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District Mental Health Programme (DMHP)- Summary report of Chandigarh, Haryana, Himachal Pradesh and Punjab states

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The visit to the 4 DMH Programmes was part of the National level review of the DMHP in 25 districts in 22 states. The review was undertaken by Prof. R. Srinivasa Murthy and Dr.Nagarajiah of the Departments of Psychiatry and Psychiatric Nursing. The review was undertaken from June 8-21st 2003.

The proformas used for the Review along with the findings for each of the centres is attached as Appendix I.1-4. The schedule of visits and the persons met and the activities undertaken is attached as Appendix 2.

The Report contains

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 - (ii) suggestions for improving the DMHP of the State;
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EXECUTIVE SUMMARY

The review of the 4 DMHP s in the States of Haryana, HimacjhaL Pradesh, Punjab and the Union Territory of Chandigarh has brought to focus both the strengths and limitations of the current DMHP implementation.

The striking positive aspect is the recognition given to mental health as an important part of public health. Equally important is the acceptance by the departments of Psychiatry and tyjre mental health professionals that approaches to non-institutional and community mental health care programmes as primary approach to reach the mentally ill persons. In each of the centers, with marked variation, the services for a large number of mentally ill persons have become a reality. Training programmes have been organized for primary health care personnel.

The limitations are two levels. From the programme impact and the operational aspects. The care has not reached the primary care facilities in any organized manner in any of the four centers. Beyond training, no attempt has been made to understand the care provided by the PHC personnel, the provision of essential drugs, the support from the professionals and supervision of the work has not occurred. Though this INTEGRATION is the essence of the programme none of the programmes have reached this level of implementation. At the operational level, there are a large number of problems requiring greater clarity, guidelines and central coordination.

In summary, the DMHP , though in its Sixth year, is in its infancy requiring great care and nurturing.

Given below are the SIX objectives and what has happened in each of the Centres.

DMHP Objectives:

1.To provide sustainable basic mental health services to the community and to integrate these services with other health services;

Chandigarh: Community services but not integration with health services;

Haryana: Community services but not integration with health services;

Himachal Pradesh: Community services but not integration with health services;

Punjab: Minimal community services but not integration with health services;

2.Early detection and treatment of patients within the community itself;

Chandigarh: Yes

Haryana: Yes

Himachal Pradesh: Yes

Punjab: Yes-mimimal.

3. To see that patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities;

Chandigarh: Partial

Haryana: Partial

Himachal Pradesh: Partial

Punjab: To a very limited extent

4. To take pressure off the mental hospitals;

Chandigarh: Not applicable

Haryana: Yes

Himachal Pradesh: Yes

Punjab: Not applicable

5. To reduce the stigma attached towards mental illness through change of attitude and public education;

Chandigarh: Yes

Haryana: Yes

Himachal Pradesh: Yes

Punjab: In initial stages.

6. To treat and rehabilitate mental patients discharged from the mental hospitals within the community.

Chandigarh: Partial

Haryana: No

Himachal Pradesh: Partial

Punjab: No

A. The summary findings and recommendations applicable to the total DMHP programme:

Based on the 4 DMHP evaluation, the following aspects of the current DMHP need revision. They are considered under (i) general (ii) technical aspects (iii) operational aspects and (iv) additional components to be added to the programme.

DMHP - GENERAL

1. Strengthening of the central coordinating and supportive mechanism (“ *currently there is stony silence from the center for our queries*”)
2. Core technical group for regular review and monitoring of the programme
3. Extension of the DMHP beyond 5 years with the central assistance.
4. Identification of nodal officer as to have administrative control over funds.
5. Development of human resources at the State level.
6. Development of State level mental health plan of action keeping in kind the resources and needs of the State.
7. Improvement of the undergraduate training in psychiatry and making it an examination subject and increasing the duration of training to two months.
8. Deputation of doctors, nurses for DPM/DPN to NIMHANS, Bangalore.
9. Flexibility in the programme, number of posts, depending on the local needs. Flexibility of purchase of the equipment eg., spending money for Boyles apparatus for something else in case the apparatus is already easily available in civil hospital.
10. Govt. of India or its authorized/monitoring agency should respond quickly to the different queries raised by Nodal officer/Nodal institutes. Commonly asked questions by Nodal officer or queries which have already been answered to one nodal officer should be circulated to all in order to facilitate their works.
11. Training component of the personnel under the programme should have a booster training programme of 5 days in case of M.O. and health workers after approximately 6 months of their first training.
12. Districts under the programme should not be more than 70-100 kms from the Nodal Centre.

DMHP - OPERATIONAL ASPECTS.

1. Clear guidelines for implementation of the programme.
 - Recruitment of staff
 - Purchase of equipment
 - Purchase of drugs and range of drugs
 - Vehicle – type and amount to be spent
 - Training of personnel
 - District clinic
 - Records to be maintained at different levels
2. State level and district level review mechanisms
3. Regional nodal officer
4. Centralised purchase of equipments/supply directly to DMHP.

5. Autonomous State level mental health societies to be formed to coordinate the DMHP
6. Budget for drugs after 3rd year to be increased
7. Workshop for all DMHP staff at NIMHANS immediately and periodically at least once in Two years
8. Uniform TA/DA rates for trainees of DMHP
9. Revision of salary structure and job description of the DMHP staff
10. Networking of the centers and newsletter/web site
11. Preparation of a district mental health programme manual to guide the nodal officers
12. Innovative approaches to recruit staff with short period of training to doctors, psychologists, social workers and nurses.
13. Computer based records and reporting system
14. Utilisation of the interest of unspent money.
15. Utilisation of unutilized money out of remaining funds such as training to medical officers.
16. Summary records and reports pertaining to number of patients on treatment / follow up / IEC etc., to be sent by the Zonal Officer to State level and national level committee once in 3 months.

DMHP – TECHNICAL ASPECTS

1. Revision of the training manuals of Doctors and Health workers.
2. Development of IEC material (video, audio and print) at a central level and distribution to centers for local adaptation
3. Models for monitoring of the work done by the medical officers and health workers
4. Follow up evaluation of the impact of care of persons who have taken treatment from DMHP
5. Development of indicators for review at the monthly meeting of PHC personnel by the DMO/CMO.

DMHP - ADDITIONAL COMPONENTS

1. Add common mental disorders care into the training manuals and programmes
2. Rehabilitation and after-care of chronically ill to be included
3. Primary prevention activities to be included
4. Involvement of school teachers in the public education activities
5. Involvement of voluntary organizations
6. Private general practitioners training and involvement in the DMHP
7. Training programmes for family members to be funded activity
8. Urban mental health
9. Telephone / mobile phone facility
10. Internet facility to be funded from DMHP
11. Minimum two psychiatrists in each team under DMHP
12. Public address system for training purposes and IEC
13. Provision of pharmacist in the team of DMHP
14. Incentive for nodal officer

B. The observations about each of the DMHP programmes along with the areas for future actions

B.1. Chandigarh DMHP:

Two images define this centre.

IMAGE 1:

“You should have seen him before the meeting.. he used to collect all the rubbish including bones and keep it in his pockets “

“we took him to many religious places and faith healers without any benefit”

“Now he is working well and free of symptoms”

“It is a miracle that he has recovered after 8 years”

During the field visit we met Mr.Rahman in his home. Our visit resulted in a small crowd and as soon as they realised that we were part of the mental health care team, excitedly the onlookers said, “Rahman is now completely well, you do not know how sick he was... you, know, he used to keep to himself and collect all the rubbish, people used to be afraid of going near him” “ the treatment has made him into a new person” “ family is happy to see that he is back to normal after nearly 9 years” “ we did everything in the past like magical and religious treatment and nothing helped”.

Mr.Rahman, about 40 years old has been living in Mani Majra area. In March 2002 he visited the psychiatry OPD of Civil Hospital with a history of 8 years of continuous illness characterised by abnormal behaviour, not working, collecting waste material and hoarding the same, laughing and smiling to himself and completely dependent of the family for all his needs. Following the visit patient and family was advised treatment which they did not take.(we did not have “viswas” in this treatment and were continuing religious treatment”) but the family did not take the treatment. In January 2003, a follow-up visit was made by the social worker as part of review of the records and recognition of the needs of the patient. This follow-up visit and work with the family resulted in regular treatment . This has resulted in gradually recovery and currently he is free of active symptoms and has started working again after nearly 9 years!

IMAGE 2:

“Domestic violence experienced by women is a big problem.. please arrange for a helpline for women”

“alcohol and drugs have destroyed the peace of this community”

The Anganwadi centres is located in a brick building with a big compound. There are two big rooms for the 4 Anganwadis to care fort the children. The centre is surrounded by a compound leaving enough space for children to play with the play

material in the playground .The centre was full of little children, most of them looking small in build for their age.

During the discussion with the 4 Anganwadis and 4 helpers, their knowledge about mental retardation was clearly evident. They also described children who were very quiet, who were withdrawn and children who were disturbing to others by their overactivity. They clearly identified the children's behaviour with that of the home situation. The four issues they identified were (i) unemployment,(ii) drug use and abuse (iii) lack of literacy of women and economic dependency and (iv) loss of community life, as majority are migrants to the city. They had helped women with emotional problems during the adult literacy classes and during the self-help group meetings. When suggested, they were open to include modules for self-care of women as well as acquire skills to support women in distress.

SALIENT POINTS OF THE CHANDIGARH DMHP PROGRAMME:

The Chandigarh DMHP is strongly linked to the Government Medical College, Chandigarh. This linkage is the strength of the programme. The Departmental staff have not only provided the technical support to the DMHP it has also given prestige to the staff of the DMHP, as an extension of the Medical College. The extensive and well funded health infrastructure of the Union Territory is an another advantage, though this has not been fully utilised to the advantage of the programme. The easy availability of the administrative support and lack of barriers to recruit the staff, purchase the vehicle, other supplies are other advantages to the success of the programme. The leadership of Prof.B.C.Chavan is an another important factor. The professional team of psychiatrist, clinical psychologist, social worker and statistician are very competent and committed to the programme. The support of the chief medical officer of the Civil Hospital where the service is located and the Director of Health Services is an another strength of the programme.

The programme has established an excellent District psychiatric unit in a general hospital. The Unit is popular and has a wide range of services with an active outreach programme.

Of the psychiatric problems, drug use and abuse are the most important and frequent as seen from the out-patient and inpatient reports. In the last few months, suicide has come to the forefront and the media has drawn attention to the same.

The centre has prepared a large number of IEC material and they are using them on a regular basis.

The centre has also started a day care centre and making efforts to bring together families of the mentally individuals to form self-help groups.

The implementation of the programme has established very well the existing mental health needs in the community, the limitations of the existing mental health care facilities(PGI,Sector 16 and GMC) and the need for community based facilities and

services .The increased utilisation of services is a testimony to the value of a district psychiatric unit.

However, the involvement of the medical officers in the care of the mentally ill individuals has not occurred. This has many dimensions. Firstly, only one batch of 10 doctors have been trained and these were from the general hospitals and not from the peripheral dispensaries. Secondly, the posting of further doctors had to be stopped due to the 15 days one time training. Thirdly, those trained doctors were not followed by the DMHP team to understand the mental health care provided by them; and lastly, no psychiatric drugs were provided to the trained doctors.

Suggestions for full implementation of the DMHP:

1. The component of the training of the primary health care personnel, namely, the primary health care doctors and the health workers need to be taken up on priority. The training can be broken down to short and repeated on weekly basis to be considered to decrease the interruption of the routine medical care.
2. The trained persons should be followed up regularly by (i) supply of records to physicians and health workers (ii) periodic visits(say once a month) to provide support to the physicians and review of the records; (iii) referral back of patients coming to the DMHP clinical unit ;(iv) review of the mental health programme in the monthly meeting similar to other programmes (v) providing telephones to all dispensaries to facilitate the doctors seeking advice over the telephone from the DMHP and (v) refresher meetings to review the work and update the knowledge and skills. There is scope for involving the over 250 private general practitioners by training programs.
3. The problems of drug abuse, suicide, domestic violence can be addressed by increasing the role of the Anganwadis towards increasing coping skills of women, providing counseling skills to Anganwadis and increasing infant stimulation programmes in the Anganwadis.
4. Initiation of the Life Skills education programmes in the schools of Chandigarh.

B.2. HIMACHAL PRADESH:

Two images define the programme:

IMAGE ONE:

“He had been ill for over 12 years and it was impossible for even 5-6 persons to control him during the periods of illness”

“We wasted a lot of money going to different places till we started getting good free treatment from the Bilaspur Centre and with this he is now well”

“ Since two people in the house had mental illness, people say that everyone in the family is mentally ill and talk among themselves”

The village was a good one hour from Bilaspur, the centre of DMHP. First we reached to nearest road point by a vehicle. From the main motorable road, we started walking (trekking) for about 15 minutes in the hot summer heat (around 38C) climbing and getting down along the way. It was difficult to imagine how any ill persons can be shifted in this terrain. At the end of 15 minutes, we met Mr. Ram Yadav, with his father. They were living in a well built house with electricity. Seeing the team sweating profusely they offered the welcome cold water and narrated the saga of suffering and losses. Mr. R. Y. has had a number of episodes of mania. He recovers with treatment but relapses on leaving out the medicines. Currently, for the last six months, he is keeping normal life and regularly taking antipsychotics and prophylactic medicines. The father and son travel across the lake to reach the monthly clinic and get the free medicines. Patient is normal in behaviour but yet to return to full work. During the interview, his elder brother's wife joined the team. She narrated her own psychotic episode of short duration and recovery. She is completely well and not on any treatment. The neighbours in the audience, the family members appreciated the value of the DMHP and the availability free medicines. They urged that the DMHP should be continued and extended to other districts in the State.

IMAGE TWO

It was the second Saturday of the month. While the rest of the hospital was closed for the holiday the psychiatry OPD was full of activity. It is difficult to describe a phenomenon like that we saw at the OPD. There were over 100 patients and their relatives waiting from early morning. There were some who were acutely ill. One of them was a person who was continuously talking (muttering) to himself, the second was a young lady in a state of high elation and continuous distractibility, the third had an epileptic attack (known person on antiepileptic drugs) and the fourth was a young man with altered state of mind. The rest of the people were men and women who had waited for the doctors attention for some weeks. The clinic runs on a first come first served basis and those whose numbers did not get called were given medicines (old patients) and new cases would take their turn at the next Saturday clinic.

The care process was unique combination of examination, information to the patient and the family along with public education. Very unusual indeed. People were good humored and expressed deep commitment to Dr.Dhatwalia and the treatment practice. It was remarkable that they accepted and ran the serial numbering system by themselves!

From the clinic there was no doubt that there are a large number of persons who need psychiatric care. People are willing to take modern medical care as well as make efforts to utilise the services was also clear.

SALIENT POINTS OF THE HIMACHAL DMHP PROGRAMME:

The TWO striking aspects of the programme in the state is the extreme paucity mental health resources in the state(5 psychiatrists, no other mental health professionals, less than 50 psychiatric beds both in public and private sectors) and non-availability of psychiatric drugs in health facilities, and strong beliefs in the community about supernatural causation of mental disorders) and the strongly personal approach of the two most popular psychiatrists(one in the public sector and the other in the private sector). It is noted that the medical college has only two psychiatrists and no inpatient facility.

The public sector psychiatrist, Dr.Dhatwalia of Hamirpur, represents the single most image of mental health care. He has been working for over 25 years in various centres like Mandi, Hamirpur and now Bilaspur and has a messiah like following in the general population. He works very hard and is accessible to people. He strongly believes in TOTAL non-institutional care, even for acutely ill patients-“ we do the treatment and the family should take the responsibility of care, they can not get rid of their responsibility by spending money and handing over the care to hospitals”. There is a revolution in the districts around Bilaspur was clear from the field visit and the weekly clinic at Bilaspur. Over 100 patients attended the clinic from 10 a.m. to 4 p.m. All of these patients were seen on a first-cum-first served basis in an orderly fashion. The relatives came with the patients and took medicines and advice.

The other centre of major care is the private psychiatric setting is at Dharampur. Dr.Virendra Mohan, has been working for over 29 years. He has a following that could be the envy of any psychiatrist. There is an element of institutional care and patients spend considerable amount of money for care. There is a system of postal supply of medicines from this centre. A reflection of the lack of specialist human resources is the situation in Dharampur, where Dr.Mohan is the only formally trained professionals and all the others are persons of the general public trained at the centre. The Centre has a positive public image and a strong following in the State and neighbouring states.

Free drugs are not available for psychiatric care except in the DMHP area. Even in Hamirpur, these drugs are purchased by the patients/families. Dr.Dhatwalia firmly believes that the population is well off in the area and buying drugs on their own is not a problem.

The infrastructure for primary health care is impressive. The sub-centres are well built, fully stocked with medicines, the health workers are knowledgeable about national programmes and the public uses these services as the main and preferred source of medical care.

The current recording system does not allow for assessment of the impact of the programme most other care is provided by the patient maintained cards except for the initial evaluation cards. Similarly, there is no follow-up of the 69 trained doctors and over 100 health workers.

SUGGESTIONS FOR FULL IMPLEMENTATION OF THE DMHP:

1. There is an urgent need to build up the full mental health team- namely psychiatrist, clinical psychologist, psychiatric social worker, statistician and psychiatric nurses. This is essential for regular care to be available to the population (currently it is available on twice monthly basis at Bilaspur and as orientation camps at different places on two other places in rotation as CAMPS) and to increase the range of services from clinic to the in-patient unit and the community. The non-physician members of the team can follow-up the drop-out patients, organise public education, community based rehabilitation and preventive programmes. Innovative measures will have to be used to create the mental health like starting the MBBS doctor, MA level personnel, general nurses and providing them with focussed training of few weeks to few months to enable them work at the district.
2. The integration of mental health care at the level of sub-centres and primary health care facilities is an another challenge. It appears that even the trained persons are not involved in the care except to refer patients to the psychiatrist. This has to change for the true implementation of the DMHP. Some of the steps that should be taken are:
 - (i) refresher training to all the doctors at Bilaspur (a 5 day refresher training is already initiated by the medical college and it is planned to shift the venue to the district headquarters) and the health workers;
 - (ii) Specifying the clinical and preventive role of the PHC Personnel;
 - (iii) Introduction of records for the health workers and doctors;
 - (iv) Supply of psychiatric drugs to doctors and possibly to the subcentres for follow-up care (similar to the DOTS programme). The terrain of H.P. calls for greater involvement of the health workers in clinical care, both in emergencies and for follow-up.
 - (v) Review of the programme during the monthly meetings at the PHCs and at the District level.
3. Altering the current CAMPS to be run by the medical officers, with the psychiatrist providing professional support. This is going to be the most difficult part of the change as Dr.Dhatwalia's identity and image is so strong that this shift will require conscious effort by him to decrease his role and for the DMHP team to be strong to establish its own identity. CAN THIS CHANGE OCCUR IS THE CENTRAL CHALLENGE FOR THE PROGRAMME FUTURE?

SUGGESTIONS FOR THE STATE MENTAL HEALTH PROGRAMME

1. The specialist human resources in the state has to be addressed on a priority. The starting of the Himachal Pradesh Institute of Mental Health and Neurosciences , away from (15 kms) Simla and about a kilometre from the main road will not solve the need in the short –term period. The Department of Psychiatry at the Indira Gandhi Medical College, Simla should be strengthened without fail with additional psychiatrists, full mental health team and an in-patient unit of at least 20 inpatient beds. This will provide not only psychiatric services, but will assure that adequate training to undergraduates is offered. In addition, this can be the centre for postgraduate education .Most of the specialist human resources in the state has been built on deputation of the in-service doctors for PG training(66% of PG seats are reserved for in-service doctors) and once postgraduate courses are available the numbers of specialist personnel will increase. **Deputation of the State level officers for postgraduate diploma education at centres like NIMHANS, Bangalore and CIP,Ranchi.**
2. On a short basis, there is need for doctors trained in psychiatry to function in each of the districts. One approach would be to organise training of 3 full months for groups of 2-3 doctors from the in-service at the medical college so that they would return to work at the districts. Within one year all the districts would have essential psychiatric services. (A similar approach has been used by other states and NIMHANS, Bangalore has developed a 3 month module of training of psychiatrists). Similar approach to training other mental health team members can be initiated in cooperation with the respective University departments.
3. The essential psychotropic drugs should be included in the list of drugs at the different health facilities. A suggested list for the different levels is given as Appendix I.
4. Massive and continuos public education using both the formal and informal methods of public education should be launched.

B.3. HARYANA

Image 1.

“ We see a lot of patients with psychological problems as part of general health care”
“Nearly 50% of women who come to me have psychosomatic problems in a background of alcoholism in husbands and domestic violence”
“We need more counseling skills as part of psychiatry training”

The meeting was with a group of doctors and the S.M.O. of the hospital. They readily recognised the importance of mental health care as part of primary health care. They appreciated the good training they had received as part of the DMHP. They related the psychological problems of patients to larger societal changes like unemployment, excessive use of alcohol, domestic violence and use of other drugs. In terms of their responsibility for this group of patients, they recognised that they are the best professionals to provide care but shared the limitations in providing care due to limited professional skills, lack of time, privacy and specialist support. The long meeting ended with recognition by the Rhotak and Kurukshetra teams to organise more support to doctors working at the peripheral institutions.

SALIENT POINTS OF THE HARYANA DMHP PROGRAMME:

The Kurukshetra DMHP has been fully supported by the Department of Psychiatry, Postgraduate Institute of Medical Sciences, Rhotak. This support is the foundation for the programme implementation. The State has also deputed a senior medical officer with DPM degree in Psychiatry from the State services to head the district level service activities, as there was difficulty to recruit the staff as per the salary scales offered by the DMHP.

The programme of training of the primary health care doctors has been organized well. The doctors have understood the importance of mental health. However, no follow-up support in terms of supply of medicines, regular visit by the mental health team for support and supervision has occurred.

The health workers have been trained and they are motivated to do the work. No follow up action has been taken.

The acceptance of the need for mental health care in the State by the administrators is high.

The following statements of DHS and Health Secretary illustrate this attitude:

“ This programme is a human rights issue”

“This is our duty, mentally ill are part of the society”

“whether we like it or not, we have to look after the needs of the society”

“ I want mental health models for the state that is cost-effective”

In the last one year, the State has formed Task Force to develop a State level Institute of 150 beds at Rhotak.

SUGGESTIONS FOR FULL IMPLEMENTATION OF THE DMHP:

1. There is an urgent need to build up the full mental health team from the DMHP funds- namely psychiatrist, psychiatric social worker, and statistician . This is essential for regular care to be available to the population and to increase the range of services from clinic to the in-patient unit and the community. The non-physician members of the team can follow-up the drop-out patients, organise public education, community based rehabilitation and preventive programmes.
2. The integration of mental health care at the level of sub-centres and primary health care facilities is the chief challenge. Currently, even the trained persons are not involved in the care except to refer patients to the psychiatrist. This has to change for the true implementation of the DMHP. Some of the steps that should be taken are:
 - refresher training to all the doctors at Kurukshetra and the health workers;
 - Specifying the clinical and preventive role of the PHC Personnel;
 - Introduction of records for the health workers and doctors;
 - Supply of psychiatric drugs to doctors and possibly to the subcentres for follow-up care (similar to the DOTS programme).
 - Review of the programme during the monthly meetings at the PHCs and at the District level.
3. Utilising the postgraduate students to support the DMHP by periodic posting to Kurukshetra. Additionally the thesis topics for Postgraduate students can be taken from the DMHP. Some topics suitable are: (i) the evaluation of the mental health care by the primary care doctors; (ii) the evaluation of the mental health care provided by the health workers; (iii) impact of the mental health care by DMHP on the patients , families and communities.

SUGGESTIONS FOR THE STATE MENTAL HEALTH PROGRAMME:

1. The chief challenge for Haryana is the development of Human resources for the State mental health care programme. The state has less than 50% of mental health professionals as compared to the neighboring_state of Punjab. It would be a long time to have adequate trained specialist human resources if the fully trained psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses have to be trained in the State. As a measure to build up district level mental health team(currently 6 districts do not have any psychiatrist either in the public or private sector) a programme of SHORT-TERM training of about 3 months should be taken up.
2. The State has no custodial care institution. This is an advantage in terms offering openings to develop innovative approaches to long =term care. The State can initiate dialogue with voluntary organisations and families with persons needing long-term care to develop community based care programmes. This will be more

cost effective(for example the estimated daily cost of psychiatric patient is Rs.500/ per day, which is more than the cost of the costliest half-way home in the country) and offer better quality to the ill individuals.

3. The essential psychotropic drugs should be included in the list of drugs at the different health facilities. A suggested list for the different levels is given as Appendix I.
4. Massive public education using both the traditional and folk media to educate the public on matters of mental health on a regular and continuous basis.

B.4. PUNJAB

Image 1:

Tribune March 17,2003.

As a transit state, Punjab is under the dark shadow of narco-terrorism and drug menace. The Chief Minister's Office is examining a preliminary report on this issue. The drug abuse pattern reveals that if narcotics are more abused in Malwa and Majha, it is tranquilisers in Doaba. Multiple drug abuse is more common in all three regions with rural areas and urban slums high on drug abuse, smuggling and trade.

Preliminary findings show that 40 per cent Punjabi youth in the age group of 15 years to 25 years has fallen prey to drugs and 48 per cent farmers and labourers are addicts. There is at least one addict in 65 per cent of the families in Majha and Doaba. The derivatives of opium (70 per cent) as well as tranquilisers, pain-killers (35 per cent) etc. are in great demand. Their usage depends upon the geographical area, type of drug, age and occupation of addict.

As a border state, Punjab has proximity to the 'golden crescent' — Iran, Afghanistan and Pakistan — major producers of opium. As a transit point for drug-trafficking, Punjab districts have slowly but surely become a victim to drug abuse, which impinges as much on national security as it weakens the morale, physique and character of Punjabi youth.

The range of narcotics and drugs includes raw opium, "bhuki", smack, heroin and synthetic drugs—morphine, pethidine, dextropropoxyphene (proxivon); cough syrups laced with codeine (phensidyl, corex) and tranquilisers like diazepam or calmpose. The drug abuse, says the report is also linked to HIV/AIDS infection in intravenous drug abusers and sex workers.

Punjab has little mechanism to deal with de-addiction and proposes to involve NGOs, social, religious and educational activists and institutions, health department and, of course, the police. "We are for an integrated approach to this twin problem", says Principal Secretary to the Chief Minister S.K. Sinha. As he is also the Administrative Secretary, Home, the proposals on dealing with narco-terrorism/drug menace are to be taken up with the Union Ministry of Home Affairs through MPs for an in-depth survey, its financing and setting up centres equipped to deal with addicts at the physiological, psychological medical and counselling levels.

The state has also identified that the main source of supply of these "killer" drugs are drug-peddlers (57 per cent), who tap farmers, labourers and truck drivers; quacks and chemists (56 per cent), who look for youth. On the socio-psychological level, it has been observed that peer group influence, distressing home environment, myths related to sex

potency, physical and mental alertness, thrill seeking curiosity, unemployment are some common factors leading to drug abuse.

Some skeleton services are available in medical colleges and institutions to deal with addicts but more are required to be introduced. One worrisome factor in de-addiction efforts is a high rate of relapse. The dropout rate is estimated to be more than 50 per cent after six months of treatment and between 85 per cent and 90 per cent after one year. This calls for pepping up follow-up action.

IMAGE 2:

The Amritsar Mental Hospital is an old psychiatric Institution catering to the custodial care of patients of the states of Punjab, Haryana (since 1986) and Himachal Pradesh. Even today there are patients of these states in the Centre. In 1994, a new OPD Block was opened. In the last two a brand new complex of buildings are built for a 450 bed facility and the centre is designated as Institute of Mental Health. The estimated cost is over Rs.40 crores with additional expenditure for furniture and equipment estimated at around Rs.5 crores. The new facility has a variety of clinical facilities ranging from administrative block, OPD, facilities for acute care, voluntary patients, rehabilitation, forensic patients and long term care.

During discussion, Dr. Goyal, Director of the Institute, pointed out that the need for custodial care is mainly in regard to those long stay patients of the past. In the last two and a half years, less than a dozen patients have been added to this group. It is not clear what the 450 beds will be used for. Walking along the long and wide corridors and wards, the thought that could the money spent used better by (i) innovatively approaching the care of over 200 hundred patients in custodial care (support to families to accept the families, foster care, NGO involvement etc) and (ii) setting up of small sized (20 bedded) psychiatric units at the 19 districts. As Dr. Paramjit Singh, Professor of Psychiatry, Amritsar Medical College shared at the XII Annual Conference of Punjab and Chandigarh in November 2001, it is "THE OPPURTUNITY LOST"

SALIENT POINTS OF THE PUNJAB DMHP PROGRAMME:

The DMHP at Muktsar was allotted by the Central Government in 1997-98 and the State conveyed its willingness to implement the DMHP on 19-2-1998. Nothing happened for the next three years. Dr. Paramjit Singh, current Nodal officer for DMHP reported the following in the October 2000 workshop:

"I am sorry to inform in Amritsar, this programme has not taken up yet, the first letter after joining as head of the department of psychiatry, I received from the Principal was requesting the Ministry of Health and Family Welfare, New Delhi, to please take back the funds, which we have, that is about Rs.17,00,000. The understanding was that in this period of over two years, money remained un-utilised, for two years and it was in the current account of the Principal, and there was a serious audit objection and they have asked to pay the interest about 4,00,000 for the non-utilisation of funds. So everybody was scared. Now it is my job is to sort out all these problems and I hope during the deliberations of this workshop and in my main presentation I will discuss all these things".

However, in the three years since the progress has been limited. It is only in the last two months, a psychiatrist is in position at Muktsar and the OPD and the in-patient services have been opened. The training provided for over 60 doctors and health workers has not been followed.

The developments of the last few years is as follows:

“initially the programme faced a lot of difficulties in the implementation of the scheme. Therefore a high powered DMHP Implementation Committee(DMHP-C) was constituted under the Chairmanship of Principal Secretary, Health and Family welfare, Punjab on 12-6-2002 for speedy implementation of the project. Two meetings in August 2002 and January 2003 were held to remove various obstacles faced in the implementation of project. Equipment and medicines have been purchased by the Nodal Institute and placed at the disposal of DMHP”

The formal launch of the programme was fixed on 20th June 2003(by coincidence at the time of the evaluation team visit) and it was to have included a training programme for opinion leaders .However, the launch was postponed due to the announcement of the panchayat elections.

The State of Punjab reports that there is an acute shortage of trained manpower. No expenditure has been made by DMHP for the salary component of the scheme till date.

The discussions with about half a dozen medical officers brought out that the trained specialists felt this is not part of their responsibility. The other doctors recognised the high proportion of their patients suffering from emotional problems but inadequacy in providing care(for want of essential drugs- only diazepam is available in most centres- inadequacy of skills and the highly lecture oriented training and lack of support and supervision by specialists).The menace or “epidemic” drug abuse dominated the discussion.

In contrast, the meeting with about a dozen health workers was very positive. They reported the value of the training programme as there was no mental health training as part of the basic training. Each of the health workers, reported a number of patients of a wide variety of mental disorders in their places of work. However, most of them had not received care as the PHC doctors were not providing the service or the District team for psychiatric care was not there till recently. The menace of drug dependence dominated the discussion along with the high rates of depression in women, mainly as a consequence of the problems of drug abuse, domestic violence and unemployment.

In the state there are 89 psychiatrists, 18 clinical psychologists, 21 psychiatric social workers, 10 psychiatric nurses, 847 psychiatric beds(580 in public and 267 in private sectors) and 60 psychiatric outpatient services (13 in public and 47 in private sector).

SUGGESTIONS FOR FULL IMPLEMENTATION OF THE DMHP

All the initiatives to implement the DMHP starting from staff recruitment, training of the health personnel, provision of services, monitoring of the programme is the need of the State. The State has the advantage of learning from the experiences of other States in the country in general and the regional states in particular.

SUGGESTIONS FOR THE STATE MENTAL HEALTH PROGRAMME

1. The State of Punjab presents a picture of contrasts. There is high awareness of the mental health issues in the State at all levels- the media, the general public, health workers, doctors, administrators and politicians especially regarding drug dependence. However, against this background there are two contrasting responses. The available funds and approach to provide community mental health care remains almost unutilised for 5 years, while a simultaneous building of a Rs.40 crore which will meet only limited needs of the State has been built during the same period. There is an urgent to reconsider and develop a State level mental health plan rather than responding to the issues on an ad hoc basis.

2. Drug abuse is the mental health priority for the State. Addressing this could galvanise the population to mental health initiatives. For this to occur a radical new approach of non-institutional care is needed. The other two challenges are development of human resources for mental health care and active involvement of private sector and voluntary organisations in mental health care.

3. The essential psychotropic drugs should be included in the list of drugs at the different health facilities. A suggested list for the different levels is given as Appendix I.

5. Massive public education using both the traditional and folk media to educate the public on matters of mental health on a regular and continuous basis.

