

REPORT OF EVALUATION OF DISTRICT MENTAL HEALTH PROGRAMME

1. Background of the District Mental Health Programme

1.1. Mental disorders are known to be widely prevalent all over the country. In recent years, the understanding of human brain and mind and their intricacies have increased considerably. Greater availability of a variety of medications as well as other forms of treatment for conditions such as psychosis, depression and other mental disorders have given new hope to large number of persons suffering from these disorders and their families. To give mental health care its rightful place in overall national health programme, a 'National Mental Health Programme for India' was developed in 1982. The Central Council of Health and Family Welfare recommended its implementation all over the country. The main objective of the programme is to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of society. This objective is to be achieved by i) integration of mental health care services with the existing general health services, ii) utilization of the existing infrastructure of health services to deliver the minimum mental health care and iii) provision of appropriate task oriented training to the existing staff.

1.2. Feasibility studies carried out by the National Institute of Mental Health and Neuro Sciences (NIMHANS) in Bangalore and few other centers in the country showed that it was possible to integrate mental health care with the existing general health services.

1.3. Subsequently, NIMHANS operationalized the mental health programme in a whole district of about 2 million population – in Bellary district in Karnataka State. The Bellary district programme demonstrated the possibility of taking care of mentally ill persons away from mental hospitals and dependents of psychiatry in medical colleges to district and taluk hospitals and primary health centers.

1.4. All the States and Union Territories were sensitized to implement the national mental health programme in their respective states, through series of workshops for state level health administrators, planners and mental health professionals. It was suggested that modest and viable mental health care programmes be developed in each state and union territory. However, states

and union territories themselves were unable to initiate any meaningful programmes due to various constraints, most notably, paucity of funds.

1.5. A national workshop organized by NIMHANS, in collaboration with Ministry of Health and Family Welfare, Govt. of India involving all the state health departments in February 1996, strongly recommended that National Mental Health Programme should be activated by the plan sanction of funds from Central Government. The workshop further recommended that District Mental Health Programmes should be implemented in each state/union territory and the “Bellary programme” as developed by NIMHANS could serve as a model. The emphasis should be in involving the families in looking after the mentally ill and special emphasis should be given to poor, weaker and underprivileged sections of the society. The workshop also suggested various requirements and components such as human resources, equipments, beds etc for such a District Mental Health Programme.

1.6. The Ministry of Health and Family Welfare, Govt. of India formulated District Mental Health Programme (under National Mental Health Programme) as a centrally funded 5 year pilot scheme with an outlay of 28.5, 21.5, 20.7, 21 and 24 lakhs of rupees during the 1st, 2nd, 3rd, 4th and 5th years of the scheme respectively in 1996-97. The pilot programme was to be implemented in two phases, the Phase I was to be taken up during 1996-97, and the Phase II was to be a continuation of the programme during the IX Five Year Plan (1997-2002).

1.7. Accordingly, the District Mental Health Programme was launched during 1996-97 in four districts – one district each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu. The programme was extended to 7 more states during 1997-98 – the states of Arunachal Pradesh, Haryana, Himachal Pradesh, Punjab, Madhya Pradesh, Maharashtra and Uttar Pradesh. The programme has subsequently been expanded to one district each in the States of Kerala, West Bengal, Gujarat and Goa and the union territory of Daman & Diu during 1998-99, Mizoram, Manipur, Delhi and union territory of Chandigarh during 1999-2000, and Tripura and Sikkim during 2000-2001. Kerala and Assam started the programme in a second district during 1999-2000, Andhra Pradesh took up their second district and Tamil Nadu started the programme 2 more additional districts during 2000-2001. Thus, the district mental health programme has been initiated in 27 districts spread across the country, situated in 20 states and 2 union territories.

1.8. The objectives of the centrally funded District Mental Health Programme (under National Mental Health Programme) scheme are as follows: i) To provide sustainable mental health services to the community and to integrate these services with other services, ii) Early detection and treatment of patients within the community itself, iii) To see that patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in cities, iv) To take pressure off mental hospitals, v) To reduce the stigma attached towards mental illness through change of attitude and public education, and vi) To treat and rehabilitate mentally ill patients discharged from the mental hospital within the community.

1.9. The district programme is expected to provide services to the needy mentally ill persons and their families through district level outpatient services, a 10 bedded inpatient service at the district hospital, liaison with primary health centers, referral services and follow up services. The programme is also expected to remove stigma of mental illness by creating awareness and if feasible, carry out a community survey.

2. Objectives of the evaluation

2.1. The Ministry of Health and Family Welfare, Govt. of India has formulated a programme for comprehensive expansion of mental health services in the country during the X Five Year Plan. One of the thrust areas identified for increasing access to mental health care during the X Five Year Plan period is expansion of the district mental health programme to 100 districts in the country. When the Expenditure Finance Committee considered the proposal for expansion of the district mental health programme in December 2002, the Committee recommended that the expansion be undertaken only after an evaluation of the pilot district mental health programme implemented during the IX Plan period.

2.2. The task of evaluation of the district mental health programme was entrusted to NIMHANS by the Ministry of Health and Family Welfare, Govt. of India (vide D.O. No. V.15011/7/2001-PH(Pt) dated the 7th April 2003). While there was no specific Terms of Reference for the evaluation NIMHANS was asked to provide suggestions if any for improvement of the programme.

2.3. The overall purpose of the evaluation was to assess the degree to which each of the district mental health programme in different states and union

territories was fulfilling the stated goals of the programme (see Section 1.8). Since most of these goals are not easily expressible in valid quantitative and measurable terms, it was considered appropriate to use the 'structure – process – outcome' model of evaluation.

2.4. More specifically, the objectives of the evaluation were as follows: -

- i) To review the progress made by various states and union territories in implementation of the centrally funded district mental health programme
- ii) To identify impediments and bottlenecks, if any, in successful implementation of the programme
- iii) To suggest feasible strategies for overcoming obstacles in the implementation of the programme
- iv) To consider mid-course corrections/changes, if any, in the various components of the programme
- v) To assist in further expansion of the district mental health programme in the country.

3. Methodology of evaluation

3.1. Constitution of Expert Team for Evaluation

An expert team under the chairmanship of Director, NIMHANS was initially constituted to carry out the evaluation. The members of the team had wide experience in developing different types of mental health services. Some of the members had participated in the development of the district mental health programme at Bellary. The background of the team members was multi-disciplinary, ranging from Psychiatry, Neurology, Clinical Psychology, Psychiatric Social Work and Psychiatric Nursing. The list of the Expert Team is given in Appendix I.

3.2. Development of Evaluation Questionnaire

The Expert Team for evaluation of the programme developed a comprehensive questionnaire. The questionnaire was based on an earlier mail-survey-questionnaire, which was used for the review of the district mental health programme carried out in October 2000. Details regarding personnel, training programmes, equipment, medicines, IEC components as well as information about patient care were sought. Difficulties and bottlenecks, if any, in the initiation and implementation of the programme were also enquired into. Copy of the questionnaire is given in Appendix II.

3.3. Mail Questionnaire Survey

The evaluation questionnaire was mailed to all the 27 nodal officers of the district mental health programme through the state/union territory health secretaries for completion, about a month prior to the local site visits by the Experts.

3.4. Site visits

2 members of the Expert Team visited all the 27 districts where the mental health programme is being implemented and the respective state/union territory capitals with adequate prior information to the nodal office as well as state health administration.

During the site visits detailed unstructured interviews were carried out with programme staff, nodal officers, state/union territory health administrators, principals of medical colleges or directors of health services, trained health personnel such as doctors from general health services and multipurpose health workers as well as patients on treatment and their families. The team of 2 experts also observed ongoing activities such as district level and primary health centre clinics, and IEC activities. The visiting team also reviewed patients' clinical records, other records/documents related to programme implementation, availability of psychotropic medications, and other equipments. Suggestions for improvement and better implementation of the programme were sought from various categories of health personnel. The site visits were carried out during the period of June and July 2003.

4. Findings

4.1. Duration of the implementation

While evaluating the performance of the district mental health programmes all over the country, it is important to note that the programmes were started at different points in time and have been in operation for varying periods. **The programme was started in 4 districts during 1996-97, 7 more districts during 1997-98, 5 districts during 1998-99, 6 districts during 1999-2000 and 6 more districts during 2000-2001.**

The intervals between the initial communication from the Central Government to the states, formal approval by the state government and the actual starting of the programme following the release of the first installment of grant have been variable (Table 1). Thus, the programme has been in operation for more than 5 years, only in 5 states. In two states, the programme was initiated as recently as 2002. Some of the centers reported various types of difficulties they faced to obtain the administrative approval for starting of the programme, receiving as well as using the funds allotted for the programme. The modalities of control and monitoring of funds were different from centre to centre, contributing to difficulties in accessing the funds.

4.2. Background characteristics

Although the district mental health programme scheme of Government of India has a standard format and uniform budget for all the state, the districts where the programme is being implemented are highly variable in their background characteristics. For example, the districts are located in 20 states of which, 6 are smaller states such as Mizoram, Manipur, Sikkim, Tripura, Arunachal Pradesh and Goa, where the average populations of districts are lower than typical districts in bigger states. The population of one of the states namely, Delhi is predominantly urban. Of the two union territories where the programme is being implemented, while Chandigarh is urban, Daman and Diu are remote and rural. The population of the districts ranged from 30,000 to 41 lakhs indicating the huge variation in the population size. Similarly, the area covered ranged from 72 sq km to 9600 sq km indicating the vastness of the area to be covered in some of the districts. The number of taluks in the districts ranged from 1 to 45.

The number of Primary Health Centers varied from none to 94, the number of doctors in the general health services ranged from 3 to 635 with a nodal value of 101 and the number of health workers ranged from about 30 to as many as 1200. the availability of other health care facilities also varied widely, for e.g., the number of general practitioners varied from 0 to as large as 2900, the number of private hospitals ranged from 1 to 346 and districts in the Kerala had the largest number of practitioners and hospitals of alternate systems of medicine (range – 0 to 360).

4.3. Nodal Centre

The nature of the designated nodal centre in each state/union territory was different. While the responsibility of implementing the district mental health programme was given to well established postgraduate departments of psychiatry in states such as Rajasthan, UP, Assam, Maharashtra and Haryana, the superintendents of the mental hospital were assigned this responsibility in Kerala. In Tamil Nadu and Andhra Pradesh, department of psychiatry of the medical college is located in the mental hospital (re-designated as Institute of Mental Health) and the head of the department of psychiatry also holds the dual position as superintendent of the mental hospital. In both these states, the nodal responsibility to implement the district mental health programme was assigned to them. In many other states, the nodal responsibility rested with either the office of the Director of Health Services (e.g. Goa, Arunachal Pradesh) or with the head of the district hospital (e.g. Gujarat).

4.4. Choice of district for implementation of the programme

It was noticed that one of the factors, which contributed to the successful implementation of the programme, was the choice of district. Whenever the districts were chosen with adequate consultation and planning of logistics the programme appeared to be implemented satisfactorily (e.g. UP, Kerala, Himachal Pradesh). In states such as Maharashtra and Gujarat, the chosen districts were away from either the nodal centre or the state capital. In Madhya Pradesh, the initial district chosen was more than 800 km away from nodal office, the programme could not take off and the district had to be changed.

4.5. Personnel

Several centers faced a variety of problems in recruiting personnel for the district mental health programme based on the prescribed staff pattern of the scheme. While delays occurred in recruitment in some of the centers, most centers are unable to have the full compliment of staff even today. In 24 of the 27 centres, there is a psychiatrist with minimum qualification of DPM and in 14 of them, psychiatrist has an MD. Psychologists with a minimum qualification of MA (Psychology) were functioning in 15 centres and qualified social workers could be recruited only in 8 centres. The pattern of appointments too varied, depending on the rules of the state government. While in many centers, some or all of the staff were deputed from the regular government service to work in the district mental health programme, in others they were recruited on 'contract basis'. Recruitment rules, minimum required qualifications, rules regarding reservations, availability of persons with requisite qualifications and frequent turnover of staff were reported as major bottlenecks in availing the services of the prescribed number of staff for whom funding was provided.

4.5. Equipment, vehicle and other infrastructure

The use of electric shock treatment ? (ECT) varied from centre to centre, as psychiatrists at some district centers did use ECT an important treatment modality. ECT machines were available only in 14 centres. The cost of the ECT equipment ranged from Rs.7000/- to Rs.1,43,000/-. Similarly, the cost of resuscitation equipments acquired in different centers varied widely. All but 3 centres had purchased a vehicle for the programme. In Gujarat, the vehicle procured for the programme is a bus which is converted to function as a mobile mentl health clinic. The spending on POL varied from Rs.1,500/- to 3 lakhs.

Most centers had computers and related accessories provided by the scheme in good working condition, but their prices varied from about Rs.40,000/- to Rs.1,35,000/-. The spending on contingencies too varied widely.

4.7. Availability of medicines

in general, a minimum range of essential medicines used commonly for treatment of mental disorders were available in adequate quantities in most centers at the district clinics. Availability of medicines in taluk hospitals and PHCs varied. While there was general agreement that the budget provided for medicines was adequate, many centers reported difficulties in obtaining approvals and sanctions for purchase of drugs and the various, time consuming formalities they had to go through. In spite of these difficulties, few centers had

purchased a long list of various non-essential as well as non-psychiatric medicines. It was suggested that some of the newer anti-psychotics and anti-depressants which have lesser side effects should be included in the list of essential drugs of the programme.

4.8. Training in mental health for different categories of personnel

21 of the 27 centres had carried out training programme for district level doctors ? and the numbers trained varied from 18 to 96. The duration of the training ranged from 1 day to 2 weeks. 13 of the 27 centres had conducted training programmes for PHC personnel, particularly doctors. The total numbers trained at centers varied from 8 to 103. The faculty for the training consisted of nodal officers and other faculty of the psychiatry department to which the programme was attached. Some of the centers evaluated the training for doctors through pre and post training assessments.

In addition to doctors from the general health services, some centers had trained health workers, nurses and anganwadi (ICDS) workers. School teachers were trained in mental health in 6 centres. Non-medical volunteers, professionals from the mass media and community leaders were the other categories of personnel who underwent mental health training in few of the centers. Their numbers ranged from 5 to 230 and the duration of their training varied from 1 to 5 days.

District programmes with full-fledged departments of psychiatry as their nodal centre did not have difficulties in organizing training programmes in mental health. Most centers could not carry out any follow-up after the initial training programme. No meaningful 'continued on-the-job training' or refresher training could be organized. Why?

4.9. Case records and Reporting System

Case records of various types, starting from the simple to the most detailed were maintained, particularly for patients seen at the district clinic, in different centers. There were no standard reporting formats followed at any centre. The need for a simple recording and reporting system, which can be used across all the centres, was felt. If such a system can be computerized, monitoring of the district programme all over the country could become more efficient.

4.10. I.E.C. Activities

Most of the centers had carried out a variety of educational and awareness building activities on different aspects of mental disorders and mental health. Some centers developed mental health educational and promotional materials in

active collaboration with the health education cell of the health department. Participation of other governmental agencies, voluntary organizations and philanthropists was conspicuous in some of the centers. Some of the centers were able to effectively use the local print media as well as other forms of mass media. Public talks, exhibitions, skits, street plays, use of educational slides in local movie theatres, providing information through local cable TV were methods used by some centers for I.E.C. Most centers expressed the need for centralized development and distribution of basic educational materials.

4.11. District mental health clinic

Outpatient clinical services were well established in 15 of the 27 centres, at the district hospital. In many of these district hospitals, no mental health cure of any sort existed prior to the starting of the district mental health programme. In 8 of the centers, the outpatient clinic was conducted daily, while in the rest, the clinic was held either on alternate days or once in 3 days. The number of new patients seen during the first year of the clinic varied from a low 4 to 2500 and the number of follow-ups during a year varied from about 10 to more than 17,000. Patients and family members interviewed by the members of the evaluation team at every centre where district level clinics were functioning testified to alleviation of their symptoms and general satisfaction with the availability of mental health services, closer to their homes. Family members reported improvement in functioning and coping of their sick relatives and improvement in the overall quality of life of the whole family. Scrutiny of records showed that the demand on services as well as utilization of services was steadily increasing. The overall coverage of services seemed to be expanding. None of the centres reported about the shortage of funds for medications. the availability of free drugs for patients added to the value of the clinical services. It seemed to contribute to regular follow-up as well as recovery particularly in psychiatric patients.

4.12. In patient facility at the district hospital

Starting of a 10-bedded inpatient facility at the district hospital is an important component of the district mental health programme. 14 of the 27 centres had established the 10-bedded inpatient facility. While in few centers either exclusive wards or specially designated sections of wards were available for psychiatric inpatients, most centers admitted psychiatric patients along with other patients in general medical wards. The starting of the inpatient facility at the district hospital seemed to have contributed substantially to reductions of stigma towards mentally ill persons. The number of patients admitted during the first

year ranged from 8 to 350 with the duration of stay of patients ranging from 5 to 20 days. The number of inpatients during the site visit of the expert team varied from 1 or 2 to 6 in different centers. It was reported that most centers did not have to use all the 10 beds simultaneously at any time.

4.13. Community outreach and liaison with primary health centers

Outpatient services for mentally ill persons at taluk level hospitals and/or primary health centers were established only in 6 of the 27 centres. The frequency of such clinics varied from twice weekly to few times a month. Effective participation by trained primary health centre personnel in providing services at the PHC occurred only in few centers. While many centers had trained PHC staff, they were not actively followed up. The number of PHC personnel who were motivated to regularly carry out mental health care varied. Trained PHC personnel interviewed by the expert team in some of the centers were well informed about mental health care. The number of new patients seen in peripheral health care centers varied from 5 to over 5000 and the number of follow-ups ranged from 60 to over 16,000.

4.14. Community Survey

None of the centers were able to carry out community surveys of mental disorders, as they were still involved in setting up the service components of the scheme effectively.

4.15. Overall performance of different centers

Taking into consideration the objectives of the DMHP scheme and the various components prescribed by the scheme to achieve these objectives, it can be noted that centers are functioning at different levels of efficiency contributing to different levels of outcome and effectiveness. At the negative end are two centers namely Vizianagaram district assigned to the Department of Psychiatry at Andhra Medical College in Visakhapatnam, Andhra Pradesh and Shivpuri district in Madhya Pradesh assigned to Gwalior Mansik Arogyashala. No meaningful work has even begun at these two centers. At the more positive end are centers started during the first phase of the scheme namely districts in Assam, Rajasthan, Tamil Nadu and Andhra Pradesh and some of the centers started during the subsequent phases of the scheme, most notably districts in Kerala, Uttar Pradesh, Himachal Pradesh, Haryana and the union territories of Chandigarh and Daman. While centers in Arunachal Pradesh and Punjab are as yet not adequately functioning, all the other centers have begun the programme satisfactorily and are at different levels of implementation.

A variety of factors can be attributed to the differential efficiency and effectiveness of the programme in different states/union territories. These include the motivation and commitment of the nodal officer and the programme staff, interest and administrative support of the state health authorities (which include senior officers of Directorate of Health Services, Directorate of Medical Education, Principal of Medical College, Head of the District Hospital etc.) and absence of an effective Central Support and Monitoring mechanism at the Government of India level. Funds have never been a constraint. However, accessing funds have caused problems in certain centers.

4.16. Achievement of objectives of the scheme

At the centers where the programme is functioning adequately, the objectives of the scheme have been achieved. Mental health services have been decentralized to the district level if not to the level of PHCs, from mental hospitals and medical college hospitals, with partial integration of these services with the general health services. Mental health services have been started in places where none existed. The possibility of early detection and treatment of patients within the community has been enhanced in all the districts where the programme is being implemented. The distances to which patients and their relatives have to travel have been considerably reduced. There are indications to suggest that the caseload of mental hospitals located in states where the programme is being implemented is declining. The community rehabilitation facilities for chronic mentally ill who are discharged from mental hospitals need to be developed in all the programme sites. Interaction by the expert team with a variety of sections of the population at programme sites indicate that stigma attached to mental disorders is steadily reducing. All the states where the programme is being implemented have gained experience to further plan and improve mental health services in their states.

5. Suggestions / Recommendations

5.1. The DMHP scheme should be extended for a further period of 5 years at all the existing centers as a centrally funded scheme

5.2. As a first step towards further expansion of the DMHP scheme during the X plan, the scheme should be implemented in at least one district of the states and union territories which have not taken up the scheme already. The states and union territories are – Bihar, Orissa, Karnataka, Meghalaya, Nagaland,

Jammu & Kashmir, Uttaranchal, Chattisgarh, Jarkhand, Pondichery, Andaman & Nicobar and Lakshadweep.

5.3. The states and union territories which have already requested for starting more districts in their respective states should be given priority in further expansion of the DMHP scheme all over the country.

5.4. During the next phase of the scheme, resource allocation to the districts should be proportional to the geographical size and population of the district. The budgetary provisions of the DMHP scheme should be reviewed and revised. Districts could be classified as small, medium and large and budgetary provisions could be made accordingly. Clear guidelines regarding use of funds under various budget heads with adequate autonomy and flexibility for the state level authorities should be developed. The salary of the DMHP staff should be revised appropriately with inclusion of fixed additional allowances for fieldwork at the peripheral health care institutions.

5.5. A 'central coordinating and monitoring cell' to oversee the overall development of the DMHP scheme should be set up on a priority basis. Such a support and supervisory body should have DMHP scheme as its exclusive full-time responsibility and should be handled by an individual of adequate seniority and mental health care experience. the cell should receive regular progress reports from all the centers and should monitor the scheme by periodic site visits. Adequate budget should be provided for the creation and functioning of such a cell.

5.6. An advisory group of experts with adequate mental health and public health expertise and experience should be set up to provide technical advice to the DMHP scheme. The advisory group should be given the following tasks: -

- i) Develop operational manual for DMHP
- ii) Review of priority conditions to be taken up by DMHP
- iii) Review the current content and curriculum and develop standard training programmes for health personnel
- iv) Review current infrastructure and budgetary provisions of DMHP and revise them meaningfully

- v) Revise the list of essential drugs for DMHP
- vi) Prescribe the minimum training requirements for staff to be recruited in DMHP
- vii) Assist in the development of basic IEC material for DMHP
- viii) Develop simple computerized recording and reporting format for centralized monitoring of the programme
- ix) Develop time bound target of activities to be completed by DMHP at each centre
- x) Develop a specific feasible research component in the DMHP such as Evaluation of a particular component of the programme

5.7. A revised workshop should be organized soon involving nodal officers and senior health administrators from all the states and union territories where the DMHP is ongoing to review the results and recommendations of the current evaluation of DMHP and plan future expansion of the scheme. Such a workshop could be organized at Delhi, Bangalore or one of the DMHP centers.

5.8. It is recommended that, as far as possible the nodal officer should be a trained psychiatrist and the nodal institution should be a Department of Psychiatry or an Institute of Psychiatry.

5.9. Currently there is no participation of the private sector in the DMHP. Participation by private consultant psychiatrists as well as general practitioners in the DMHP should be explored and facilitated.

5.10. Since trained psychologists and social workers may not be available easily for appointment in the DMHP, there may be a need to develop suitable specific short-term programmes for these personnel to be conducted at NIMHANS.

5.11. At all centers, it was reported that persons with various common mental disorders as well as alcohol and substance use related problems are increasingly being seen. Therefore, there is need to review the priority conditions in the DMHP and make suitable amendments. There is a need to develop feasible community based models of care for common mental disorders, alcohol and

substance use related problems which can be implemented by the general health care personnel under supervision of a psychiatrist.

5.12. It was noted that one of the weak components of the programme is the training in mental health for primary health centre doctors and its follow up. There is an urgent need to actively take up the issue of strengthening psychiatric education and training in undergraduate medical education in all the medical colleges in the country. Psychiatric teaching should be integrated with the overall medical education

5.13. It was felt that facilities for training in-service candidates as psychiatrists should be increased. The specific suggestion is to increase the DPM seats for in-service candidates so that following training they could work as personnel for DMHP.

5.14. During the next phase of development of DMHP preventive and promotive aspects of mental health should also be considered and taken up wherever possible. This could include school mental health programme, programmes with NGOs, involvement of Anganwadi teachers, etc.

6. Appendices

- I. Expert Team for Evaluation of District Mental Health Programme**
- I. Evaluation Questionnaire**

Appendix I

Expert Team for Evaluation of District Mental Health Programme

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