad. The funds had been received by the Nodal center, Maharashtra Institute of Mental Health in Pune in 1998 itself but unavailability of requisite personnel led to delay in programme initiation (programme initiated in 2000). This was confirmed by the nodal officer supervising the programme in Raigad The health system in Raigad has two district level hospitals that work parallel to each other; they are Civil Hospital and Zilla Parishad Hospital. The fund was given to the Civil Hospital with a view to expand and upgrade the service facility for the treatment of mentally ill patients, beginning at the district level and diffusing towards the periphery level. Under the Civil Hospital there are several Rural Hospitals, Cottage Hospitals and Sub-district Hospitals which run their service facilities. The next lower levels in the hierarchy are the Primary Health Centres (PHC's) and ANMs/ sub centres respectively. The fund allocated for Civil Hospital was supposed to be used for the execution of DMHP at all these lower level hospitals which are under Civil Hospital in this district. The fund was channelized to Civil Hospital through a Nodal Officer, who is associated with Maharashtra Institute of Mental Health in Pune.

The last installment of the DMHP fund, from the Central government to the Nodal institute, was received in 2002. Since the fund was not totally exhausted within the programme period, the nodal officer with the permission of the Central Government, extended the programme till 2008 with the balance amount. The Nodal Officer also revealed that since the psychiatrist for the DMHP team was appointed after 2002, therefore programme was extended beyond the period for its full effectiveness. However, it could be continued only till October 2008.

1. Allocation and Utilisation of Funds.

	9th Five Year Plan			
Expense Categories	Scheduled Expenses	Actual Expenses	Balance	% of utilization

Staff Salary	1,369,767.44	0.00	1,369,767.44	0.0%
Medicines/Stationary/Contingencies	1,094,186.05	487,129.00	607,057.05	44.5%
Equipments/Vehicles, etc	900,000.00	1,230,720.00	-330,720.00	136.7%
Training	918,604.65	0.00	918,604.65	0.0%
IEC	367,441.86	0.00	367,441.86	0.0%
Total	**4,650,000.00**	**1,717,849.00**	**2,932,151.00**	**36.9%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 46,50,000.00 was received through three installments for the district of Raigad under the DMHP in the 9th Five Year Plan of which 36.9% had been utilized.

- The table above shows that no expenses had been incurred for the payment of salary to the staffs. It had been reported by the Nodal Officer that the staffs whoever were working under DMHP received their salary from the State Government.

- The analysis also shows that, under the 9th plan period, there had been an over spending of 36.7% for purchasing of equipments/vehicles, etc.

- On the other hand, for buying medicines/stationeries, only 44.5% of the allocated funds had been utilized.

- The two most important component of the DMHP, namely, "Training of the DMHP Staffs" and "Raising Community's Awareness using IEC materials", which could ensure the proper diagnosis and treatment and lowering of social stigmas, were dealt with low priority which is clear from the fact that no funds allotted under these two heads had yet been utilized.

2.Perception on Programme Implementation

To gather an overall perception on the programme implementation and its effects, views have been taken from the Health Staffs working under DMHP and those who are associated with the psychiatry wing of Civil Hospital, 60 beneficiaries who have

been receiving treatment under the programme and 30 members of the general community from areas where the programme is being implemented.

It is necessary to note that DMHP has been implemented in Civil Hospital, Raigad as one of the many programmes running under the Civil Surgeon (Civil Hospital, Raigad). In that sense it is a value addition to the psychiatry wing that is in service in this hospital, and not an independent separate programme in this district.

2.1 Composition of DMHP team

In Raigad, there have been continuous changes of the DMHP staff from 2000-2008 due to frequent transfers and resignations. The psychiatrist hired in 2000 was a permanent salaried staff of the state government. In 2000, the total staff strength was one psychiatrist who headed the DMHP team with 1 sister in charge, 4 Psychiatric Nurse and one Social Worker. The Psychiatrist was replaced twice once in 2001 and 2002. The sister in charge changed in 2006 and again in 2007 and at present the post is lying vacant. The 4 staff nurses (drawing salary under DMHP) continued their work till 2005-06.The social worker left once in 2001 and subsequently in 2002.

Now the separate psychiatry wing that was established at the District Hospital for implementing DMHP comprises of only two staff. One Psychiatrist and one Social Worker, who are permanent staff of the district hospital. All the other staff who were in the system at the time when the programme was initiated have either left or been transferred from the hospital, hence there is an acute shortage of manpower at the district level. As per the Nodal officer, the frequent changes in manpower have led to some amount of instability in the smooth operation of DMHP at the district. In fact, due to these transfers, at present there is no staff which has been trained under DMHP in the hospitals which were at lower levels in the hierarchy. This is negatively affecting the programme at the peripheral levels.

The changes in staff have been tabulated to give a clearer picture:

Staff	2000-2002	2002-2004	2004-2006	2006-2008

Psychiatrist	1(changed twice once in 2001,once in 2002)	1	1	1
Psychiatric social worker	1	2 (changed in 2001)	2	1
Psychiatric Nurse	4	4	4	Vacant
Sister In Charge	1	1	1	Vacant since 2007

2.2 Training

Training is a mandatory part of DMHP for the first three years after initiation of the programme. Training programmes were initiated at the district level for general staff across different levels. The training team mainly consisted of the Nodal Officer and the Psychiatrist at the district (Civil) hospital. Around 15 staff at Rural Hospital Level had been trained among which only 3 people are working presently in Raigad district. Similarly of the 34 people who were trained at PHC level, only 10 are now available. For last 3-4 years, formal trainings are not happening in Raigad under DMHP because of scarcity of funds. An acute shortage of trained manpower prevails in this district. At present the lower levels (hospitals and PHC below the district hospital) are not being able to diagnose or treat cases due to lack of training about mental health.

2.3 Diagnosis, Treatment and Referral

The section on diagnosis, treatment and referral has been dealt in two parts. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiaries about the diagnosis and treatment they received and their satisfaction levels.

2.3.1 Heath System viewpoint

The referral system is designed in such a way that the patients who are diagnosed but can not be treated at the PHC level are referred to the RH (Rural Hospital). Those who cannot be treated at RH level are referred to the Civil Hospital. Patients who can not be treated in the Civil Hospital in the District are further referred to Thane Mental Hospital at Thane.

Besides the OPD at the Civil Hospital, a team of two people from Civil Hospital comprising of the Psychiatrist and the Social Worker, visit once a week to one of the

Rural Hospitals at Pen or Roha areas. The doctors opined that on an average around 40-60 patients turn up during their visit to the Rural Hospital. The District Hospital OPD also has an in flow of an average of 139 patients per month (according to the OPD register). Of these around 19% were new patients. Presently no regular visits are being made to the PHC level. This status prevails since October 2008.

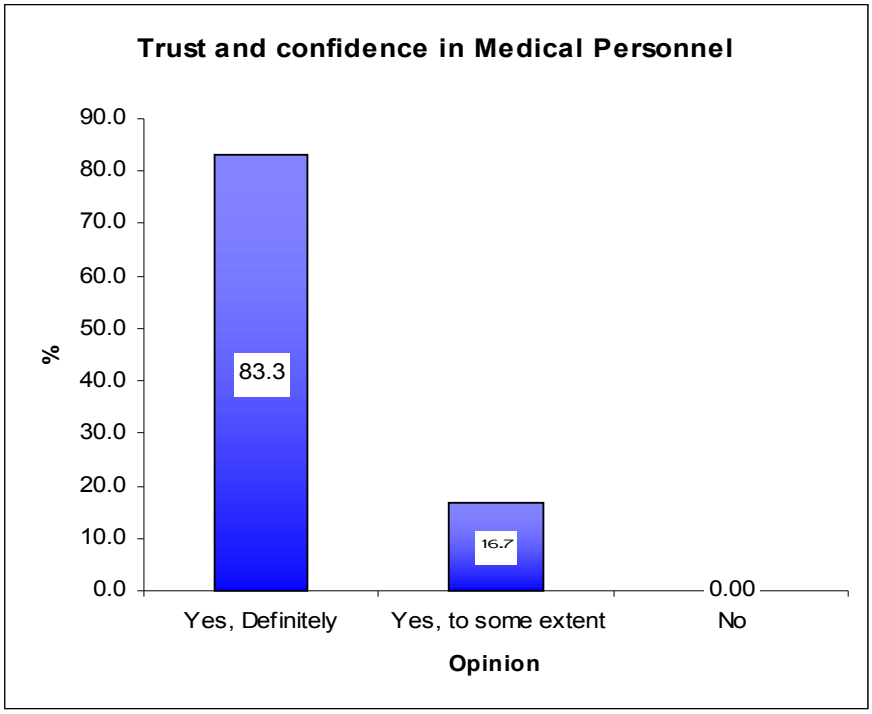
2.3.2 The beneficiaries view point

The beneficiaries who were interviewed by the Planman Team were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. The beneficiaries were interviewed both at the level of the district hospital and also from the areas surrounding the rural hospitals. Of the 60 beneficiaries interviewed in the district, around 28 % were referral cases (those who had been referred from a lower medical institution to a higher one).

2.3.2.1 Perception about the Doctor

Most of the beneficiaries (83%) interviewed reported that they had complete trust in the doctor whom they had met. The rest of the beneficiaries in Raigad district (17%) said that they had trust to some extent. Most of the beneficiaries (92%) also said that that they met the same doctor during their each visit to the hospital. Their rating of the overall satisfaction level with the doctor/psychiatrist was also on the higher end (6-8 on a scale of 1-10).It needs to be mentioned here that in spite of frequent changes in the DMHP team in Raigad, the patients seemed to have received consistent services.

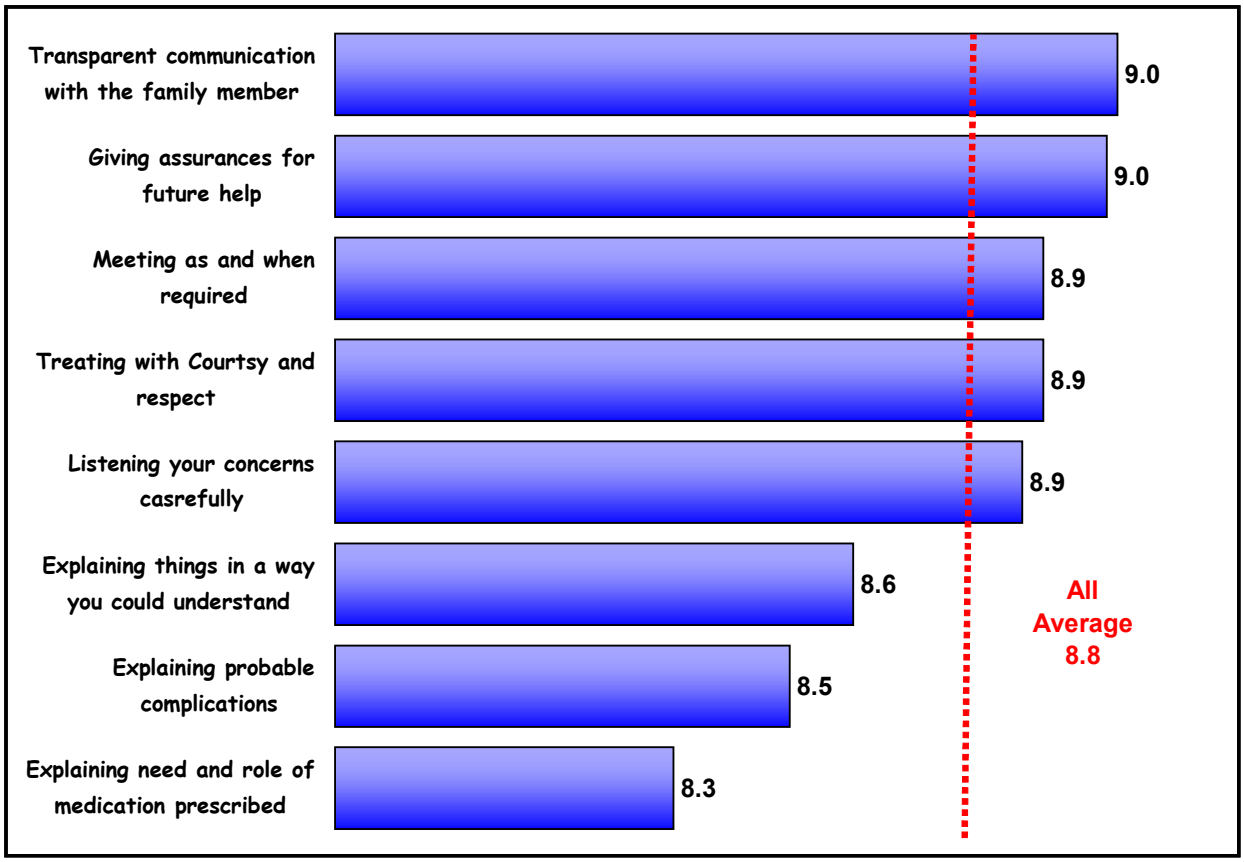
Fig 1 .Trust and Confidence in Medical Personnel (for Raigad)



The beneficiaries of Raigad have also given a rating between 1 to 10 (where 1 is least satisfactory and 10 most satisfactory) reflecting higher trust on the doctor who treated them. The average rating is 8.78 which reflect that the trust level is really high.

The graph below reflects the level of trust achieved by beneficiaries on various aspects of interaction with the psychiatrist. Of these "giving assurance for future help", "treating with courtesy and respect", "meeting as when required" and "listening your concerns carefully" are found to be above the average level of 8.78. Ranking on rest of the other aspects are less are also high (above 8) but bit lower than the average.

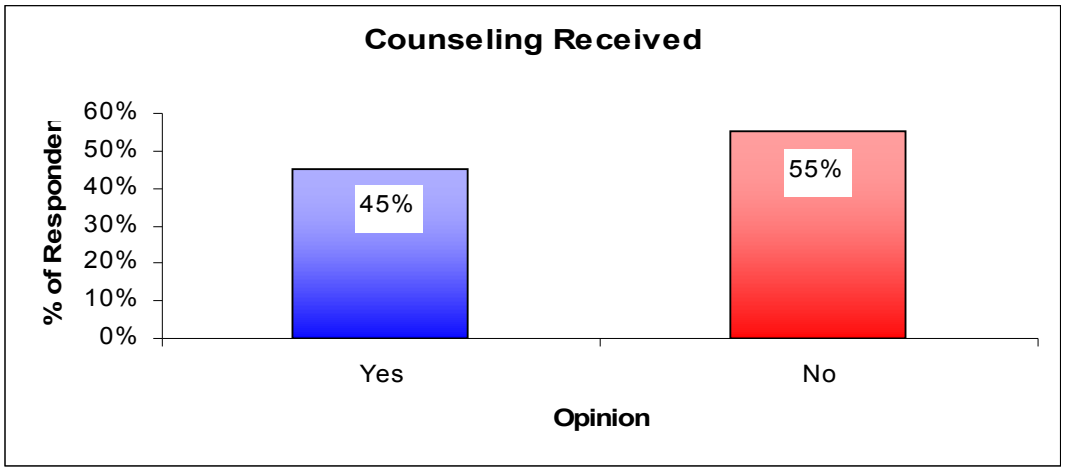
Fig. 2. Level of satisfaction on various aspects of interaction with the doctor



2.3.2.2 Counseling Received

As far as counseling in concerned nearly 45% of the beneficiaries interviewed agreed that they had received some counseling during their treatment. However, majority (more than half) denied of receiving any counseling during the period of their treatment. It should be noted here that there is no Counselor (post is vacant) at Civil Hospital in Raigad. So those who received counseling would have had their session with the Social Worker.

Fig 3. Benfeciaries perception on the counseling received during treatment



2.3.2.3 Overall treatment

Most of the beneficiaries, who were interviewed during the survey, seemed to be mostly satisfied with the overall treatment that they had received. This was reported by nearly 4 out of the 5 (79%) beneficiaries interviewed, who were extremely satisfied with the treatment received. These beneficiaries were of the opinion that the Psychiatrist and the Social Worker provide all the information they require and assist whenever required.

2.4 Availability of Drugs

2.4.1 Health System viewpoint

As per the health officials, from the initiation of the programme there has been no shortage of medicines as such. In case there is a shortage of a particular medicine then substitute medicine is prescribed so that the patients with weak economic background do not have problems concerning availability of medication. Along with that requisition for medicines is given to the concerned authority. Drug registers are properly maintained and drugs are also dispatched to other hospitals according to their demand.

A short list of drugs which are available in the hospital is given bellow-

- Tab Chlorpromazine (CPZ) 100 mgs
- Tab Imipramine 75 mgs

- Tab Phenobarbitone 30 mgs
- Tab Phenobarbitone 60 mgs
- Tab Diazepam

2.4.2 The beneficiaries view point

Most of the beneficiaries who were interviewed by the survey team also confirmed that most of the medicines prescribed are given by the medical personal treating them. Around 97 % of the respondents are satisfied with the availability of drugs in the hospital. More than half the respondents who received medicines reported that the purpose of medication was somewhat explained to them. Around 35 % of the respondents also confirmed that that the purpose of medication was clearly explained to them.

2.5 Awareness about Mental Illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1 Health System viewpoint

Awareness generation has been one of the targets of DMHP. As per the health officials interviewed, the growth in number of patients being treated at hospitals across all levels is a direct result of awareness that has been created in the process of implementing the programme. Some members of the health staff believe that DMHP is partly successful in this district because of the awareness it has managed to spread. The health staff also opined that training and awareness programmes should cover all areas of the district to make the programme more successful. In order to strengthen their point they cited the percentage growth (around 20%) in number of new patients per month at the district civil hospital. However, this was not case in the other health institutions which were targeted under the DMHP at the periphery level, such as Rural hospitals and the PHCs. Lack of proper planning for spreading awareness in the rural areas was cited as one of the main reasons.

2.5.2 Community perception regarding awareness

2.5.2.1 Information on DMHP and mental health

Awareness about the mental illness among the community members was recorded through door to door survey and also discussion with common people through FGD at very informal level in the areas where the programme in being implemented. The analysis points out that the awareness level was mainly on account of information generated from the District Hospital and through sources of media. More than 2 out of every 5 respondents interviewed reported that the doctor at the District Hospital had informed them about mental illness. Information gained through other sources of media was reported by 2 out of 5 respondents as well. A very small percentage of people confirmed having attended a health awareness camp.

2.5.2.2 Awareness about symptoms and perception of mental health

As far as symptoms of mental illness are concerned, the awareness in the community was found to be diverse, not confined to certain symptoms. 64 % of the respondents reported "having Fits" to be a common symptom of mental illness. However according to 17 % of the respondents all the symptoms mentioned may indicate probability of mental illness. This indicates that maybe these community members could not identify separate symptoms as indicators of mental illness. Majority of the people consider mental illness as a disease. Nearly 7 out of 10 respondents reported treatment at a hospital as a method of cure. More than half the respondents contacted also agreed that counseling and medicines are the common ways of curing mental illness. However treatment by occult practitioners and shock treatment were also recommended by more than half the respondents as well. This kind of mixed awareness levels do not present a favorable picture of the impact of awareness initiatives that were undertaken .Perhaps the frequent changes in personnel have led to lack of planning and hence a coordinated approach towards spreading awareness.

District Mental Health Programme (DMHP)

Snapshots from Maharashtra-Buldana:

Maharashtra was one of the states taken up by the Ministry of Health and Family Welfare in the 10th Five Year Plan for implementation of DMHP. In Buldana district, the programme was initiated on 7th May, 2007. Fund allocated for this district was given to the Civil Hospital which is located in the district town of Buldana. It was channelized to the Civil Hospital through the Nodal Officer who is associated with Maharashtra Institute of Mental Health in Mumbai. He is also the additional director of mental health appointed by Central Government.

The health system in Buldana has two district level hospitals that work parallel to each other; they are Civil Hospital and Zilla Parishad Hospital. The fund was given to the Civil Hospital with a view to expand and upgrade the service facility for the treatment of mentally ill patients, beginning at the district level and diffusing towards the periphery level. Under Civil Hospital several Rural Hospitals and Sub-district Hospitals run their service facilities. The next lower levels in the hierarchy are the PHCs (Primary Health Centres) and ANMs respectively.

1. Allocation and Utilisation of Funds.

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	870,000.00	0.00	870,000.00	0.0%
Medicines/Stationary/Contingencies	450,000.00	0.00	450,000.00	0.0%
Equipments/Vehicles, etc	600,000.00	9,390.00	590,610.00	1.6%
Training	500,000.00	0.00	500,000.00	0.0%
IEC	200,000.00	2,357.75	197,642.25	1.2%
Total	**2,620,000.00**	**11,747.75**	**2,608,252.25**	**0.4%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: “Payment of staff salary”, “Purchasing medicines, stationary and other contingencies”, “Purchasing equipments, vehicles, etc”, “Training” and “IEC”. The key findings that came out are:

- A fund of Rs 26,20,000.00 had been sanctioned as the first installment for the district of Buldana in May, 2007 under the DMHP during the 10th Five Year Plan of which only 0.4% had been utilized.

- Because of the various legal procedures, the allocated fund reached late to the nodal centre and further delay occurred because the requisition for medicines/stationeries and the equipments were also sanctioned late.

- It has been reported that the staff so far appointed for DMHP are the salaried employees of the state government. And hence, no expenses have so far been incurred for the payment of the staff's salary.

- The programme is at a very initial phase in this district. The community level awareness spreading activities have just begun which is clear from the fact only 1.2% of the allotted amount has been spent.

2.Perception on Program Implementation

To gather an overall perception on the program implementation and its effects views have been taken from the Health Staffs working under DMHP and those who are associated with the psychiatry wing of Civil Hospital, 63 beneficiaries who have been receiving treatment under the program and 30 members of the general community from areas where the program was being implemented. It is important to note that DMHP has been implemented in Civil Hospital, Buldana as one of the many programmes running under the Civil Surgeon, Civil Hospital, Buldana. In fact it is a value addition to the pre existing psychiatry wing of this hospital.

2.1. Composition of DMHP team

In Buldana Civil Hospital, no separate staff was hired for DMHP. In 2000, there was one doctor in the hospital with specialization in psychiatry who supervised the DMHP team consisting of some Psychiatric Nurses (male/female) and one Social Worker. However, subsequently a separate DMHP section was established within the psychiatry wing .This section constituted of only two staff members: One Psychiatrist and one Social Worker. All the other staff who were in the system at the time when the programme was initiated have either left or been transferred from the hospital. Currently there is an acute shortage of manpower at the district level.

2.2. Training

Training programmes were initiated at the district level and several staff across different levels was trained in the initial years of programme initiation. Since these training programmes were held in the initial phase of DMHP the current staff could not report about the number of such programs or their duration. Therefore 4 out of 5 staff members interviewed reported that they had not attended any training session. For the last 3-4 years, formal trainings are not happening in Buldana district under DMHP. Therefore there is an acute shortage of trained manpower at lower levels in this district. The non utilization of the allocated fund for training programs as shown above further emphasizes the lack of training programmes in the district.

2.3.Diagnosis, Treatment and Referral

The section on diagnosis, treatment and referral has been dealt in two parts. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

The referral system is designed in such a way that the patients who can not be treated at the PHC level are referred to the RH (Rural Hospital). From the RH level the patients if required are referred to the Civil Hospital, Buldana. Patients who can not be treated in the Civil Hospital are further referred to Nagpur Mental Hospital at Nagpur.

On Tuesdays and Fridays the DMHP team is stationed at the Civil Hospital itself and runs the OPD there. The team of two people from Civil Hospital, consisting of the Psychiatrist and the Social Worker also visits the sub district hospitals and rural hospital. Documents at the District hospitals show that these visits are made on every Saturday of the month and the 4th Thursday of the month. The Sub District hospitals and rural hospitals are both at the level of a CHC. The Sub District hospitals and Rural Hospitals covered are Malkapur and Khamgaon sub district hospital, Rural Hospitals in Mehkar,Chikhli,Deulgaon and Buldana. During these visits diagnostic camps are held and medicines are also given as per requirement.

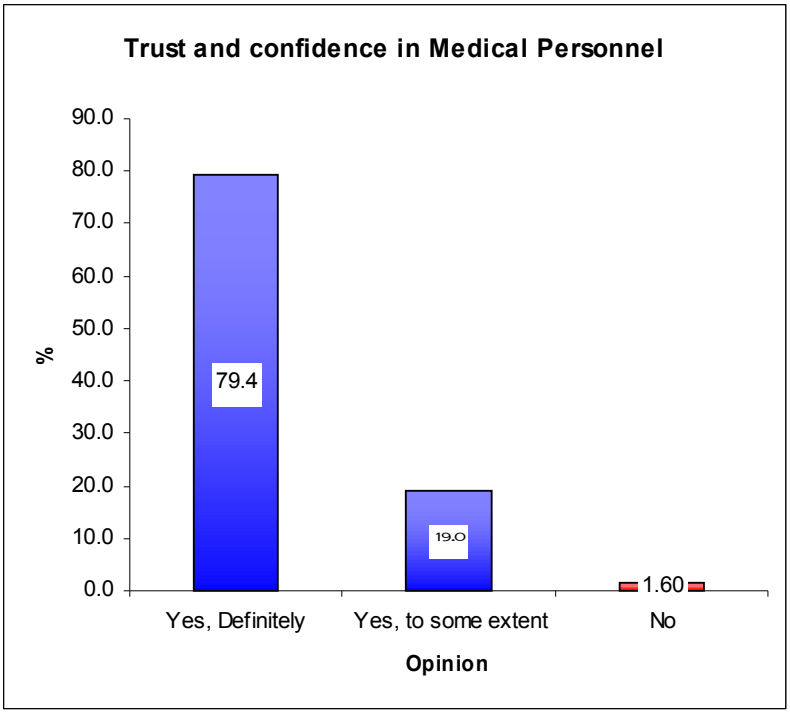
2.3.2. The beneficiaries view point

The ICMR Planman Consulting team also interviewed 60 beneficiaries from villages surrounding the District Hospital, Sub District Hospital and Rural Hospitals where DMHP was being implemented. The beneficiaries were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. More than half (53.4%) of the beneficiaries said that they had visited the doctor at the district hospital as their first point of contact. There were around 27% cases of referral. Moreover 1 out of every 4 beneficiaries also reported that they had visited the doctor at the Mental Hospital as their first point of contact.

2.3.2.1. Perception about the Doctor

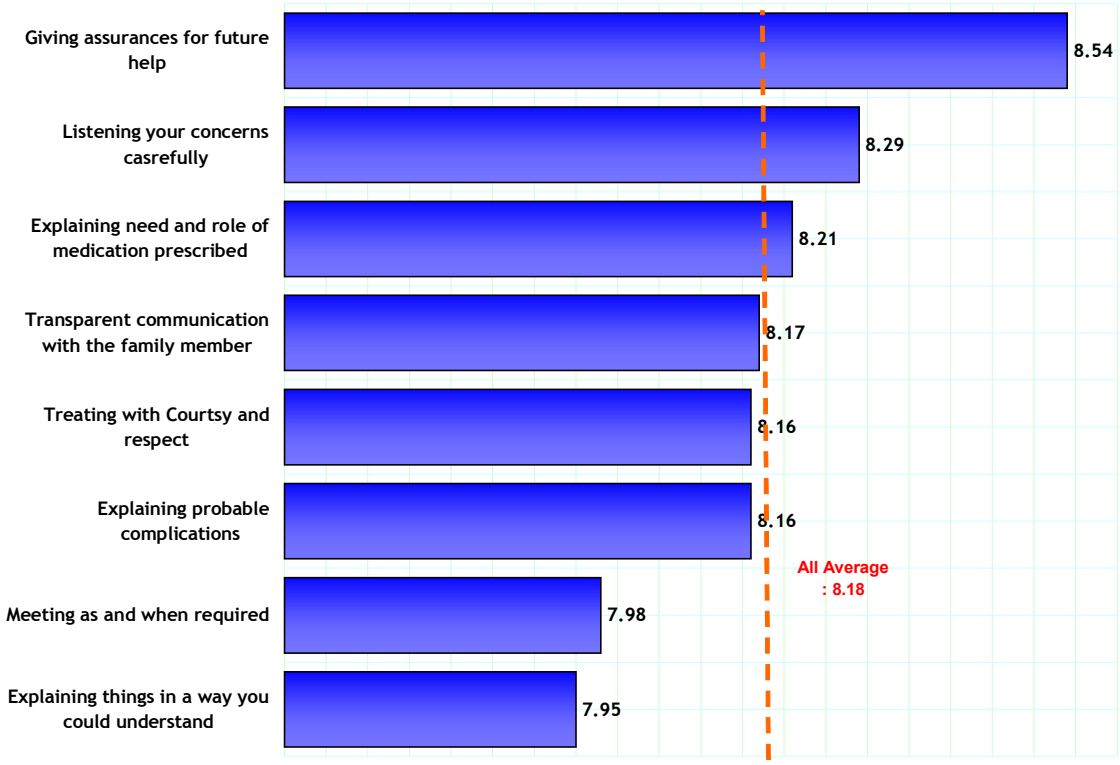
Out of the beneficiaries interviewed more than 8 out of 10 (82.5%) them confirmed that they met the same doctor during each visit to the health institution where they had gone for their treatment. Only 2 out of 10 (17.5%) said that they met different doctors during their each visit to the health institutions. Most of the beneficiaries said that they have trust and confidence level in the medical personnel to whom they had met for their treatment.

Fig.1 Trust and Confidence in Medical Personnel



The above graph shows that nearly 4 out of 5 (79.4%) beneficiaries interviewed reported that they had high degree of trust and confidence on the medical personnel they had met during their treatment. Nearly 1 out of every 5 beneficiaries (19%) had trust and confidence only to some extent. This shows that most of the beneficiaries had expressed trust and confidence on the medical personnel that they had met for their treatment.

Fig.2 Satisfaction on interaction with the Medical Personnel



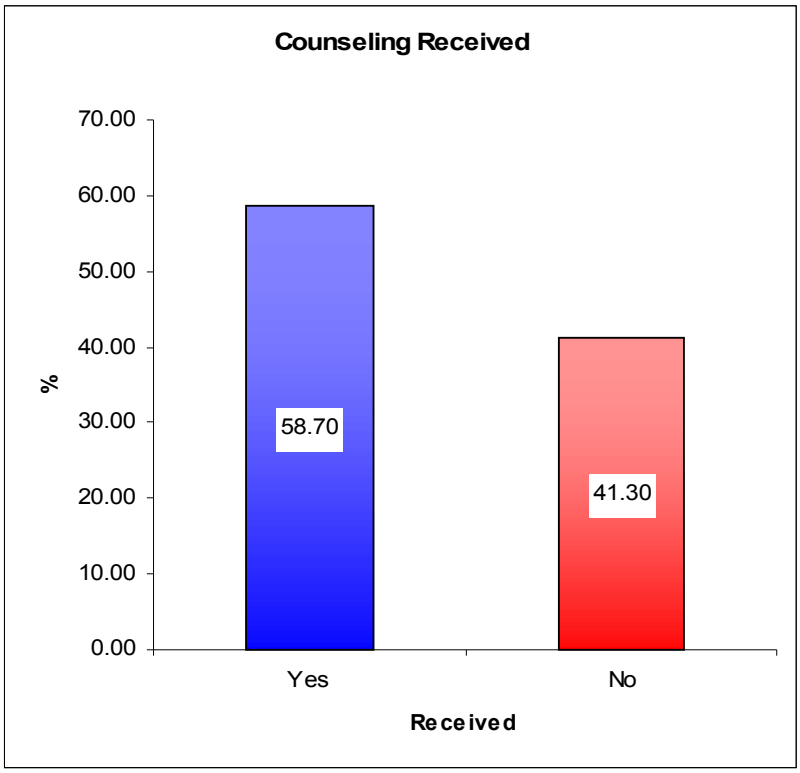
From above graph we can see that the satisfaction levels on the following aspects were above the composite mean: “giving assurance for future help”, “Listening carefully to the concerns”, and “explaining need and role of medication prescribed”. The rest of the aspects were found to be below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the medical personnel they have met on the grounds that the doctors have given assurance for future help, have listened to their concerns carefully and have explained the need and role of medications prescribed. However, the beneficiaries had below average satisfaction on the aspects such as “transparent communication with the family members”, “treating with courtesy and respect”, “ explaining probable complications”, “meeting as and when required” , and ”explaining things in a way that the patients could understand”.

2.3.2.2 Counseling Received

In Buldana district, on being asked whether the beneficiaries had received counseling from the health institution where they had gone for their treatment, more than half, (58.7%) reported that they have received counseling sessions. Only 4 out of 10 (41.30%) had reported that they did not receive any counseling session.

It is to be noted that there is no Counselor in the district, the post being vacant till date. The Social worker and Psychiatrist provide counseling sessions to the patients at the Civil Hospital. So those who have received counseling from here actually had their session with the Social Worker or the Psychiatrist. There is no separate room for counseling. Counselling is done at the OPD room itself.

Fig 3. Counseling Received by the beneficiaries



2.3.2.3. Overall treatment

There was a considerably high level of satisfaction found among the beneficiaries interviewed in Buldana. On being questioned about the satisfaction level of the overall treatment that they had received, almost all of the beneficiaries have given ratings between 7 to 9 on a scale of satisfaction from one to ten(one being not satisfied and ten being absolutely satisfied).

Interactions with the beneficiaries also revealed that the beneficiaries are extremely satisfied with the service that they avail from the Civil Hospital, and the performance of the Psychiatrist and the Social Worker is enormously commendable.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

Drugs are available at the hospital. Staff at the District hospital reported that the medicines supplied by the government to the hospital are treated like national property which should not be wasted. That is the reason why drug registers are maintained and near expiry drugs are dispatched to the lower level hospitals where there is more demand and therefore likely usage of these medicines before expiry.

In case there is a shortage of a particular medicine a requisition is immediately sent, and a medicine with similar properties and effect is prescribed so that the patients who are economically not well off do not have a problem concerning medication. More than half the staff members interviewed also opined that in case of unavailability, they even prescribe the drugs and ask the patients to procure it from the market.

However, in reference to the budget section and as was also confirmed by the nodal officer and the civil surgeon, no utilization of funds sanctioned under DMHP have been made for the procurement of medicines.

2.4.2. The beneficiaries view point-

2.4.2.1. Drugs availability

Almost all the beneficiaries (96.8%) interviewed confirmed that they received medicines from the hospital when they had gone for treatment. More than 7 out of 10 (73%) also confirmed that the purpose of the medication was clearly explained to them. Around (14.3 %) revealed that the purpose of the medication was explained to them to some extent only. However 12.7 % also reported that the purpose of medication was not at all explained to them.

2.5. Awareness regarding Mental Illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1 Health System viewpoint

Awareness generation has been one of the success points of DMHP in the District of Buldana. Documents available at the District hospital confirm the organization of various awareness programs at the District hospital and Rural hospital in Buldana. Moreover awareness programs were also organized for adolescents and the teaching staff and even prison inmates. Organizing of mental health day and Depression screening day were some of the other activities reported by the staff at the hospital. The growth in number of patients being treated at hospitals across all levels is a result of the awareness that has been generated. However the staff also reported that there has always been a lack of proper awareness generation mechanism at the periphery level due to lack of planning.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Around 24% of the respondents from the community reported that they had been informed about mental illness by the doctor at the district hospital. 1 out of 5 respondents also reported attending mental health camps and knowledge of mental health from other sources of media. This confirms that awareness camps had been held in this area. Only 14% of the community members interviewed confirmed that they had come to know about Mental illness from the monthly meetings organized by the NGOs and from the doctor at the CHC/ Rural Hospital. However, none of the community members had received any information on mental illness through street plays and demonstration.

2.5.2.2. Awareness about symptoms and perception of mental health

The opinion of the community members who were interviewed shows that there is fair degree of awareness in the community. The symptoms of mental illness cited by the community were varied; the community members have recognized most of the symptoms of mental illness. Excessive drug abuse was recognized by a higher percentage (74.2%) of the community members interviewed during the survey. This was followed by the symptoms: lack of sleep, being sad and depressed and excessive anxiety which was recognized by nearly 3 out of 10 community members interviewed during the survey.

Regarding the community perception about the curability of mental illness, it was observed that more than 7 out of 10 of the community members opined that mental illness can be treated at the hospital. More than half the respondents also opined that mental illness can be cured with the help of medicines, counseling. However, nearly 7 out of 10 confirmed that mental illness could be cured by shock treatment and 38% also recommended visiting occult practitioners.

All of the interviewed community members have had agreed that family members of the community should recognize change and behavior of people and discuss it with their doctors/health workers. More than 9 out of 10 have also said that mentally ill individuals should be taken to the nearest health centre for treatment and they need care from the family and the community. However nearly 2 out of 10 (19.4 %) of the community members interacted opined that mental illness is caused due to evil spirit or black magic. Nearly half the people interviewed also considered that mental illness

was hereditary. Thus in spite of various awareness programs there are mixed perception on mental illness and its curability and various myths and beliefs are still present in the population.

Suggestions/Recommendations

- The central government has given the fund to the hospital. But now there are further procedures to get NOC from the concerned authority so that the psychiatry wing can start using the fund. The whole process is lengthy and time consuming, and hence it is delaying the fund utilization process while it is necessary to implement it soon. So it will be better if the NOC is given directly to the Psychiatry wing of the hospital from the central government, and the directions for the utilization of the funds are also made directly to the psychiatry wing by the central govt. If direct communication with the psychiatry wing is not possible, then fund transfer can take place directly to the Regional Mental Hospital, and after that, from there it can be transferred to the psychiatry wing.

- There should be proper procedure to prepare the IEC materials, so that it can be easily and uniformly distributed or made into use at different places, and awareness generation would also be made easier.

- There is need for proper training process. Presently there is an acute lack of trained staff across all types of hospitals, like Civil Hospital, CHC, PHC, ANM etc so it is necessary to train them.

District Mental Health Program (DMHP)

Snap shot from Andhra Pradesh-Prakasham:

DMHP was initiated in Prakasham district in the year 2006 under the 10th year plan. The Nodal Office for DMPH program in Prakasham is Guntur Medical College; the key administrative responsibility of DMHP vests with the Nodal Officer, Head, and Psychiatric Department.

Situated in the south-eastern part of India, Prakasham is an administrative district in Andhra Pradesh. Previously known as Ongole, this district was renamed as Prakasham in order to pay homage to the great patriot and Andhra Leader, Tanguturi Prakasham Panthulu, also known as Andhra Kesari (Lion of Andhra). Some of the main towns in Prakasham district are Ongole, Markapuram, Chirala, Addanki, Kandukur, Parchur, Giddaluru, Podili, Dornala, Cumbum, Kanigiri and Chimakurthi. The district headquarters are located at the town called Ongole.

The DMPH program was initiated on 1 April 2006 from the APVVP Hospital (District Hospital); the program has successfully completed tenure of over two-and-half years and is still providing invaluable services to mentally retarded patients in and around the district.

A separate psychiatric wing was established in the district hospital and the program was being implemented from this wing to various parts of the district. The OPD at the psychiatric wing of this hospital was operational only on four days of the week.

Allocation and Utilization of funds:

	10th Five Year Plan

Expense Categories	Scheduled Expenses	Actual Expenses	Balance	% of utilization
Staff Salary	870,000.00	1,054,146.00	-184,146.00	121.2%
Medicines/Stationary/Contingencies	450,000.00	252,415.00	197,585.00	56.1%
Equipments/Vehicles, etc	600,000.00	519,553.00	80,447.00	86.6%
Training	500,000.00	30,347.00	469,653.00	6.1%
IEC	200,000.00	47,977.00	152,023.00	24.0%
Total	**2,620,000.00**	**1,904,438.00**	**715,562.00**	**72.7%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 26,20,000.00 as one installment had been sanctioned for the district of Prakasham in 2005-06 under the DMHP in the 10th Five Year Plan of which 72.7% had been utilized till 2007-08.

- The analysis clearly shows that, under the 10th plan period, there had been over spending of nearly 21% incurred in paying the staff's salary.

- For purchasing and maintenance of the equipments and vehicles, around 87% of the allotted money had been spent in the last three years. While close to 56% had been utilized in buying medicines, stationeries, etc.

- The above spending pattern clearly indicates to the fact that the major thrust of the DMHP in Prakasham had been to main the "institutional set up" and "building up of physical assets" in the form of retaining of the staffs and buying equipments and vehicles. "Training of the DMHP staffs" and "Raising the awareness level in the society", the two most important component of the DMHP, which could ensure the proper diagnosis and treatment and lowering of myths and superstitions in the society, was not assigned the priority which is clear from the fact in spending for IEC materials, the utilization rate is 24% and that for training the percentage is below 10.

2. Perception on Program Implementation

To gather an overall perception on the program implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the program along with 60 beneficiaries who were receiving treatment under the program and 30 members of the general community from areas where the program was being run.

2.1. Composition of DMHP team

In order to implement DMHP in Ongole, a psychiatrist was appointed at the District Hospital along with nursing and other staff members. However, it was reported that the psychiatrist, unhappy with the salary structure, left the job within a few months. Thereafter, the program has been running with the support of one psychologist and few other health staff. Currently the DMHP team consists of one psychologist, one psychiatric nurse, three counselors (they are on temporary basis and are no more associated with the program implementation) and a data entry operator.

The team comprising of the psychologist and the staff nurse visits the CHC's on the following schedules 2nd and 4th Thursday at Kandukur and 1st and 3rd Thursdays at Markapuram. To meet other requirements the Psychiatrist and other resource doctors like Neurologist, Pulmonologist are also taken on the visit to CHC's depending on the availability of this resource.

Training:

As training is an essential component of the DMPH program implementation. The training programs implemented under DMPH last year were five in number, in which 2 programs were at the district level, 1 program was at CHC level and 2 programs were at the PHC level. The staff reported that these training programs were held for a day and the allotted budget for each of these programs was between Rs 40,000-50,000. Currently 30 staff at the CHC level and 25 health staff at the PHC level were reported to have received training. However on being questioned about the effectiveness of these training program, the health staff at CHC and PHC level refused to comment.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

The DMPH OPD operates for four days in a week, during which the patient inflow is extremely good. The duration for this OPD is between 9:30 am – 2 pm.

Currently the patients are diagnosed by a Psychologist and one nurse who provides medicines to the patients. Though there is a separate wing for Psychiatry in the District hospital the patients who require hospitalization are directed to go to other hospitals in other towns as the Psychiatry wing does not have enough infrastructure and human resource capabilities for admitting inpatients and providing continued treatment and care.

The DMHP staff as well the health staff at the opined that since the Psychiatrist has left the job and due to inadequate infrastructure the patients are facing difficulties in terms of faster treatment, quick response and non availability of facilities for treating cases of severity and that which require emergency measures.

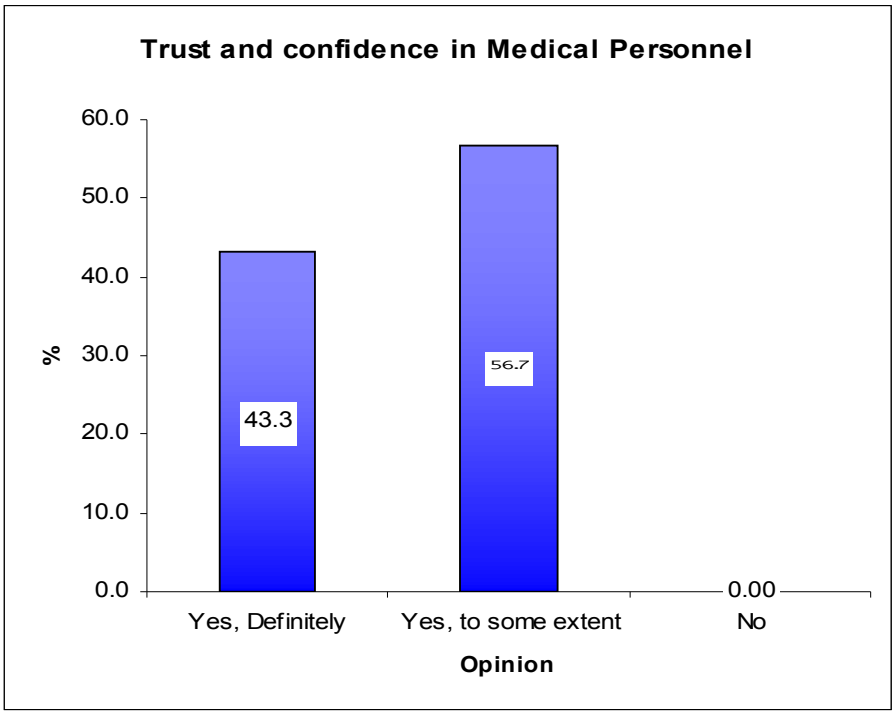
2.3.2. The beneficiaries view point

The ICMR Planman Consulting team also interviewed 60 beneficiaries from areas surrounding the District Hospital where the OPD was being run and also from some villages surrounding the CHC's and PHC's in the district. The beneficiaries were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. 38% of the beneficiaries interviewed had stated the Doctor at CHC as their first point of contact, while 32% had stated that it was the Doctor at the PHC. Only17% of the beneficiaries reported that the doctor at the District hospital was their first point of contact. These figures confirm the effective reach of the program at the lower levels as well.

2.3.2.1. Perception about the Doctor

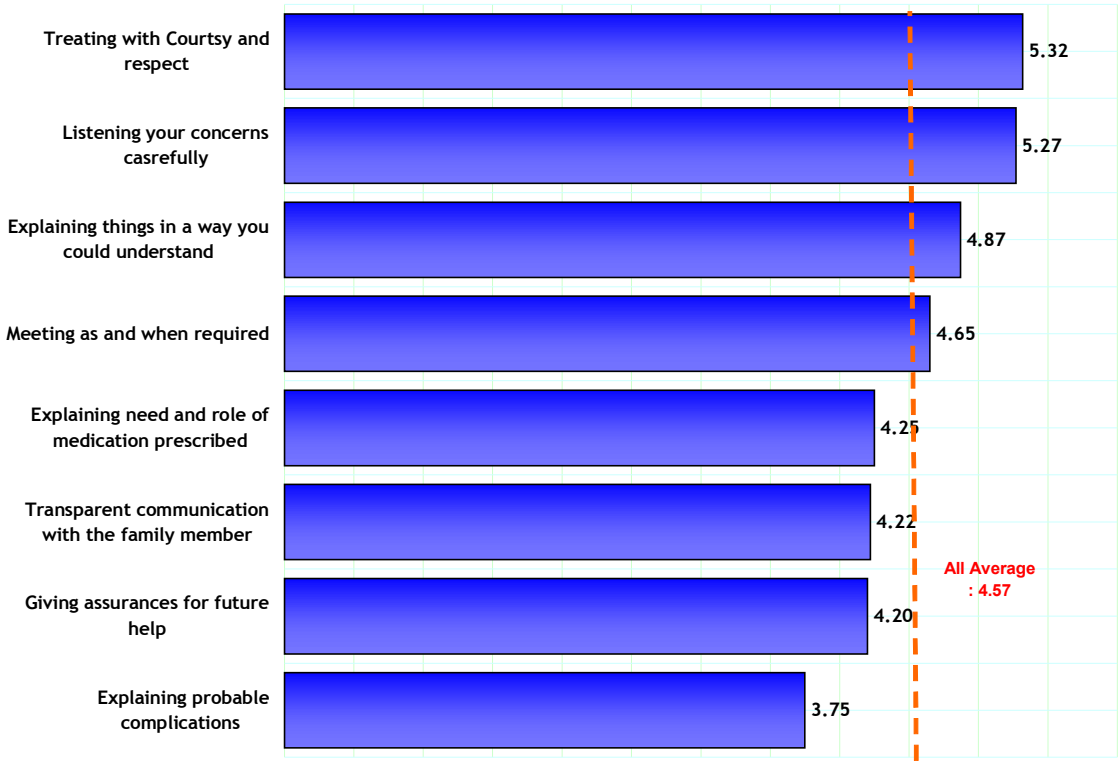
All the beneficiaries said that they had an average level of trust in the doctor whom they had met. Most of them had also stated that they met the same doctor always. They also felt that the doctors are caring and also treated them with respect and dignity. Overall the beneficiaries in this district had a fair opinion of the doctor from whom they were receiving the treatment. This is further highlighted in Fig1. below.

Fig 1.Trust and Confidence in Medical Personnel



The above graph shows that around 43% of the beneficiaries interviewed said that they had high degree of trust and confidence on the medical personnel they had met during their treatment. More than half the beneficiaries interviewed also reported that they had some degree of trust on the doctor they had visited for treatment. This shows that all of the beneficiaries had expressed an average level of trust and confidence on the medical personnel that they had met for the treatment.

Fig.2 Satisfaction on interaction with the Medical Personnel



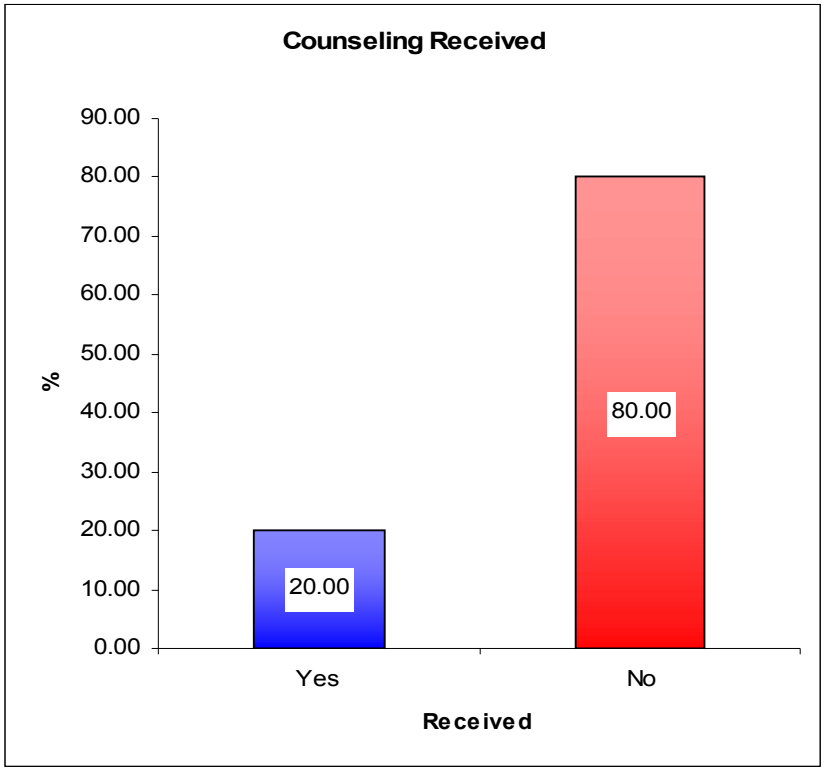
The above graph shows that the satisfaction levels on the following aspects were above the composite mean: treating with courtesy and respect, listening carefully to the concerns, explaining things in a way that the patients could understand and meeting as and when required. The rest of the aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the medical personnel they have met on the grounds that the doctors have listened to their concerns carefully, have treated them with courtesy, have explained the things in a way that the patients could understand and have met them as and when they required. However, the beneficiaries had below average satisfaction on the aspects such as "doctors' explanations on the need and role of medications prescribed", "giving assurance for future help" and "transparent communication with the family member". The aspect "Explaining probable

complications" received the lowest rating on the satisfaction level indicating that beneficiaries were most dissatisfied on this aspect of the treatment.

2.3.2.2. Counseling Received

The beneficiaries were also asked whether they had attended any counseling session during their treatment. Only 1 out of 5 patients reported that they had received counseling a significant number of the patients interviewed (more than 80%) reported that they had not received counseling at the diagnostic clinics. This proves that the clinical psychologist in the DMHP team provided counseling to the selected patients only as per requirement. Regarding the frequency of such counseling sessions, 4 out of every ten beneficiary interviewed (40%) also reported that they had attended such sessions around 3-5 times.

Fig 3. Counseling Received by the beneficiaries



2.3.2.3. Overall Treatment

There was an average level of satisfaction found among the beneficiaries of Prakasham with regard to the overall treatment. 7 out of every 10 beneficiaries contacted had given an average rating of 5 on a scale of 1 to 10(one being not satisfied and ten being absolutely satisfied). Moreover, 15% gave a rating just above average, namely 6 on a scale of 1 to 10 (one being not satisfied and ten being absolutely satisfied).

2.4. Availability of Drugs

2.4.1. Health System viewpoint

The DMHP team reported that there is a continuous flow of drugs at the district. Among the health staff interviewed 3 out 5 respondents opined that the drugs were quiet sufficient. Moreover, 2 out of 5 respondents felt that the drug supply was sufficient. Separate drug registers are maintained at each level, but the DMHP drug inventory is maintained at the District hospital. The District hospital maintains the inventory of all the drugs received and the number and type of tablets distributed at each level namely CHC/ PHC. Since the Guntur Medical College is the key implementing agency for DMHP at this district, the drugs are supplied from Guntur only. The DMHP staff reported that while sending a requisition for drugs they not only forecast the required drugs based on the OPD inflow but also keep an additional buffer to prevent a case of non availability of drugs. It was also reported that drugs are distributed at the CHC and PHC level when the team visits these areas for diagnostic and treatment camps every month. The team reported that due to the regular inflow of drugs the patients usually do not have to buy the drugs on their own. The team also reported that attempts were made to explain the side effects and the purpose of the drugs to the patients but due to shortage of manpower detailed explanations were not possible always.

2.4.2. The beneficiaries view point-

2.4.2.1. Drugs availability

Majority of the beneficiaries interviewed (more than 90%), confirmed that they had received drugs at the hospital where they had gone for treatment. More than half the respondents (51%) also confirmed that the purpose of the medication was clearly explained to them. 4 out of every 10 people interviewed also stated that the purpose of medication was somewhat explained to them

2.5. Awareness about mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

Under the DMPH scheme, in Prakasham district a total of 5 awareness camps were conducted i.e., 2 at district level, 1 at CHC and 2 at PHC level. The awareness was created with the help of distributing leaflets, pamphlets. The camps were held inside a school or any other closed space area around a CHC or PHC. The main objective of conducting these camps were orientation about early detection of mental illness, addressing various queries regarding mental health; focusing on orientation of rural people towards scientific approaches of treating mental illness. General Mental Health Check up programmes were also conducted at these camps. The patients screened at these programs were further referred District Hospital or other hospitals based upon the severity of the case.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

Around 6 out of every 10 community members interviewed confirmed that they had come to know about mental illness through IEC materials.1 out of 5 respondents also reported having attended a mental health awareness camp. This confirms that awareness camps had been held in this area. One out of four respondents reported having received information from the doctor at the CHC. Moreover, 17% reported that the doctor at the District Hospital had informed them about mental illness, while 13% had been informed by the doctor at the PHC and the ANM.

2.5.2.2. Awareness about symptoms and perception of mental health

The opinion of the community members who were interviewed shows that there is a fair degree of awareness in the community. The symptoms of mental illness cited by the community were varied; the community members have recognized most of the symptoms of mental illness. Around 90% of the community members reported “having fits” as one of the symptoms. Depression, Excessive Anxiety and fear and nervousness were some of the other symptoms which were recognized by the more than half of the community members interviewed during the survey.

Regarding the community perception about the curability of mental illness, it was observed that around 70% of the people also said that it can be treated at the hospital. More than half the community members also opined that mental illness can be cured with the help of medicines and counseling. Treatment by occult practitioners however was also recommended by more than half the community members interviewed. Similarly while more than half the community members also stated that mentally ill patients should be taken to the nearest health center and safe and effective drugs are available for treatment of mental illness; around 69% of the community members still believed that mental illness is caused due to evil spirits. Most of the

interviewed community members have also agreed that government has taken many initiatives to identify and treat mentally ill people.

Recommendations

- Procedures for recruitment of allocated personnel for effective implementation of DMHP have to be made at the district
- Effective management of the allocated funds has to be ensured. For this an accountant or fund manager needs to be allocated to the team.
- More emphasis should be given on awareness and training for effective utilization of the lower levels of the health system for implementation of the program.

Snap shot from Andhra Pradesh-Medak:

Medak district in Andhra Pradesh was chosen for the implementation of DMHP under the 9th Plan period. The Institute of Mental Health, Hyderabad is the Nodal Office responsible for implementing the program in Medak. As reported by the Nodal officer DMHP in Medak officially started in 1998. However, the Medical superintendent at the District hospital who is supervising the program said that in 1998 when the program was supposed to be initiated, the District Hospital did not have proper infrastructural set up for such programs. Thereafter the program could not be initiated due to lack of personnel for implementing such a program. In May 2006 a team was finally recruited and a separate section of the district hospital was allotted for initiating the program. Therefore, DMHP program was initiated in Medak only in mid of May 2006 from the District Head Quarter Hospital (District Hospital) at Sangareddy. The program had thereafter been functioning in spite of hindrances caused by lack of manpower for DMHP. The hospital staff as well as the Medical Superintendent opined that the low salary structure made it difficult to retain people under DMHP. The program was scheduled to complete its term in December 2008 and was found to be operational only in records during the evaluation visit. There was no dedicated DMHP staff at the District Hospital during the visit. In Medak, the evaluation team could not interact with any beneficiaries due to non availability of beneficiaries who were receiving treatment under the program. The health staff at the District Hospital also reported that very few beneficiaries turn up at the OPD and they do not maintain a record of these patients due to lack of dedicated personnel for DMHP. Interaction with 30 community members from around the District Hospital revealed a very general perception on symptoms and curability of mental illness. More than half the community members revealed lack of sleep, excessive anxiety and having fits as common symptoms of Mental Illness. Almost all the community members agreed that mental illness can be treated at a hospital and with proper medicines.

District Mental Health Programme (DMHP)

Snapshot from Karnataka :

Gulbarga district in Karnataka was selected for evaluating the impact of implementation of DMHP under the 10th Five Year Plan.

The District Mental Health Programme in Gulbarga district was initiated on 14th December 2004. The fund for DMHP came in favour of the Nodal Officer of DMHP and Assistant District Health Officer, District Health and Family Welfare Office.

The fund flow for DMHP is completely controlled by the District Health and Family Welfare Office. DMHP was implemented at the District Hospital Gulbarga, CHC level, PHC level as well as at Sub centre level. All the requirements of the District Hospital, CHCs or PHCs are provided by the District Health and Family Welfare Office.

1. Allocation and Utilisation of Funds.

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**
Staff Salary	370,000.00	153,939.00	216,061.00	41.6%
Medicines/Stationary/Contingencies	850,000.00	449,449.00	400,551.00	52.9%
Equipments/Vehicles, etc	200,000.00	182,157.00	17,843.00	91.1%
Training	900,000.00	862,044.00	37,956.00	95.8%
IEC	300,000.00	103,944.00	196,056.00	34.6%
Total	**2,620,000.00**	**1,751,533.00**	**868,467.00**	**66.9%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A fund of Rs 26,20,000.00 had been sanctioned as the first installment for the district of Gulbarga in 2004-05 under the DMHP during the 10th Five Year Plan of which about 66.9% had been utilized till October 2008.
- The budget analysis shows that, of the money received for the payment of staff's salary, 41.6% has been utilized so far and in buying the medicines/ stationary/ contingencies the percentage of utilization has been above 50%.

- More than 90% of the allocations made under the first installment for buying of equipments/vehicles have already been utilized.

- Training, the most important component of the DMHP, which could ensure the proper diagnosis and treatment, has been dealt with substantial priority as it can be seen from the table above that more than 95% of the allotted money have already been spent.

- However, it also came out that the other important goal of DMHP which is "increasing awareness level among the community members" has been relegated with lesser priority. So far about 35% of the allocated funds have been spent on IEC materials. And this indicates that there lies immense scope of improvement of community's awareness level.

2. Perception on Program Implementation

To gather an overall perception on the program implementation and its effects views were taken from the Health Staff working under DMHP or those who had received training under the program, 60 beneficiaries from the district who were receiving treatment under the program and 25 members each of the general community from areas where the program was being run.

2.1. Composition of DMHP team

The Assistant District Health Officer has been promoted as the DMHP Nodal officer, under whom DMHP is operating in Gulbarga. The health staff running DMHP in Gulbarga are permanent salaried State Government employees. The District Hospital in Gulbarga does not have a Psychiatric wing. There is no Psychiatrist as well. The health personnel responsible for implementing DMHP in the district hospital consist of one Psychologist and one Psychiatric nurse. It was reported that the prime reason that the post of psychiatrist is still vacant was that the salary structure offered under DMHP was very low. Therefore, nobody was willing to work under DMHP. The State Government, keeping it in mind that the vacant posts should be filled, has raised the salary structure in 2008. However, no additional appointments have been made thereafter as well as no health worker has come up to work under DMHP.

2.2. Training

Training is a mandatory part of DMHP for the first three years after initiation. Under the 10th plan period of DMHP in the district Gulbarga, various training programmes were held for district doctors, PHC/CHC doctors, nurse, ANM and other health workers. The manpower who were trained at the CHC level and Taluka level comprise of 70 medical officers. In addition to it, 134 medical officers at the PHC level were also given training. Apart from these, 732 ANMs (both male and female) were also imparted training. The Anganwadi workers were also given an orientation and training on mental health issues for detection of psychiatric illness in the society.

The health staff of Gulbarga district reported that almost all doctors at all the CHC and PHC within the district of Gulbarga had received training under DMHP. During the last year a total of 38 batches of different health workers were imparted training under DMHP. Recently, in September 2008 two rounds of training were held. 230 Medical officers were trained in the first round which lasted for 3 days. The second round lasted for 6 days and 171 Medical Officers were trained in this phase. A day long training session was also held to train 732 Junior Health workers. In addition to this, 240 Anganwadi workers were given orientation on Mental Health issues. The staff seemed to be satisfied with these ongoing trainings and also revealed that more training and guidelines should be provided to them to make the programme even better. The staff reported that the training materials and medium used in these training sessions included PowerPoint Presentations and Video presentations made on an LCD projector.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two sections. One section captures the viewpoint of the DMHP team. The other section tries to capture

the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1 Heath System viewpoint

As mentioned earlier, there is no psychiatric wing at the District hospital. Therefore, there is no Psychiatric OPD in Gulbarga .The DMHP programme is run with the help of one Psychologist and one Psychiatric nurse. The mentally ill patients who come to the District hospital are treated and diagnosed by the Psychologist with the help of the psychiatric nurse. There is no separate facility for inpatients in Gulbarga District Hospital, so the mental patients who need hospitalization are admitted in the general ward. It was reported that referral cases from the CHC or PHC level are very rare. At the CHC or the PHC level, the mentally ill patients are treated by the doctors who have received training under DMHP to provide basic treatment and medication to them. The cases which cannot be dealt with at the CHC or the PHC level are mostly referred to the district hospitals of other districts. The MO at the CHC and PHC reported that they do not refer patients to Gulbarga District Hospital because there is no facility of a Psychiatric ward for the indoor patients.

The register of Psychotherapeutic medicine at the Gulbarga District Hospital is maintained by the Psychologist. Medicines are distributed as and when needed by the patient. Drug registers are also maintained at the CHC and PHC level.

2.3.2. The beneficiaries view point

The ICMR Planman Consulting team also interviewed 60 beneficiaries from areas where the DMHP was being implemented. The beneficiaries were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Around 38 % of the beneficiaries reported that they had visited the doctor at the PHC as their first point of contact and 35 % reported CHC as their first point of contact. However 12 % also reported that they had gone to Sub Centers as their first point of contact. This shows that DMHP is being implemented at the lower levels of the health system as well, i.e. below the district hospital.

2.3.2.1. Perception about the Doctor

The beneficiaries who had received treatment under DMHP reported to the research team of ICMR that they were satisfied with the service that has been provided to them by the doctors. However, a very negligible percentage had complained that the medicine given under DMHP were not very effective. Other than this, the beneficiaries in Gulbarga were satisfied with the diagnosis and treatment that they have received under DMHP.

All the beneficiaries interviewed confirmed that they had met the same doctor during each visit to the health institution. The beneficiaries also expressed trust and confidence in the doctor they had visited. This is shown in the below graph which depicts that almost all (97%) of the beneficiaries interviewed reported to have complete trust and confidence level in the medical personnel while the rest reported that they trusted the medical personnel to some extent only.

Fig.1 Trust and Confidence in Medical Personnel

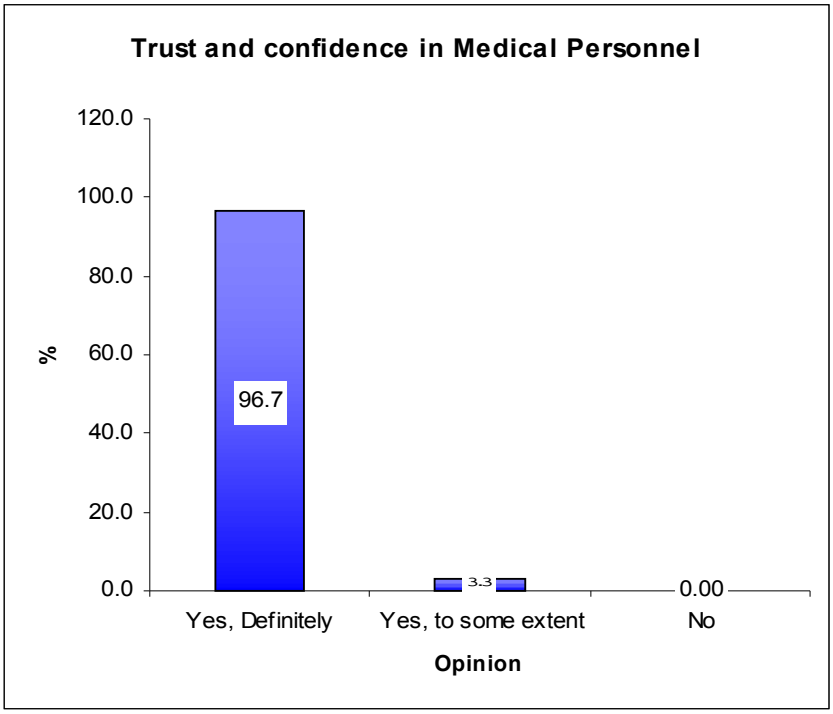
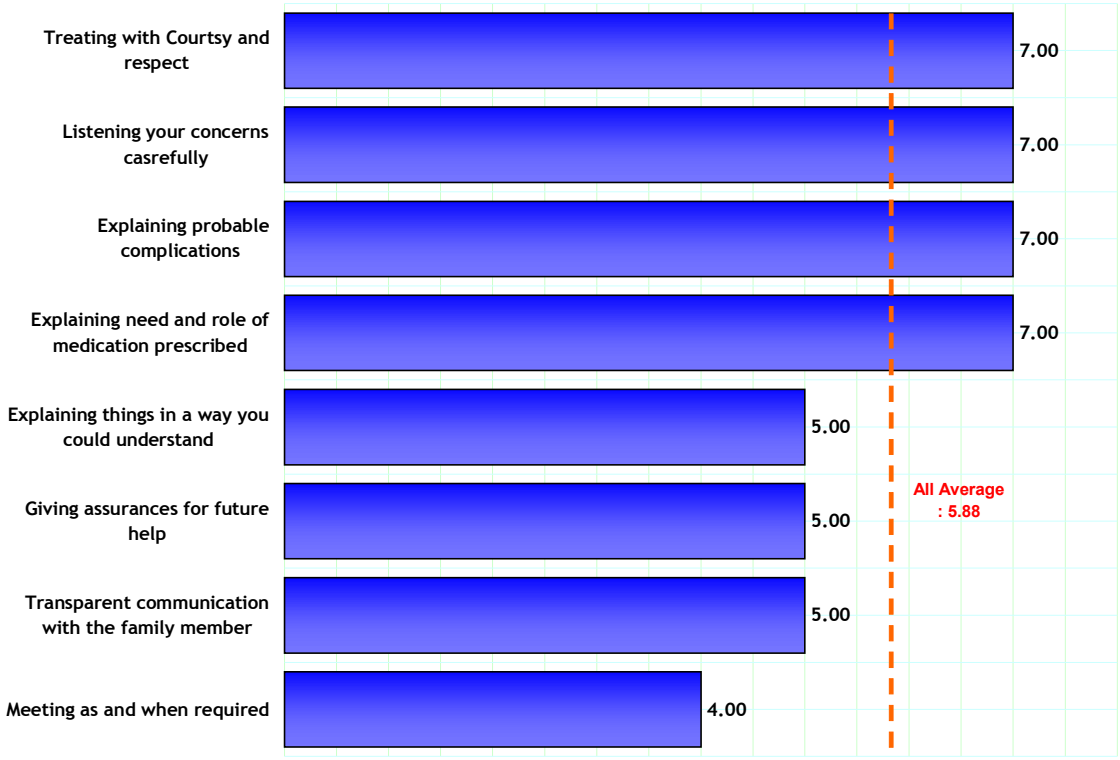


Fig.2 Satisfaction on interaction with the Medical Personnel



From the above given graph we can see that the satisfaction levels on the following aspects are above the composite mean: **"treating with courtesy and respect", "listening carefully the concerns", "explaining need and role of medicines prescribed" and "explaining probable complications"**. The rest of the aspects are below the composite mean. This statistics shows that the beneficiaries who have been interviewed were fairly satisfied with the medical personnel they have met on the grounds that the doctors have treated them with courtesy and respect, have listened to their concerns carefully, have explained the need and role of medicines prescribed and have explained probable complications. However, the beneficiaries had below average satisfaction on the aspects such as **"explaining things in a way that the patients could understand", "meeting the doctors as and when required", "transparent communication with the family members"** and **"giving assurance for future help"**

2.3.2.2. Counseling Received

The beneficiaries were also asked whether they had attended any counseling session during treatment. All the patients interviewed said that they had not received counseling. This fact questions the effectiveness of the presence of a Psychologist in the DMHP team.

2.3.2.3. Overall treatment

On being questioned about the satisfaction level of the overall treatment that they had received, most of the beneficiaries have given a rating between 7 to 8 on a scale of satisfaction from one to ten(one being not satisfied and ten being absolutely satisfied). Thus satisfaction level of the beneficiaries in Gulbarga with regard to the overall treatment received can be considered to be above average.

2.4. Availability of Drugs

2.4.1. Health System viewpoint

According to most of the health staff implementing DMHP, there is no shortage of medicines at any health institution of the District. Almost all the medicines enlisted under DMHP were reported to be available. The staff stated that at the time of shortage, a requisition is filed at the next higher institution and the medicines are provided as soon as possible. The flow of drugs follows a specific sequence. The G.M.S Bangalore provides medicines to the G.M.S Gulbarga, which in turn provides them to the District Health Office, CHC and PHC. The District Health office again provides the medicines to the Taluk Head Officer, the CHCs and PHCs under it.

The drug register is maintained at the Gulbarga district hospital by the Psychologist. The medicines are distributed by the medical personnel as and when required by the patients on showing a prescription of the same. At the CHC and PHC level drug register is maintained by the health workers present there.

2.4.2. The beneficiaries view point-

2.4.2.1. Drugs availability

Almost all (98.3%) the beneficiaries interviewed confirmed that they received medicines from the hospital when they had gone for treatment. Similarly, more than 9 out of 10 (95 %) also confirmed that the purpose of the medication were explained to them clearly.

2.5. Awareness regarding Mental Illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

In Gulbarga, only one awareness camp was organized. This camp was held in the Taluk level for creating awareness among the local people. The awareness was created with the help of putting up hoardings and banners and also giving orientations on mental health issues. These camps were organized by the DMHP team stationed at the District Hospital. These orientation programmes were given for early detection of mental illness in the society and also for removal of stigma attached to mental illness in the community.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

More than 7 out of 10 community members (76 %) confirmed that they had come to know about Mental illness at a health awareness camp. This confirms that awareness camp had been held in this area. However, 1 out of 5 respondents also reported that they had to come to know about mental illness from the doctor at the CHC. None of the community members had received any information on mental illness through street plays and demonstration or IEC programmes.

2.5.2.2. Awareness about symptoms and perception of mental health

The opinion of the community members who were interviewed shows that there is a fair degree of awareness in the community. The symptoms of mental illness cited by

the community were varied. Lack of sleep, feeling sad and depression and excessive anxiety were some of the symptoms which were recognized by most of the community members interviewed during the survey.

The community perception about the curability of mental illness showed a mixed response. It was observed that more than 7 out of 10 community members opined that mental illness can be treated at the hospitals. 3 out of 5 respondents also recommended medicines as a cure for mental illness. However, around 7 out of 10 (68 %) also said that mental illness can be cured by occult practitioners and by shock treatment. This proves that more than half of the people still believed in this method of cure.

Almost all of them, (96%) said that family, members of the community should recognize change and behavior of people and discuss it with their doctors/health worker. More than 9 out of 10 (92%) were of the view that health workers should educate families to involve their mentally ill kith and kin in work related to socializing by maintaining an activity sheet and very effective and safe drugs are available to treat mental illness. However, around 3 out of 10 (36%) of the community members interacted also opined that mental illness is caused due to evil spirit or black magic.

Recommendations

Improve the salary structure under DMHP for proper allocation of the staff to implement the program efficiently.

District Mental Health Programme (DMHP)

Snapshot from Tamil Nadu:

DMHP was initiated in Madurai in the year 2001 under the 10th year plan. Officially the programme began functioning from 2002 after the procedures of fund availability and staff had been taken care. DMHP was initiated in the just district after the shocking Erwady fire tragedy (Place where mentally ill patients were chained and black magic was used for treatment). The Nodal Office implementing the program in Madurai was the Institute of Mental Health Chennai. The programme for Madurai district was being implemented from the Usalampatti Government Hospital in Usalampatti taluk. The taluk is an administrative division below the district and the taluk hospitals are at the same level as Community Health centers. The Madurai District Hospital also has a separate psychiatric wing, but this wing is not associated with DMHP. As reported by the Nodal office in Chennai, due to administrative issues, the DMHP programme was implemented from the Usalampatti Government Hospital instead of the District hospital in Madurai.

The DMHP staff at the Usalampatti taluk Hospital reported that the program is being implemented through mobile clinics in various taluks of Madurai. The DMHP team visits 7 taluk hospitals per week namely Usalampatti, Melur, Thirumangalam, Periyur, Vaadipatti, Solavandaan and Manadimangalam. Only in very severe situations are the patients referred to the District hospital for treatment and care. The psychiatric wing of the District hospital in Madurai is not associated with DMHP. However the District hospital and the mobile DMHP clinics together had been quiet successful in spreading awareness in the rural areas around Madurai.

1. Allocation of funds

	10th Five Year Plan			
Expense Categories	**Scheduled Expenses**	**Actual Expenses**	**Balance**	**% of utilization**

Staff Salary	**870000**	705,250.00	164,750.00	81.1%
Medicines/Stationary/Contingencies	**450000**	935,000.00	-485,000.00	207.8%
Equipments/Vehicles, etc	**600000**	0.00	600,000.00	0.0%
Training	**500000**	300,000.00	200,000.00	60.0%
IEC	**200000**	250,000.00	-50,000.00	125.0%
Total	**2,620,000.00**	**2,190,250.00**	**429,750.00**	**83.6%**

The plan wise allocation of the budget by the Ministry of Health and Family Welfare is scheduled to be under the different broad heads which are: "Payment of staff salary", "Purchasing medicines, stationary and other contingencies", "Purchasing equipments, vehicles, etc", "Training" and "IEC". The key findings that came out are:

- A total fund of Rs 26,20,000.00 had been sanctioned to the district of Madurai under the DMHP in the 10th Five Year Plan of which slightly more than four-fifth of the allocated amount had been utilized till 2006-07.

- The analysis clearly shows that there had been an overspending of about 107% of the allocated funds on the purchase of medicines/stationeries/contingencies.

- In the case of payments to staffs, a little more than 80 percent of the allocated amount was spent.

- The budget analysis in the district of Madurai establishes the fact that **"Training"** and **"Community's Awareness"**, which are the two most important component of the DMHP, and are meant for ensuring the proper diagnosis and treatment and lowering of social stigma and myths, received fair amount of attention. Especially in case of IEC, an extra amount of 25% had been spent over and above the allotted amount.

***Note**: Due to the unavailability of documents with the Directorate Medical Service (DMS), Chennai, showing the expenses on equipments under DMHP, the utilization proportion on equipments could not be presented.*

2. Perception on Program Implementation

To gather an overall perception on the program implementation and its effects views were taken from the Health Staff working under DMHP or those who had

received training under the program, 59 beneficiaries who were receiving treatment under the program and 30 members of the general community from areas where the program was being run.

2.1. Composition of DMHP team

The first DMHP team was formed in the year 2002 and it comprised of 1 Psychiatrist, 1 Clinical Psychologist and 1 Social Worker. Apart from this the team contained 1 staff nurse and a driver who were working on deputation job and not the permanent members of the team.

Presently, the DMHP team that is stationed at the Usalampatti taluk hospital has 10 contractual staff. The coordinator of the program is the Psychiatrist (Asst Prof Level).The composition of rest of the team is as follows: 1 Clinical Psychologist, 1 Social worker, 4 Nurses and 1 Male nursing assistant. In 2004 the social worker in the team changed and a new statistical assistant joined the team. Recently in 2008 the psychiatrist who was part of the team left and a new psychiatrist was appointed twice.

The changes in the team are shown in the table below

Staff	2002-2004	2004-2006	2006-2008
Psychiatrist	1	1	1(changed in 2008 itself)
Clinical Psychologist	1	1	1
Psychiatric social worker	1	1(changed in 2004)	1(changed in 2008 itself)
Psychiatric Nurse	1	1	4
Nursing assistant	-	-	1
Statistical assistant	1 (Joined in 2004)	1	1
Junior Clerk	1(Joined in 2004)	1	1

2.2. Training

Training is a mandatory part of DMHP. In Madurai, the DMHP team revealed that Training had been imparted in the initial years during 2002-2003. Initially in 2002 the Medical Officers of the PHC, Para medical staff and Non medical staff received training from the psychiatrists and faculty members from Institute of Mental Health Chennai

and Institute of Psychiatry, Madurai. This training program extended for a period of 15 days. The main features of this training programme were reported as:

- Case demonstration and Field Training of staff
- Distribution of Books on mental Illness

Further in 2003 100 PHC Medical officers from both the districts of Madurai and Trichy were jointly given training at the Medical College in Madurai. In the year 2003 -2004 again 50 PHC Medical officers from both the districts of Trichy and Madurai were given training. In addition to these training 100 paramedical staff were given week long training once in 2002 and again in 2003. These trainings were also accompanied by distribution of booklets (in Tamil), case demonstration and field training. Since there have been changes in the staff at various levels since 2003 only 1 out of 5 respondents interviewed during the evaluation reported to have attended a training programme.

2.3. Diagnosis Treatment and Referral

The section on diagnosis treatment and referral has been dealt in two parts. One section captures the viewpoint of the DMHP team. The other section tries to capture the viewpoint of the beneficiary about the diagnosis and treatment they received and their satisfaction level.

2.3.1. Heath System viewpoint

Both In-patient and outpatient services were reported to be available at Usalampatti Government Hospital. Moreover, the hospital is also equipped with modern ECT Equipment - Brief-pulse Therapy with ECG, EEG monitoring facility to improve quality of treatment. As stated earlier, DMHP was being implemented in the District through mobile clinic services at 7 taluk hospitals. The Out Patient service was carried out by the mobile psychiatric team at each Taluk hospitals on the following days:

- Monday the team is stationed at the Usalampatti taluk hospital
- Tuesday the team visits the Thirumangalam taluk hospital
- Wednesday the team visits the Melur taluk hospital
- Thursday the team visits the Usilampatti and Peraiyur taluks
- Friday the team visits the hospital in Vadipatti taluk
- Saturday the team visits both the taluks of Sholavandan and Manadimangalam

At each of these hospitals the duration of OPD was between 7.30 a.m to 1.30 p.m. Medicines were also provided by the team at these diagnostic clinics. The patients in need of hospitalization were admitted at the in patient unit of Usalampatti Government Hospital.

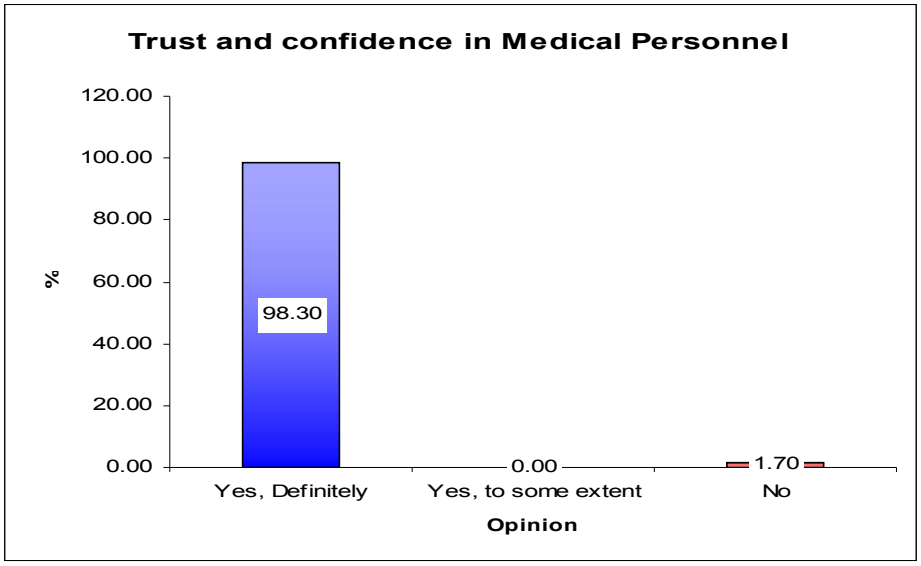
2.3.2. The beneficiaries view point

The ICMR Planman Consulting team also interviewed 59 beneficiaries from areas surrounding the taluk Hospitals where the OPD was being run once every week. The beneficiaries who were interviewed from various taluk hospitals were questioned on their knowledge of the illness diagnosed and satisfaction level regarding the treatment that they were receiving. Of the 60 beneficiaries interviewed, none were referral cases (those who had been referred from a lower Medical institution to a higher one). The beneficiaries reported that since the DMHP team visited the taluk hospitals every week, they came directly to the nearest taluk hospital for treatment.

2.3.2.1. Perception about the Doctor

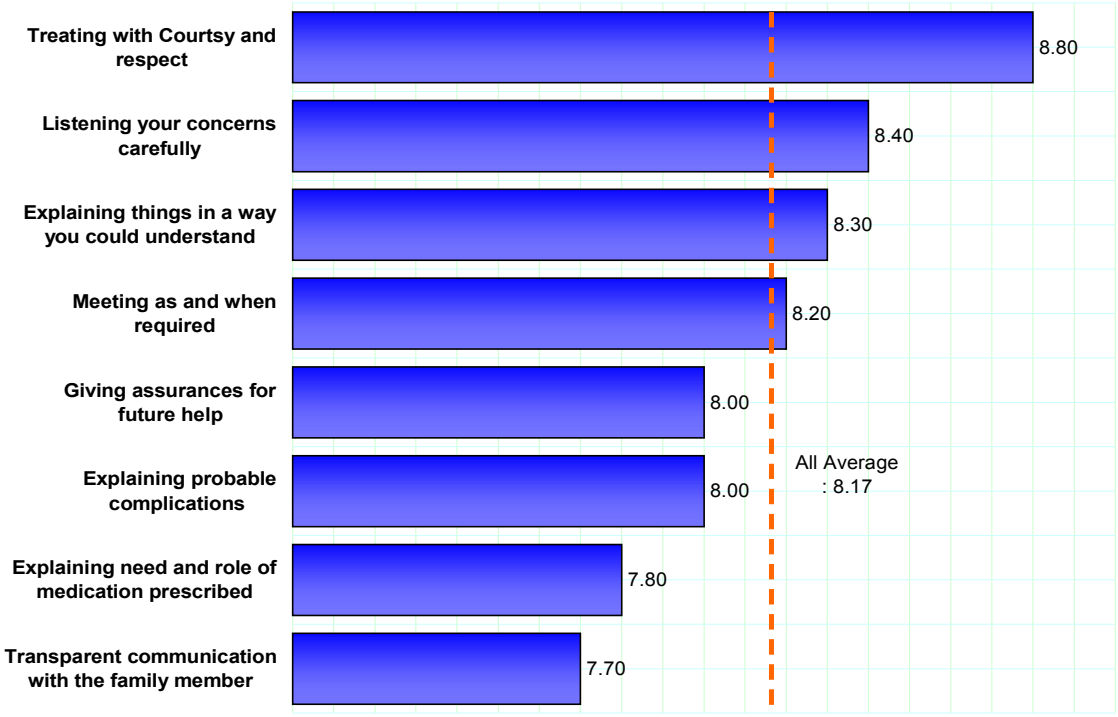
All the beneficiaries said that they had trust in the doctor whom they had met. Most of them had also stated that they met same doctor always. They also felt that the doctors are caring and also treated them with respect and dignity. However a majority of them felt that the patient's condition and the diagnosis were clearly explained to them. A significant proportion of the beneficiaries however reported that the doctors did not explain about the patient's condition or probable complications to the family members. This may be due to the fact that most of the patients are illiterate and they will not able to understand even if explained properly.

Fig 1.Trust and Confidence in Medical Personnel



The above graph shows that almost all the beneficiaries interviewed said that they had high degree of trust and confidence on the medical personnel they had met during their treatment. This shows that all of the beneficiaries had expressed high level of trust and confidence on the medical personnel that they had met for the treatment.

Fig.2 Satisfaction on interaction with the Medical Personnel

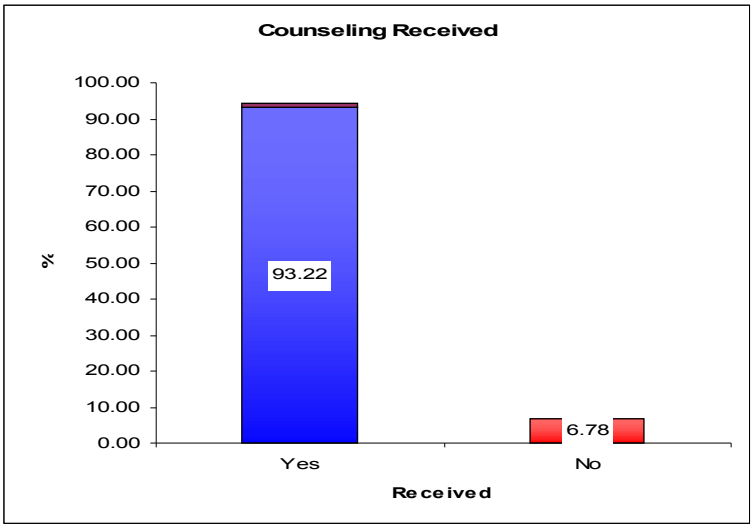


The above graph shows that the satisfaction levels on the following aspects were above the composite mean: treating with courtesy and respect, listening carefully to the concerns, explaining things in a way that the patients could understand and meeting as and when required. The rest of the aspects are below the composite mean. This statistics reflects that the beneficiaries who have been interviewed were fairly satisfied with the medical personnel they have met on the grounds that the doctors have listened to their concerns carefully, have treated them with courtesy, have explained the things in a way that the patients could understand and have met them as and when they required. However, the beneficiaries had below average satisfaction on the aspects such as "Explaining probable complications", "doctors explanations on the need and role of medications prescribed "giving assurance for future help" and "transparent communication with the family member"

2.3.2.2. Counseling Received

The beneficiaries were also asked whether they had attended any counseling session during their treatment. Most of the patients interviewed (more than 90%) reported that they had received counseling at the diagnostic clinics and were satisfied with the session as well. This clearly proves that the clinical psychologist in the DMHP team gave counseling to the patients. Regarding the frequency of such counseling sessions, more than 60% of the beneficiaries also reported that they had attended such sessions around 3-5 times.

Fig 3. Counseling Received by the beneficiaries



2.3.2.3. Overall Treatment

There was a high level of satisfaction found among the beneficiaries of Madurai. Most of the beneficiaries contacted had given an unusually high rating of 9.9 on a scale of 1 to 10(one being not satisfied and ten being absolutely satisfied).

2.4. Availability of Drugs

2.4.1. Health System viewpoint

The DMHP team reported that the drugs are usually obtained from the health department situated in the district collector office of Madurai district (Director of Medical Services).The District hospital and the taluk hospitals under DMHP all receive the drugs as per requisition from the office of the district collector. It was reported that since there is a parallel psychiatric unit at the District hospital, there has never been problem of drug inflow in the district. There is a common drug inventory maintained at each hospital by a pharmacist.

The DMHP team also distributes medicines at the weekly diagnostic clinics at each taluk. The team reported that due to the regular inflow of drugs the patients usually do not have to buy the drugs on their own. The side effects and the purpose of the drugs were clearly explained to the patients.

2.4.2. The beneficiaries view point-

2.4.2.1. Drugs availability

Majority of the beneficiaries interviewed (more than 95%), confirmed that they had received drugs at the hospital where they had gone for treatment. 9 out of 10 respondents (93%) also confirmed that the purpose of the medication were clearly explained to them.

2.5. Awareness about mental illness

This section has inputs both from the health system officials about their perception of the success of DMHP in creating awareness and the community perception about mental illness. The most significant impression of DMHP at the level of community is awareness regarding mental illnesses and curability of mental disorders.

2.5.1. Health System viewpoint

All the members of the DMHP team reported that the awareness regarding mental health has increased to a great extent. The wide range of IEC activities and festivals that were conducted in the various taluks in Madurai had dispelled lot of myths about curability of mental illness. The health staff reported that before the inception of DMHP, the villagers (also predominant among some literates) used approach a priest for black magic in case of mental illness. However the wide ranging awareness programs have increased awareness which was clearly visible in the rising rates of patients who had come for treatment at Usalampatti government hospital. As per reports from the hospital, the number of cases of mentally ill patients coming to the hospital for treatment rose from 200-900 between July 2002-March 2003.In 2004 there was a further rise to around 1200 patients per month. The hospital also reported a rise in the in patients after initiation of DMHP. The awareness programs conducted under DMHP in Mysore include the following:

(a) Information, Education and Communication activities (IEC Activities)

IEC activities were utilized to educate the lay public about different aspects of mental health and illness. Main thrust was on identification and prevention of mental illness. Public lectures, short plays, exhibitions, school awareness programs are some of the IEC activities planned in DMHP. Liaison with the local school teachers and parents in identifying and managing children with mental retardation and behavior problems and Counseling in alcohol and drug abuse were also provided under DMHP.

(b) Mental Health Festival:

Mental health festival was conducted to create awareness among the public. This was reported to have been conducted during the year 2002-03 in different hamlets of Madurai District. The mental health festivals are based on the principles of any village festivities. As in any other festival, entertainment is given importance to draw the crowd and create awareness. A cine music troop was hired to play cinema songs. In interior villages musical performance was interspersed with small skits, depicting different aspects of answering question from public mental illness.

(c) Flip Charts and Newsletter:

Multicolor flip chart depicting relevant mental illness and its symptoms were printed for the para-medical personnel. Flip charts carried artwork depicting different mental illness. Care has been taken to maintain the cultural relevance in the pictures. All the village health nurses were provided with the flip charts. A demonstration and training has been imparted to Village Health Nurses using the flip charts.

A four pages quarterly newsletter is published to disseminate information among medical and para-medical personnel. The newsletter contains both English and Tamil articles so as to increase its reach among the people.

2.5.2. Community perception regarding awareness

2.5.2.1. Information on DMHP and mental health

More than 6 out of every 10 community members interviewed confirmed that they had come to know about mental illness at a health awareness camp. This confirms that awareness camps had been held in this area. 1 out of 5 respondents also reported that doctors at the CHC had informed them about mental illness. Only 5% reported that they had received information from the District Hospital, Doctor at the PHC and other health workers.

2.5.2.2. Awareness about symptoms and perception of mental health

Analysis of the opinion of the community members who were interviewed shows that there is fair degree of awareness in the community. The symptoms of mental illness cited by the community were varied; the community members have recognized most of the symptoms of mental illness. Around 85% of the community members reported "being sad and depressed" as one of the symptoms. Lack of sleep, having hallucinations and excessive drug abuse were some of the other symptoms which were recognized by the around three fourth of the community members interviewed during the survey.

Regarding the community perception about the curability of mental illness, it was observed that around 3 out of every 4 respondents from the community opined that mental illness can be treated at the hospital. More than half the community members also advocated cure with the help of medicines and counseling. However a similar

proportion of respondents also recommended shock treatment as a method of cure; While 3 out of 10 respondents also recommended visiting an occult practitioner. 2 out of 5 respondents also opined that mental illness is incurable. Almost all of the respondents had agreed that mentally ill people need help and care from their family members. Most of the interviewed community members have also agreed that government has taken many initiatives to identify and treat mentally ill people.

Recommendations & Suggestions

- ❖ It has been observed that majority of patients visit District hospitals (about 71%), followed by CHC (8.7%), PHCs (7.6%) and Sub-Centre (2.3%) for availing mental health services. It is recommended to strengthen the services at Sub-Center, PHC, CHC level so that the services become more accessible to the patients.
- ❖ Central Government in consultation with State Governments should ensure continuity of DMHP beyond the plan period – Some districts have discontinued the programme after the plan period for lack of support from State Government. Our suggestions: gradual shifting of financial burden to State Government to be ensured by an undertaking to this effect and integration of mental health services in State and District Programme Implementation Plan (PIP).
    - o Plan period I – 100% Grant by Central Government to continue
    - o Plan period II - Central & State Government to share the finances (1:1)
    - o Plan period III onwards – 100% to be allocated by state government
- ❖ Ensure regular flow of allocated funds. Irregular flow of fund has affected the implementation of programme adversely.
- ❖ It has been observed that there is a significant delay in initiation of programme even after the release of funds in some districts. Initiation of programme should be ensured in time bound manner after the receipt of funds.
- ❖ Ensure appointment of Psychiatrists and other staff exclusively for DMHP and their continuity. This could be ensured by revising the pay as per the prevailing market rate (as per Central Government rate is approximately Rs.60,000/- for Psychiatrist, Rs.30,000/- for Clinical Psychologist and Psychiatric Social Worker per month).
- ❖ To ensure professional manpower for the programme and improve quality of services. It is recommended to increase the PG training seats (M.Phil., Clinical Psychology, PSW, etc.) in the country.
- ❖ Training should be imparted regularly. Increase the frequency and ensure it is imparted to all the personnel implementing the programme. At present most of the staff are untrained. The trained ones have left or transferred.

❖ The DMHP team needs to be trained on Programme Management and organizational activities

- Also ensure refresher training and on-job training with the focus on local challenges.
- Special training for ANMs and PHC level – for diagnosis, treatment and ensuring the involvement of family members and community._

❖ Ensure effectiveness of treatment through proper mix of medication and counselling.

❖ Evolve proper mechanism for drop out cases. We found unavailability of psychiatric social worker to follow up the drop out cases.

❖ Active involvement of community based organisations/leaders for organising awareness programme w.r.t .- place, time and maximum impact area.

❖ A need for strong IEC for awareness creation/stigma reduction was felt. Mass publicity of awareness programme using local media – print, audio (community radio) and visual (local TV channels)

❖ Organising camps/ classes in schools, colleges & other Educational Institutions. There is felt need for promotive components like suicide prevention, workplace stress management, school and college counseling services

❖ Integration/ coordination of mental health programme with other health programme viz. ICDS, NRHM

❖ Regular inflow of medicines and availability at health centre.

❖ Drug procurement mechanism should be streamlined to reduce delay in procurement and achieve economy of scale (e.g. Tamil Nadu model)

❖ Ensuring proper organisational structure

❖ Supervision and monitoring of DMHP activities by State Health Society

❖ It was observed that implementation of DMHP has resulted in availability of basic mental health services at district/sub-district level. As such it is recommended to expand this programme to other districts of the country.

❖ Central and State Mental Health Authority are statutory bodies under the Mental Health Act, 1987 for regulation, development, direction and co-ordination with respect to Mental Health Services. However, it has been observed that due to lack of secretarial support these bodies are not able to discharge their role effectively. Adequate support should be provided to them.

❖ Continuous monitoring and reporting as well as regular external evaluation is recommended for mid-course correction.

Annexure I

LIST OF ABBREVIATIONS USED

A
- ANM: Auxiliary Nurse Midwife

B
- BPHC: Block Primary Health Centre
- BP: Bhugeswori Phukononi Civil Hospital
- BSM: Bankura Sammelani Medical college

C
- CBM: Capacity Building Mechanism
- CDMO: Chief District Medical Officer
- CHC: Community Health Centre
- CMO: Chief Medical Office
- CSM: Chhatrapati Shahuji Maharaj Medical University

D
- DALY: Disability Adjusted Life Year
- DMHP: District Mental Health Programme

F
- FGD: Focus Group Discussion
- FRU: First Referral Unit

G
- GMA: Gwalior Mansik Arogyashala

I
- ICDS: Integrated Child Development Scheme
- iCMR: Indian Council for Marketing Research
- IEC: Information Education Communication
- IHBAS: Institute of Human Behavior and Allied Sciences

L

- LGB: Lokpriya Gopinath Bordoloi Civil hospital

M

- MOHFW: Ministry of Health and Family Welfare

N

- NGO: Non Governmental Organization
- NIMHANS: National Institute of Mental Health and Neuro Sciences
- NMHP: National Mental Health Programme

O

- OPD: Out Patient Department

P

- PGIMS: Post Graduate Institute of Medical Sciences
- PHC: Primary Health Centre
- PIP: Programme Implementation Plan
- PSW: Psychiatric Social Worker

S

- SCB: Sriram Chandra Bhanja Medical College
- SSG: Shree Sayaji General Hospital

U

- UC: Utilization Certificate

W

- WHO: World Health Organization

Annexure II: Questionnaires used for the survey

Form Serial Code: ☐☐☐☐☐

Evaluation of District Mental Health Programme 9th and 10th Plan in India-Health Systems

Zone		State		District	

Name of Respondent _____designation: _____
Name of Hospital: _____

Address:_____
_____

Contact Number: _____

A. Capacity Building: Trainings

1. Did you undergo DMHP Trainings?

Yes ☐ No ☐

1a. If yes, what is your perception regarding the effectiveness of these trainings?(if No, ask Question no 2)

1-Not Useful	2- Somewhat Not Useful	3- Neutral (Cant say)	4- Somewhat useful	5- Very Useful	6- Don't Know

1b. What is your perception regarding the method used for imparting the trainings?

1. Not Effective	2- Somewhat Not Effective	3- Neutral (Cant say)	4- Somewhat Effective	5- Very Useful	6- Don't Know

1c. What is your level of satisfaction from these trainings in a scale of 1 to 5 (Put the number in the box below – 1 is not satisfied and 5 is extremely satisfied and 3 is neutral)

1-Not Satisfied	2- Somewhat not satisfied	3- Neutral (Cant say)	4- Somewhat satisfied	5- Very Satisfied	6- Don't Know

Yes ☐ No ☐

If yes go to Question no 2a or else go to question no 3.

2a.If Yes how long after the training were the refreshers held

Categories	Code
1 month after the training	1
2-4 months after the training	2
4-10 months after the training	3
Don't remember	4

3. Please give your recommendations regarding improvements in the training process

Categories	Code
Simple language to be used while imparting the trainings	1
Making the content more simpler with more case studies and examples	2
Making the IEC materials more customized and specific for each of the districts	3
The people imparting the training should be more approachable	4
The frequency of trainings should be increased	5
None	6
Any other (please specify _____)	7

4. Were on job trainings held? (On job training is where the doctors receive assistance from the trainers when they face problems in diagnosis/treatment)

Yes ☐ No ☐

4a. If yes, who (level, rank and hospital) provided you on job training?

Name: _____ Designation: _____ Health Center Location:_____

B. Diagnosis:

5. What are the facilities at your health centre that assist you in diagnosis? (Multiple response)

Facilities	Code
Presence of counselor who interacts personally with patients to help in trust building	1
Separate room for diagnosis	2
Telephonic assistance from nearest psychiatrist for diagnosis of complex cases	3
Assistance from visiting Psychiatrist for diagnosis of complex cases	4
None of the above	5
others (please specify) _____	6

C. Treatment & Referral:

6. What are the provisions at the health centre for elementary treatment of mental illness?

Provisions	Yes-1, No-2
Presence of basic medicines for immediate treatment	
Ambulance for transportation of severely ill cases to the District Hospital	
Telephonic assistance from nearest psychiatrist	
Others (please specify) _____	

7. What do you do with patients who cannot be treated at your centre?

Items	Yes-1, No-2
Refer them to the next higher authority	
Give them whatever medicines you have	
Send them home	
Don't Know	

D. Drugs and Personnel:

8. Do you have a regular inflow of drugs for mental illness?

Yes ☐ No ☐

9. Do you think the supplies of drugs are sufficient?

Items	Code
Quiet Sufficient	1
Sufficient	2
Not sufficient	3
Don't Know	4

10. What is done with the unused drugs? (Probe: mechanism for maintaining the inventory for these drugs)

Items	code
They are sent back to the higher authority	1
An inventory is maintained and the drugs are recorded and kept for later usage	2
Don't Know	3
Others (Please Specify) _____	4

11. What do you do in case of shortage of drugs?

Items	code
Prescribe the drugs to be purchased by the patient	1
File requisition for drugs	2
Ask the patient to wait till drugs arrive	3
Nothing is done	4
Others (Please Specify) _____	5

12. What is your perception on the management of mental illness at your centre?

1. Not Adequate	2- Somewhat not adequate	3- Neutral (Cant say)	4- Somewhat adequate	5- Very Adequate	6- Don't Know

F. Funds:

13. Do you think the funds allocated for your center to implement DMHP are adequate?

Items	code
Availability of funds is adequate	1
Availability of funds is not adequate	2
Don't know/Cant say	3

13a.Give reasons for your answer

_____
_____
_____
_____
_____

H. Awareness

14. What according to you is a Health Worker's perception of mental illness, its curability and consequences at your center?

_____
_____
_____
_____
_____

15. What according to you is the Community's perception of mental illness, its curability and consequences?

_____
_____
_____
_____

16. What do you think is the purpose of the programme DMHP? (Multiple choice)

Items	code
Integrating Mental health and general health services	1
Spreading awareness	2
Capacity building of health personnel for the management of mental illness	3
Prioritizing Mental health Issues	4
Other (specify) _____	5

17. What is your perception regarding the utility (success) of DMHP?

18. Do you have any recommendations to make the program better?

Evaluation of District Mental Health Programme 9th and 10th Plan in India-Beneficiary

Name of the Patient _____ Name of Respondent: _____
Relationship to the patient _____ Address _____
Vill/ Town _____ Dist _____ State _____ Zone _____

Diagnosis

1. What were **symptoms** of **mental illness** encountered by the patient, along with the month and year?

_____

_____

_____

Month		Year				

2. Name the **first point of contact** with **medical institution** for seeking consultancy, along with month and year? ☐

1 = ANM

2=Doctor at PHC

3 = Doctor at CHC

4 =Doctor at District Hospital

5 = Psychiatrist at Mental hospital(Specify_____)

Month		Year				

3. What was the **illness diagnosed** by the medical professional(in the medical institution)?*(Tick only 1 which is appropriate in this case)*

Neurosis	Depression ☐ Anxiety ☐ Hysteria ☐
Psychosis	Acute ☐ Recurrent ☐ Chronic ☐
Epilepsy	☐

5. How **long** were you/ the patient **treated** by the medical professional who **treated first?**

1. *Less than 3 months*
2. *3 - 6 months*
3. *6 months – 1 year*
4. *Between 1 – 2 years*
5. *Between 2 – 5 years*
6. *Between 5 – 10 years*
7. *More than 10 years*
8. *Don't know/ Can't remember*

6. Did the medical person treat you/ patient **with respect and dignity?** ☐

1. Yes, definitely
2. Yes, to some extent
3. No

7. Were you given **enough time** to discuss your / patients' condition and treatment.

☐

1. Yes, definitely
2. Yes, to some extent
3. No

8. Did you have **trust and confidence** on the medical personnel who treated first? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

9. Was a member of your/ patients' family or some one close to you/ patient **given enough information** from the medical personnel who treated about the patients mental health

Mental Retardation ☐
Alcohol & Drug Dependence ☐

4. Was the **diagnosis** clearly **explained to you**? ☐

1. Not at all *2. Somewhat explained* *3. Clearly explained*

problem? ☐ *1. Yes, definitely*
2. Yes, to some extent
3. No

10. Have you been provided any **medicines by Medical personnel** who treated you/ patient for mental health problem? ☐

1. Yes
2. No

11. Were the **purposes of medication** explained to you? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

(Ques 12 & 13 only for the patients/ respondents who are treated by other than ANM)

12. Were you told about the possible **side effects** of the medications? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

13. How far is the hospital where you are getting the treatment? _____km

14. How much you had to spend in order to reach to the hospital. Rs._____

Referral

15. Were you **referred** to some other hospital for **higher level** of treatment? ☐

0**. No (Go to question 19. **However in case the patient is still treated by ANM go to Q 29)

***1**.Yes (Go to question 16)*

16. Tick whichever is applicable in your case, along with month and year.

By (From)		To	
ANM		*PHC*	
PHC		*CHC*	
CHC		*District Hospital*	
District Hospital		*Mental Hospital*	
Month		Year	

17. How far is the hospital which was referred to you from your place? _____km

18. How much you have to spend in order to reach to the hospital. Rs._____

19. Who did you meet at the hospital where you went? ☐

1. Psychiatrist
2. General practitioner (GP)/ doctor

20. Did the Psychiatrist/ GP **listen carefully** to you? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

21. Were you given **enough time** to discuss your condition and treatment? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

22. Did the Psychiatrist/ GP/ doctor treat you with **respect and dignity?** ☐

1. Yes, definitely
2. Yes, to some extent
3. No

23. Did you have the **trust and confidence** in the Psychiatrist/ GP/ doctor you saw? ☐

1. Yes, definitely
2. Yes, to some extent
3. No

24. How many **times you visit the hospital** to meet the Psychiatrist/ GP for the treatment? ☐

1. Once in Month
2. Twice in month
3. Once in 2 months
4. Once in 3 months
5. other (Specify_____)

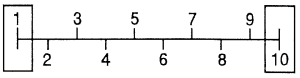
25. Has it ever happened that when you reached the hospital you **could not meet the psychiatrist/ doctor** or your prior **appointment** with the doctor was **cancelled or changed to later date?** ☐

1. No
2. Yes, it happened once/ appointment was cancelled or changed
3. Yes, it happened 2 or 3 times/ appointment was cancelled or changed
4. Yes, it happened 4 or more times/ appointment was cancelled.

26. Whenever you go to the hospital to meet the psychiatrist/ GP/ doctor, do you --- ☐

1. *Often meet the same psychiatrist/ doctor*
2. *Often meet the different psychiatrist/ doctor*

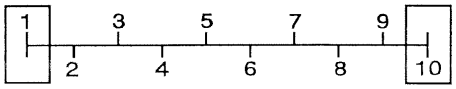
27. How **satisfied** were you on interaction with psychiatrist /doctor on following aspects?



not satisfied at all *absolutely satisfied*

- *Treating with courtesy and respect* ☐☐
- *Listening your concerns carefully* ☐☐
- *Explaining things in a way you could understand* ☐☐
- *Meeting as and when required* ☐☐
- *Explaining need and role of medicines prescribed* ☐☐
- *Explaining probable complications* ☐☐
- *Giving assurance for future help* ☐☐
- *Transparent communication with the family members* ☐☐
- *Other [specify]……..* ☐☐

28. How **much trust** did you have on **psychiatrist/ doctor** who treated you? ☐☐



very few trust *full trust*

29. Have you ever taken counseling session (e.g. therapy) from the hospitals you were referred?

0. No (Go to question 32)
1.Yes (Go to question 30)

30. If yes, how many times.

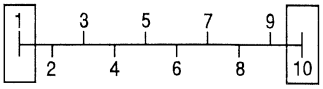
1. less than 3 times
2. 3 – 5 times
3. 6 – 10 times
4. > 10 times.

31. Did you find this counselling session to be helpful?

1. Yes, definitely
2. Yes, to some extent
3. No

OVERALL

32. Overall how would you rate the care you have received from mental health service?



not satisfied at all *absolutely satisfied*

33. In general, how is your/ patients' mental health right now? ☐

1. *Excellent*
2. *Very good*
3. *Good*
4. *Fair*
5. *Poor*
6. *Very poor*

ABOUT PATIENT

The answer should from the patient point of view.

34. What was your year of birth?

☐☐☐☐

35. What is your/ patients' **gender**? ☐

***1** = female* ***2** = male*

36. How **old** are you/ patient?

☐☐ years old

37. What is your/ patient's **civil status**? ☐

***1** = single*
***2** = married*
***3** = separated/ divorced*
***4** = widow(er)*

38. How many other **people** live in your/ patient's **household** (together with you in the same house)? [*Do not count yourself.*]

☐☐ *under 18 years old*

☐☐ *from 18 till 65 years old*

☐☐ *over 65 years old*

* Total number of people living in your household (*yourself included*) ☐☐

39. What is the **highest level of education** you have/ patient has **completed**? ☐

1. *Undergraduate*
2. *Graduate*
3. *Post Graduate*

4. *Prof. Qualification Degree (Specify)……..*

S.No. ☐☐☐

Questionnaire: Community

FOR OFFICIAL USE

Name of the Respondent	

Address & Contact Number (Specify Location)

_____

_____

Phone _____

A. Awareness

1. Do you know anything about Mental Illness ?

Yes ☐ **No** ☐

2. According to you what are the symtoms of Mental illness?

Person Concerned	Code
Lack of sleep	1
Being sad and depressed	2
Excessive anxiety	3
Fear and nervousness	4
Having fits	5
Feeling weak all the time	7
Having hallucinations	8
Over excited and moody	9
Excessive drug abuse	10
All of the above	11
Any other (Pls specify_____)	12

3. Is mental illness hereditary? Yes ☐ **No** ☐

4. Have you heard about following types of Mental illness? (M.A.) Yes-1, No-2

Psychosis (e.g. depression, talk to themselves, moody, hyperactive, etc.) ☐

Neurosis (e.g. tension, fear, worry, excessively tired, hysteria, etc.) ☐

Epilepsy ☐ Drug Addict ☐ Mentally Retarded ☐

5. Are the above types of mental illness curable? (Code) Yes-1, No-2

Psychosis (e.g. depression, talk to themselves, moody, hyperactive, etc.) ☐

Neurosis (e.g. tension, fear, worry, excessively tired, hysteria, etc.) ☐

Epilepsy ☐ Drug Addict ☐ Mentally Retarded ☐

If yes go to q6, if no go to q7

6. How can mental Illness be treated? [MR]

Person Concerned	**Code**
Medicines	1
Counseling	2
Treated at a hospital	3
Treated by Occult practitioners	4
Shock treatment	5
Can not be cured	6
Don't Know	7
Any other (Pls specify_____)	8

B. Source of Information on Mental Health

7. Could you tell me, by whom/where were you told about mental illness and its causes? (Circle the appropriate) [SA]

Person Concerned	Code
ANM	A
Any other health worker(name)	B
Doctor at the PHC	C
Doctor at the CHC	D
Doctor at the District Hospital (psychiatrist)	E
Health Awareness camp	F
Cant say/Don't know	G
Any other (Pls specify_____)	H

8. How often do you meet the following health professionals/health workers (include both cases where the health worker goes to the community as well as where the community members visit the PHC/CHC/ District hospital)

Person Concerned	Frequency Code [met only once -1,weekly-2, monthly-3, quarterly-4, half yearly-5]
ANM	
Any other health worker(name)	
Doctor at the PHC	
Doctor at the CHC	
Doctor at the District Hospital (psychiatrist)	

9. When was the last mental health awareness camp held at your village?

Last heath camp	Code
Was held only once don't remember when	A
Was held last week	B

Held last month	C
3 months ago	D
6 months ago	E
Was held only once don't remember when	D
Don't Know /Cant Say	E
Was not held at all	F

C. Process

10. How were you given this information on mental illness?

Particulars	Code
Through street play and demonstration in the village	**1**
Doctors came for a discussion	**2**
Discussion along with use of IEC (Information Education Communication) material	**3**
Any other	**4**

D. Perception

11. Please give your opinion on the following

Items	Code: (Yes-1, No-2)
Mental illness is due to evil spirit, black magic	
Mental illness is contagious	
Mentally ill individuals can have strange experiences like hearing voices and false firm beliefs	
Mentally ill people are harmful and should be avoided	
Very well educated and intelligent people can develop mental illness	
Mentally ill people needs support and care from the family and the community	
Mentally ill people can not be taken care at home	
Mentally ill individuals should be taken to the nearest health centre for treatment	
Very effective and safe drugs are available to treat mental illness	
Epileptic fits can be controlled by taking medicine regularly	
Excessive dependence on abusive drugs may cause mental illness	
Family, members of the community should recognize change and behaviour of people and discuss it with their doctors/health workers	
Health workers educate families to involve their mentally ill kith and kin in work related to socializing by maintaining an activity	

Items	Code: (Yes-1, No-2)
sheet	
Government has undertaken many initiatives to identify and treat mentally ill people	

12. Have you ever helped/taken a mentally ill relative/patient to the health centre? If yes, please rate your experience regarding the following parameters

Parameters	Experiences code [good-1,satisfactory-2, fair-3, Not very satisfactory-4, bad -5]
Availability of Doctor/health personnel	
Behaviour of the health personnel	
Basic amenities available at the health centre	
Nature of Diagnosis	
Availability of drugs/medicines	
Time taken for diagnosis	
Process of treatment	
Time taken for the treatment	
Total expenditure incurred in the process	

Thank you

Name of Investigator _____ _____Dated _____ Place _____

Name of Supervisor _____ Dated _____ Place _____

S.No. ☐☐☐

Questionnaire: COMMUNITY – (Non DMHP District)

FOR OFFICIAL USE

Name of the Respondent	

Address & Contact Number (Specify Location)

_____

_____

Village/ town _____Dist _____State_____ ___Phone_____

Awareness

1. Do you know anything about Mental Illness and its causes?

Yes ☐ **No** ☐

2. According to you what are the symtoms of Mental illness?

Person Concerned	Code
Lack of sleep	1
Being sad and depressed	2
Excessive anxiety	3
Fear and nervousness	4
Having fits	5
Feeling weak all the time	7
Having hallucinations	8
Over excited and moody	9
Excessive drug abuse	10
All of the above	11
Any other (Pls specify_____)	12

3. Is mental illness hereditary? Yes ☐ **No** ☐

4. Have you heard about following types of Mental illness? (M.A.) Yes-1, No-2

Psychosis (e.g. depression, talk to themselves, moody, hyperactive, etc.) ☐

Neurosis (e.g. tension, fear, worry, excessively tired, hysteria, etc.) ☐

Epilepsy ☐ Drug Addict ☐ Mentally Retarded ☐

5. Are the above types of mental illness curable? (Code) Yes-1, No-2

Psychosis (e.g. depression, talk to themselves, moody, hyperactive, etc.) ☐

Neurosis (e.g. tension, fear, worry, excessively tired, hysteria, etc.) ☐

Epilepsy ☐ Drug Addict ☐ Mentally Retarded ☐

If yes go to q6, if no go to q7

6. How can mental Illness be treated? [MR]

Person Concerned	**Code**
Medicines	1
Counseling	2
Treated at a hospital	3
Treated by Occult practitioners	4
Shock treatment	5
Can not be cured	6
Don't Know	7
Any other (Pls specify)	8

Source of Information on Mental Health

7. Could you tell me, who told you about mental illness and its causes? (Circle the appropriate) [SA]

Person Concerned	**Code**	**Frequency Code/Last Visit List** [weekly-1, monthly-2, quarterly-3, half yearly-4]
ANM	A	
Any other health worker(name)	B	
Doctor at the PHC	C	
Doctor at the District Hospital	D	
Any other (Pls specify_____)	E	

Perception

9. Please give your opinion on the following

Items	**Code: (Yes-1, No-2)**
Mental illness is due to evil spirit, black magic	
Mental illness is contagious	
Mentally ill individuals can have strange experiences like hearing voices and false firm beliefs	
Mentally ill people are harmful and should be avoided	
Very well educated and intelligent people can develop mental illness	
Mentally ill people needs support and care from the family and the community	
Mentally ill people can not be taken care at home	
Mentally ill individuals should be taken to the nearest health centre for treatment	
Very effective and safe drugs are available to treat mental illness	
Epileptic fits can be controlled by taking medicine regularly	
Excessive dependence on abusive drugs may cause mental illness	
Family, members of the community should recognize change and behaviour of people and discuss it with their doctors/health workers	

Items	Code: (Yes-1, No-2)
Health workers educate families to involve their mentally ill kith and kin in work related to socializing by maintaining an activity sheet	
Government has undertaken many initiatives to identify and treat mentally ill people	

10. Have you ever helped/taken a mentally ill relative/patient to the health centre? If yes, please narrate your experience regarding the following parameters

Parameters	Experiences
Availability of Doctor/health personnel	
Behaviour of the health personnel	
Basic amenities available at the health centre	
Nature of Diagnosis	
Availability of drugs/medicines	
Time taken for diagnosis	
Process of treatment	
Time taken for the treatment	
Total expenditure incurred in the process	

Thank you

Name of Investigator _____ _____Dated _____ Place _____

Name of Supervisor _____ Dated _____ Place _____