

XIIth Plan District Mental Health Programme

prepared by

Policy Group

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GLOSSARY :

CMHW – Community Mental Health Worker
CHC – Community Health Centre
CIT - Central Implementation Team
DMHP – District Mental Health Programme
DMHCC – District Mental Health Care Committee
IDSP – Integrated Disease Surveillance System
MHIS – Mental Health Information System
MND – Mental and Neurological Disorders
MoHFW – Ministry of Health and Family Welfare
PHC – Primary Health Centre
PwMI – Person with mental illness
TSAG – Technical Support and Advisory Group
SIT – State Implementation Team
SMHCC – State Mental Health Care Committee

I. Introduction :

1. The need for a National Mental Health Policy has been highlighted by several stakeholders over the past few years. This was again re-iterated during the consultations conducted by the Ministry on the draft Mental Health Care Bill. In response to this felt need, the Ministry of Health and Family Welfare (MoHFW) in April 2011 appointed a Mental Health Policy Group to frame a national Mental Health Policy and Plan. The Policy Group consists of 11 members from diverse backgrounds and includes mental health professionals, user and care-giver representatives, public health experts and senior officials of the MoHFW (see Appendix I for details about members of the Policy Group and the Terms of Reference of the Policy Group). MoHFW asked the Policy Group to take up the task of designing the DMHP as a matter of priority to be ready for the XIIth Plan period starting on 1st April 2012. The Policy Group was also informed that MoHFW wanted the DMHP expanded to all districts in the country, in a staggered manner, over the XIIth Five Year Plan period (April 2012 – March 2017).

2. The District Mental Health Programme (DMHP) is the flagship mental health intervention programme of the Government of India as part of the National Mental Health Programme. Starting with four districts in 1996-97, the programme covered 123 districts in the XIth Five year Plan.

The programme envisaged a decentralised community based approach to the problem including (I) training of the mental health team at the identified nodal institutes within the

State;(ii) increasing awareness about mental health problems and effective health seeking patterns; (iii) adequate provision of services to promote early detection and treatment of mental illness in the community itself with both OPD and indoor treatment and appropriate follow up measures and (iv) collecting data and experience for future planning, research and improving service provision.

The Ministry of Health and Family Welfare (MoHFW) commissioned an independent review of the DMHP in 2008. More recently, another review of DMHP was carried out by NIMHANS in 23 DMHP districts in four southern states.

Based on these reviews and other published and unpublished reports (see Appendix V) the Ministry of Health and Family Welfare (MoHFW) concluded that the DMHP required substantial changes and planned a complete overhaul of the DMHP in the XIIth Five Year Plan.

3. Mental health services in post Independent India developed through a series of policy and other experimental initiatives over the years. This has been closely linked to the development of the public sector health system, growth in medical education in the country, as well as to the expansion of knowledge regarding treatment and care options for mental illness. Specialised institutions, expansion of the private medical care sector and innovations from the voluntary sector have also contributed to the present scenario with regard to access to mental health services. Emerging circumstances such as the HIV-AIDS epidemic and the tsunami have also led to a response which has included psycho-social care.

Time line of key mental health policy and services milestones in India

Year	Milestone
1969	Mudaliar Committee recommendations on Mental Health
1974	Srivastava Committee recommendation of Community Health Volunteer (CHV) includes Mental health in scope of work
1975	Training of General practitioners in psychiatry started at NIMHANS
1976	Program of Community Psychiatry launched at NIMHANS
1975-80	Needs of rural population studied by NIMHANS in one primary health centre
1976-81	Raipur Rani project as part of WHO multi centric project on strategies for extending mental health care
1980-86	Pilot experiment to integrate Mental health into primary health care at one Primary health centre of population of 1 lac at select talukas of Bellary district

1982-84	Indian Council of Medical Research (ICMR) project at three sites tests out the NIMHANS material for training of GP in psychiatry
1984	Bellary model upscaled to entire Bellary district
1985-90	DMHP Pilot test in Bellary district
1985-87	ICMR Project – Mental Health in PHC – Solur, Karnataka
1987	ICMR-DST project at four locations in the country (Collaborative study on severe mental morbidity)
1995	Meeting of Central Council of Health
1996	Recommendation on starting mental health program at a workshop of all health administrators in Bangalore
1996-97	DMHP launched in 4 districts of the country
1997	Quality Assurance in Mental health care services report by National Human Rights Commission
1997-2000	Phased expansion of DMHP districts
1999	Mental Health agenda of World Health Organisation set; MH identified as priority for WHO's work
2001	World Health Day theme based on Mental Health
2001	World Health Report with focus on Mental Health
2003	World Health Survey involving 5 states
2007-08	DMHP in 123 districts
2008-09	Evaluation of DMHP by Indian Council of Marketing Research (ICMR) in 20 of 127 districts
2011	A review of 23 districts of four southern state DMHP conducted by NIMHANS
2012	WHO Executive Board adopts a Resolution (proposed by India, US and Switzerland) on co-ordinated health and social sector response to mental health problems

4. In Feb 2010, the MoHFW initiated the process for drafting a new mental health law to replace the existing Mental Health Act (MHA)1987. The first draft of amendments to the existing MHA 1987 were published by the MoHFW in March 2010. The MoHFW

subsequently conducted regional and national consultations with a broad range of mental health stakeholders and the revised draft of the new Mental Health Care Bill were based on the feedback received from stakeholders at these consultation meetings. The draft Mental Health Care Bill is currently sent to various Ministries for their comments before being introduced in Parliament.

5. There is still a large treatment gap in universal access to mental health care services in the country, notwithstanding the progress made. The gaps are even larger when it comes to preventive and promotive mental health programs as well as rehabilitation services for persons with severe and chronic mental illnesses. A more of the same approach will be too slow in realising the basic human rights of persons with mental illness. Hence a redesigned and revitalised DMHP will need to evolve collaborative arrangements with strong community participation, linkages with voluntary sector and civil society initiatives, with academic institutions from inter-disciplinary backgrounds. It will also utilise the private sector knowledge and skill base with adequate safeguards against commercial interests prevailing over public interests.

Process used by the Policy Group in preparing the DMHP proposal:

The Policy Group has prepared the draft DMHP document using the following inputs:

1. Documents: The Policy Group referred to reports and research papers regarding the existing DMHP which are listed in Appendix V. The Policy Group also referred to research papers, reports and opinion articles on models for delivering mental health care in resource poor settings, particularly in India. These are listed in Appendix VI.

2. Regional Review Meetings: MoHFW organized regional review meetings in 2011 with state nodal officers and district nodal officers of all DMHP districts to review the functioning of the DMHP. Members of the Policy Group attended these regional review meetings and a summary of the learning from these meetings is attached. (Appendix II).

3. Field Visits: Members of the Policy Group personally visited a few DMHP districts in different parts of the country to get first hand information about DMHP implementation issues. A summary of the findings from the field visits is attached. (Appendix III)

4. Consultations and inputs: The Policy Group received inputs from individuals and organizations on the Mental Health Policy group website, and invited persons representing different stakeholder groups to meetings. (Appendix VII).

5. Policy Group meetings and Teleconferences: The Policy Group participated in 6 face to face meetings and 10 teleconference meetings. At these meetings, discussions focussed on a range of issues concerned with the DMHP, including reviewing all the material gathered in the steps described above. Successive drafts of the proposed DMHP were discussed and revised at these meetings. A summary of these discussions is attached. (Appendix IV).

II. Key Lessons on the functioning of the DMHP in the XIth Plan

Large gaps exist in the coverage of the DMHP within the country. Although the DMHP is supposed to be active in 123 districts, it was barely functional in most districts. While the performance of the programme was not entirely satisfactory in most districts, there was an

emerging pattern of the programme functioning better in some states while in others there were no districts where the DMHP was implemented. The method of selection of the 123 districts itself resulted in a skewed distribution of DMHP districts with certain parts of the country (south and west) enjoying many DMHP districts while the north, central and north east states having comparatively fewer districts. In those districts where some services were available, these were largely restricted to psychiatric OPDs in the district hospital or, very occasionally at the Primary Health Centres. There was very little involvement of primary health workers such as ANMs (auxiliary nurse midwives) or Junior Health Assistants called Village Health Nurses (VHNs) in Tamil Nadu, Senior Health Assistants, accredited social health activists (ASHAs) or even the Medical Officers in PHCs, CHCs and taluk hospitals (primary care doctors) in the identification, treatment and follow up of persons with mental illness in nearly all districts. In summary, barring islands of good performance, the DMHP is yet to achieve its objectives. Shortages of health human resource and their inadequate training for mental health, lack of community engagement, little primary care workforce participation, poor governance, fragmentation of mental health in key ministries and departments, and overall lack of leadership and technical capacity contributed to the implementation failure in many districts.

Several key lessons were learned as a result of the process summarised above and these are organized in the following themes.

1. Lack of Public Health and Technical Capacity:

One of the barriers to the implementation of the DMHP was the inadequacy of technical support provided by the MoHFW for implementation to the States and individual DMHP districts. Technical support includes a range of inputs from establishing a mental health information system to human resource planning to implementing clinical management protocols. Non availability and amendment of guidelines without consultation or guidance were a source of confusion. Regular consultations and learning from the field also did not take place. The voices of persons with mental illness, carers and the voluntary sector were completely missing. Similarly interaction with the public health system even when it occurred was only with a certain framework vision without taking a health system or public health approach.

In the absence of uniform guidelines and technical support, the objectives of the programme were interpreted differently in different states; for example, the integration into primary health care and the desirability of specialist facilities or satellite outpatient clinics was interpreted by DMHP districts in different ways. In most places, the DMHP was reduced to specialist enabled outreach clinics rather than primary care based delivery of mental health services supported by the specialist.

There was also a lack of clarity of the goals of the DMHP. One review found that 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%). Psychiatrists and Clinical Psychologists stated the main purpose of DMHP was capacity building of the health system for mental health service delivery.

2. Fragmentation of Responsibilities for Mental Health Care:

a) Poor inter-ministerial co-ordination at the Central level: At the Central level, there is a

division of responsibilities and a lack of co-ordination between various Ministries whose remits cover aspects of mental health. Notably, rehabilitation is the responsibility of the Ministry of Social Justice & Empowerment while mental health is the responsibility of the MoHFW. Many persons with mental illness, especially those with chronic mental illness require a combination of medical treatment and rehabilitation to facilitate recovery. The lack of seamless provision of health and rehabilitation services to such individuals can be partly attributed to this separation of responsibilities towards health and rehabilitation and the lack of inter-sectoral co-ordination in the delivery of these services.

b) Poor inter-departmental co-ordination at the State Level: At the state level, the division of responsibilities within the State Departments of Health created problems for DMHP implementation. Departments of Psychiatry in Government Medical Colleges come under the Directorate of Medical Education while the Primary Health Centres are under the Directorate of Health Services or Directorate of Public Health in most states. In many states, the lack of co-ordination between these two Directorates impacted negatively on the implementation of the DMHP. Added to this was the lack of uniformity in the nodal officer for coordination of the DMHP – in some districts, it was the district surgeon, while in others it was the Head of Department of Psychiatry of the local medical college while in some places it was the principal of the medical college or the Secretary/ Commissioner of the Department of Health and Family Welfare.

c) Co-ordination difficulties at the District level: The location of DMHP with teaching centres (Dept of Psychiatry in medical colleges) was perceived by many as a barrier to integration of mental health with the general health care. The teaching centres had a limited public health perspective and little experience or incentive to work in primary health care settings. The expected technical support from medical colleges often did not materialise as they did not accept the core idea of integration of mental health with primary health care.

d) Poor co-ordination with NRHM: At the delivery level, there is a lack of coordination with the NRHM which has contributed towards the strengthening of the infrastructure in primary health care. However, in many cases, NRHM's agenda has not included mental health though this was raised at Common Review Mission (CRM) meetings. As a result, basic laboratory service such measurement of serum lithium is not available.

3. Poor information Base for planning services: Many districts implementing DMHP have reported service utilization by large numbers of patients. However it was impossible to ascertain how many individuals are using the services and have benefited from it since there is no information about regularity and clinical and functional outcomes. The NRHM has tried to develop a Health Management Information System (HMIS) through the National Health System Resource Centre (NHSRC), however mental health has not been included. There is an absence of state and central monitoring systems which reduces the accountability of the DMHP staff. Essential and periodic reviews and subsequent course correction were almost non-existent and contributed significantly to the poor performance, with the programme limping along with no spirit or scope for innovation. In addition, there is no information on outcome of the treatment or any other intervention including IEC activities.

The program design did not evolve over time based on experience gathered during implementation. For example, a key deficit noted during programme implementation was

the lack of simple treatment guidelines or algorithms that could be used by primary care health workers in identification and management of mental illness. However there was no technical support group in the DMHP to prepare and deliver such guidelines or algorithms.

Another glaring omission was the lack of focus on the rights of persons with mental illness and any work in sensitizing staff to ensure there were no rights violations during delivery of services.

4. Inconsistent fund flows:

Fund flow was identified as a major barrier to the functioning of the programme. Simultaneously there were many instances of under-utilization of funds and difficulties in accessing available funding. This is mainly due to administrative delay, difficulty in recruiting and retaining qualified mental health professionals, and low utilization in training and IEC components. State nodal officers also pointed out difficulties in fund flow due to lack of co-ordination between different directorates in State Health Departments. In most states, DMHP funds were sent to the Directorate of Medical Education while the Directorate of Public Health or Directorate of Medical Services were responsible for implementing the programme. Further, there were difficulties reported in accessing funds from the MOH even after submission of the utilisation certificates.

At times, good coordination could draw NRHM funds or the local Rogi Kalyan Samit (RKS) funds if and when psychotropic drugs exhausted but at most places, this was difficult. At the same time, indiscriminate provision of material such as ECT machines has meant their poor utilisation even if required. This is because of poor availability of support resources (psychiatrists and anaesthetists) in most cases.

5. Inadequate Human Resources and Training:

Lack of appropriate and trained human resources, rigid recruitment criteria for specialists and lack of involvement of non-specialists were identified as significant hurdles to the implementation of the programme. Simultaneously, some states identified transfers of trained medical officers as a factor leading to depletion of already scarce resources. One review identified the lack of training for the state nodal officers, programme officers and psychiatrists in the implementation of the DMHP as an important barrier in the implementation of the programme. However there are examples of good practice, for example Jammu & Kashmir, where the training of primary care doctors has worked very well.

There are also issues with the content of the training and in one review, health personnel suggested training to be done in simple language, using case studies, increasing the frequency of training and the need for refresher training. There was mixed opinion on the duration of training; the majority felt that the current duration of training to be inadequate. There is lack of training for other health professionals at the primary health level for example, community health workers and anganwadi workers. There is also a glaring absence of training for social workers on their role in the DMHP.

Training focussed largely on hard skills with little emphasis on soft skills, ethos of the programme, personal development and leadership training.

There is also a very narrow understanding of a mental health professional. Most often service delivery revolved around the medical doctor at the PHC or the district Psychiatrist,

negating the role of social workers, psychologists, ANMs/VHNs, community leaders and the non-specialist work force (see below). The role of the PHC medical officer was only to repeat the treatment or if there is an identification of new case to refer to the specialist. There is also little involvement of other primary care health workers such as ANMs, anganwadi workers etc in the DMHP programme. This uni-dimensional approach, besides hinging on an isolated medical model, focussed only on symptom reduction with medicines and not on recovery with a holistic biopsychosocial paradigm (see below). In some states, the DMHP staff (mostly psychiatrists) were absorbed by the state health services and continued in service. However anecdotal evidence suggests that social workers or clinical psychologists have not been so absorbed in the state health service. Attention is required to ensure continuity of services even beyond the program duration especially continuity of human resources.

6. Non availability of treatments :

Availability of psychotropic drugs has been noted as a problem in many districts. Internal review of the DMHP showed only 11 districts reported availability of essential drugs and their dispensing to patients while another review (ICMR, 2008) found that 75% of the districts faced difficulties in maintaining regular availability. Reasons identified for this was the lack of dedicated drug procuring mechanism for DMHP and the lack of financial authority to the nodal centre. The review done by NIMHANS reported that the drug list for management of mental health problems and epilepsy was too long and not based on any scientific rationale. The review carried out by NIMHANS also reported drug budgets being quickly exhausted because of purchasing expensive drugs.

There is little data on the availability of psychological and psychosocial treatments. In one review only 25% of 957 respondents reported access to counselling services. This may be due to unavailability of clinical psychologists and psychiatric social workers in many districts. MoHFW internal review reported that clinical psychologists were available in only 49 DMHP districts and psychiatric social workers were available in 47 DMHP districts. It was also noticed during field visits and reported by participants at the regional review meetings that psychologists and social workers were largely utilized for administrative work and had little time for clinical interventions with the clients of the programme. This may have further contributed to the lack of availability of psychological and psychosocial treatments.

7. IEC activities:

Reviews found lack of uniformity in IEC activities and complete lack of technical support for IEC. One review found only 10% of the districts utilized funds allocated for IEC activities, 20% of the districts did not utilize funds under IEC and 70% districts had only partially utilized the resources. MoHFW internal review reported that 9 DMHP districts conducted mass media activities such as TV/Radio shows and advertisements in newspapers to generate awareness while 13 DMHP districts had carried out community IEC activities such as community meetings, distribution of IEC materials and holding small group discussions. Lack of a coherent communication strategy has meant little systematic efforts to tackle poor awareness, and myths and misconceptions related to mental health.

8. Lack of integration of mental health in primary care:

About 61% of those accessing the DMHP services, 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 (the rest accessed sub-centre, mental hospital and others as

first point of contact). Even when persons with mental illness accessed the DMHP, there was no system to ensure they received evidence based treatments (in majority of cases treatment was restricted to drug treatment) or that they continued treatment until recovery. Consequently, many dropped out of treatment with the health system failing to respond appropriately.

The DMHP was not oriented to a continuing care model and hence there was little effort in actively following up patients and engage them in ongoing treatment or providing any form of community care. Thus there is a clear failure of the process of care delivery rather than the concept of public health care.

In one review, 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. This would suggest that persons with common mental illness too are accessing the DMHP services but, as mentioned above, the key interventions, such as counselling, were not available in primary health care centres. It appears that while PHC workforce recognize the importance of mental health in the community, they feel that there were many constraints to their involvement in mental health care, notably existing burden of work, inadequate facilities, lack of conducive work environment, lack of skills, incentives, and non-availability of additional resources (in particular human resources) for counselling and social support.

9. Limited Accessibility:

The ICMR review reported that over half of the patients had to travel more than 5 kms to access treatment services; 40% had to travel over 10 kms. (Table 1)

Table 1: Range of distance traveled to seek treatment for mental health care

	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

Patients also incur substantial costs to just access services. The ICMR review showed that patients spend Rs 43.5 (min Rs 10 – max Rs 250) on travel to the hospital to access services provided under the DMHP. These represent costs in 2008 when this review was completed and will have increased substantially since then. The costs above do not include loss of wages for care-giver and other opportunity costs and incidental expenses such as for food while travelling to treatment centres.

Unpublished data from one study showed that distance from the treatment centre was the most frequently cited barrier to both accessing treatment and also continuing in treatment (Thirthalli Jagdish, personal communication).

Missing links:

1. Inadequate provision of care for full range of mental illness:

Even though the burden of alcohol and substance use disorders is a major, and growing problem for communities across the country, there was no systematic provision of services for affected persons. Similarly, services for mental illness at the two extremes of life, viz. child and adolescence and older people, were notable only for their absence. One problem with these gaps is fragmentation of services between ministries; thus, alcohol and substance use services are provided under the umbrella of 'deaddiction centres', services for children with developmental disabilities are provided by the Ministry of Social Justice and Empowerment, while some school counseling services are provided by the Ministry of Human Resource Development.

2. Crisis management and in patient service:

Due to a complete lack of utilization data on inpatient services, it is difficult to comment on whether inpatient services were utilized appropriately by the DMHP. However observations during field visits suggested that inpatient use was inadequate. There was also a near total absence of any crisis intervention services in the DMHP. Other services such as ambulatory services, day care, mental health first aid are non-existent in the DMHP programme.

3. Continuing care in the community:

The DMHP does not provide any form of continuing care in the community. Consequently, the DMHP has failed to address the ongoing health and social care needs of persons with chronic and severe mental illness. This may have indirectly contributed to extended stay of patients in mental hospitals when they could be discharged with continuing support in the community and/or patients who were discharged from the mental hospitals having a relapse of illness or being lost to follow up.

The need for long term care (in the absence of primary care givers) also emerges as a dimension of continuing care. Skills development centres, employment cells, counselling centres are non existent at least partially due to a lack of trained human resources for these tasks.

4. Homeless and mental illness:

Except in a few places (eg. Delhi), the DMHP has not addressed the needs of the homeless persons with mental illness. The needs of homeless persons with mental health issues continue to be a cause of concern as a significant population of homeless people have mental health problems. Almost all metros and small towns and cities have a visible yet invisible population of homeless people, for whom life is harsh - with no access to care, rehabilitation and a life of dignity. Many homeless people are prone to sexual and physical assault and exploitation. While the Supreme Court has called for special attention to this group of vulnerable people, not much has progressed since, with a lack of concerted, organised effort across the country. Often, well intentioned officials organise mass 'round ups' and admissions into mental hospitals, in complete violation of their dignity and rights. They are also likely to end up languishing in mental hospitals in the absence of a well defined exit pathway from these hospitals.

5. Enthusiasm of health staff:

It appears that PHC teams recognize the importance of mental health in the community, but felt there were many constraints to their involvement in mental health care, notably existing burden of work, inadequate facilities, lack of conducive work environment, lack of skills, incentives, and non-availability of additional resources (in particular human resources) for counselling and social support.

6. Lack of involvement of users and care-givers:

There was a near total absence of users and care-givers in the design, implementation and monitoring of the DMHP. There was no provision for users and care-givers to question the health system or the staff when there were problems of non-availability of care, non-availability of drugs or any such problems.

7. Poor NGO and private sector participation:

Unlike RCH, TB and HIV/AIDS programs, the DMHP did not see active participation of and collaboration with NGOs. There was an absence of an organised approach to engagement with civil society actors. As a result, the bid to increase stakeholder participation failed, with several dynamic players wanting to play a role in mental health care, but not being offered an opportunity.

There is a significant private sector presence in mental health services. However the DMHP did not create any mechanism for co-ordination with the private sector in the delivery of DMHP services.

8. Disability certification:

While persons with mental illness received disability certification, the coverage was patchy and in majority of the cases, no Disability Allowance (DA) was given. The DA was also not synchronous with time and not adjusted for inflation.

The tool to determine extent of disability (IDEAS) was used variably in different districts and states, with some using 40% as cut off for those who are considered eligible for DA, while others used 60 to 80% as the cut off for eligibility for DA. The feedback from service users and care-givers was that psychiatrists gave low priority to disability certification and this added to the difficulty in accessing DA. Persons with mental illness in some states (for example, Tamil Nadu) access DA in the Mental Retardation (MR) category. There was no additional care-giver allowance for family care-givers taking care of persons with mental illness.

9. Intra and Inter-sectoral co-ordination:

At the Central level and in most states there is little intra-sectoral co-ordination. For example there is little convergence between the DMHP and the NRHM with the exception of Kerala. There is also little inter-sectoral collaboration between the Ministries of Health & Family Welfare and Social Justice and Empowerment at the Central level and between the health and social welfare departments at the state level except in Tamil Nadu. There is also an absence of DMHP collaboration with other sectors including PRIs except in Kerala.

10. Urban DMHP:

The needs, concerns and requirements in the urban areas are likely to be completely different. Modifications to the DMHP may be required to address the needs of the urban areas.

BOX 1 : Innovations at the State Level:

Tamil Nadu: Tamil Nadu has 16 DMHP districts. A full time State Nodal Officer has been provided to look after the DMHP districts. A district level Mental Health Society has been formed in all districts and District Collectors periodically review the progress of DMHP.

In 8 districts, DMHP has collaborated with the VAZNDHU KAATUVOM Project – a poverty alleviation project promoting sustainable livelihood for the Persons with Mental Disabilities through Self Help Groups (supported by the World Bank and implemented by Rural Development Department, Govt. of Tamil Nadu). Rehabilitation services are also provided through an NGO to persons with mental illness who have recovered.

Family Federations have been formed in the DMHP districts for the welfare of the Persons with Mental Disabilities.

Kerala: DMHP districts have co-ordinated with Panchayati Raj Institutions. There is also close working relationship with NRHM ASHAs in Kerala have been trained in counselling skills as the focus was on the ageing population and to some extent on mental health.

Jharkhand: A DMHP programme was started in Jamshedpur district with State Government initiative and utilising State Government funds.

Gujarat: State Government has covered 16 districts to provide mental health services on the DMHP pattern. The state Department of Health has also developed their own teaching and training materials. A 24 hours helpline ADHAR is run by an NGO with support from the specialist mental health service to provide suicide prevention services and provide ambulance services to transfer persons with mental illness from home to hospital for treatment.

III. Key Recommendations for XIIth Plan DMHP

Based on the lessons described above, the following key recommendations are made for the XIIth Plan DMHP as follows :

1. Program Management: A clear designated structure with adequate funding and trained staff for programme management at Central, State and District level to ensure efficient, timely and full implementation of the DMHP (see Section VI below).
2. Community Involvement: DMHP has explicit links to involve the local community and all

mental health stakeholders in the monitoring process (see Section XIII below). This will help promote local ownership and accountability of the DMHP. Community participation will be an intrinsic part of the DMHP and will also utilise the existing mechanisms such as the Village Health and Sanitation Committees (VHSCs)/ Swasthya Gram Samiti's; ASHAs; Roji Kalyan Samiti's/ Patient Welfare Committee.

3. Technical support: The recognition of the need for technical support to States and districts to enable effective implementation of the programme. This technical support includes 'mentoring' and access to trained experts to help districts in dealing with specific implementation difficulties and ensure fidelity to the core objectives of the programme (see Section XIV below).

4. Monitoring & Evaluation: There is recognition of the need for continuous monitoring and evaluation to enable course correction, if necessary, during the life of the programme. Inherent to this evaluation and monitoring is the provision for independent audit mechanisms to evaluate implementation of the programme and formal outcome evaluation of the programme (see Section XV below).

5. Revitalizing Human Resources: The DMHP proposes a number of different strategies to address the human resource challenges. These include: increasing the number of specialist professional numbers (psychiatrists, psychologists, psychiatric social workers); relaxing the educational requirements for specialists to address problems in recruiting staff; provision of a new cadre of community mental health workers based at the PHC level to help in identification of persons with mental illness, help people access the necessary treatment, provide basic counselling and help in accessing social benefits.

6. Continuing care: To address the continuing care needs of persons with severe and chronic mental illness, including the homeless population, there is provision for continuing care services in the community. These include home based continuing care and institutional continuing care services (see Section IX below).

7. Supply of medicines: There will be a close linkage with state level centralised drug procurement and distribution systems based on the Tamil Nadu model to ensure adequate supplies at all levels.

8. Recording and Reporting of Mental Illness: Recording of mental illnesses as per WHO guidelines will be introduced into the HMIS. Staff will have to be adequately trained for this task. It will be undertaken in a phased manner starting with states that already have the DMHP functional in a significant proportion of districts (see Section XVIII below).

9. Staggered Coverage of the entire country: There is a recognition of the need to increase coverage and improves access to mental health care. Hence the DMHP will cover all districts in the country in a staggered manner by the end of the XIIth Plan period.

10. Partnerships with academic institutions and voluntary organisations at District and State level will be encouraged, based on the rich experience already gained in several other public health areas such as the NRHM, RCH, TB, HIV-AIDS.

11. Life skills education will be promoted in collaboration with the concerned departments of education and the Sarva Shiksha Abhiyan building on what has already been done by the HIV-AIDS program.

12. Operational Research and other forms of research including participatory action research will be supported to fine tune the implementation of the DMHP in relation to differing state and district contexts.

13. Urban Areas:

a) The DMHP programme should also be implemented in urban areas of the country. Urban areas are different from rural areas in the following respects :

i) Many urban areas do not have the equivalent of the primary health centres as are present in rural areas

ii) Many persons with mental illness in urban areas seek services from general hospitals, teaching hospitals, private practitioners as there is relatively better availability of these service providers in urban areas

iii) Health care delivery models vary in different urban areas. In large urban conglomerations such as Mumbai, Delhi, Bangalore, the local municipal corporations have their own existing health care delivery systems which do not necessarily follow the structure of the public health system in rural areas.

iv) Urban areas have special and complex needs due to relative high proportion of immigrant population, homelessness and the presence of slums in urban areas. Urban living also has its own unique stresses which impacts on the mental health of the population.

b) Hence it is recommended that :

i) The DMHP will follow the principle that a district is the unit for planning and delivery of services. Districts with large urban conglomerations such as districts with Tier I and Tier II cities, funding for the district will be based on average population norms. So for example, if the average district has a population of 2 million and an urban district has a population of 12 million, it is expected that funding will proportionately increased to reflect this size of population.

ii) Different municipal authorities across country have different structures and systems for delivery of health care. Hence one model of service delivery is unlikely to suit all urban areas in the country. State Governments and the relevant municipal authorities in urban areas should collaboratively map proposed DMHP programme elements and human resources on their existing health delivery structures. For example, a general hospital run by a municipal corporation in an urban area would be the equivalent of the District general hospital in rural districts and the DMHP services proposed at the district general hospital should be mapped on the urban general hospital.

iii) Community Mental Health Worker (CMHW) proposed in the DMHP below, is also required in urban areas. Such CMHWs can be based at the equivalent urban primary health care centre (eg urban health outpost, municipal dispensary etc).

IV. Principles, Goals & Objectives of the DMHP in the XIIth Plan

1) The key **principles** underlying the programme components are as follows :

i) A **life course perspective** with attention to the unique needs of children, adolescents and adults.

ii) A **recovery perspective**, through provision of services across the continuum of care and empowerment of persons with mental illness and their care-givers.

iii) An **equity perspective** through specific attention to vulnerable groups and to ensure geographical access to mental health services

iv) An **evidence based perspective** by following established guidelines and experiences on treatments and delivery models.

v) A **health systems perspective** with clearly defined roles and responsibilities for each sector from community to district hospital and including a cascading model of capacity building and supervision.

vi) A **rights based perspective** to ensure rights of persons with mental illness are protected and respected by mental health services.

2) The **goal** of the DMHP is to improve health and social outcomes related to mental illness

3) The **primary** objective of the District Mental Health Programme is to reduce distress, disability and premature mortality related to mental illness and enhance recovery from mental illness by ensuring the availability of and accessibility to mental health care for all in the XIIth Plan period, particularly the most vulnerable and underprivileged sections of the population.

Other objectives of the DMHP are:

- a) To reduce the stigma attached towards mental illness;
- b) To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community;
- c) To increase access to preventive services to the population at risk, in particular, addressing the risk of suicide and attempted suicide;
- d) To inform the person with mental illness, their care givers, professionals and other stakeholders of the rights of persons with mental illness and ensure that rights are respected during the provision of care and services;
- e) to broad base mental health into other related programs such as RCH, SSA, work place intervention and similar;
- f) to ensure a motivating and empowering work place for staff by allowing an opportunity to improve their skills and recognition of their work;
- g) to generate knowledge and evidence related to the delivery of mental health care and services;
- h) to improve the infrastructure for mental health service delivery;
- i) To establish governance, administrative and accountability mechanisms to realise the above objectives;

V. Indicators :

Key indicators to monitor the performance of the DMHP programme are outlined below. The implementing teams at the Central and State level may choose to use some or all these indicators. The implementing teams shall set annual targets for these indicators in consultation with the Technical Support & Advisory Group (TSAG).

1. Input indicators and Process indicators (incl quality processes):

- a) The number of training programmes conducted for each category of human resources and located at various service delivery point (District Hospitals/Taluk Hospitals/CHC/PHCs).
- b) The availability of funds for mental health care in the districts where the programme is being implemented
- c) Availability of essential psychotropic drugs at various levels of the health care system as planned
- d) Number of mental health training programmes conducted as indicated in the training plan.
- e) Identification of service norms or standards
- f) Display of the services, norms or standards at each level of care.
- g) Display of the rights of persons accessing these services.
- h) Display of Grievance Redressal contact nos and procedures
- i) The number of cases of long-standing (> 1 year duration) illness who had previously not been in contact with health services and now in contact with services.
- j) The total number of cases seen per month, disaggregated by age, gender and major diagnostic categories.
- k) The evaluation by users of health services of the quality of care (for example, adequacy of time spent with the health worker, satisfaction with the explanation given regarding the symptoms, illness and treatment).
- l) Numbers of planned and surprise reviews by DMHP Team as planned.
- m) Concurrent audits as planned.
- n) Joint Review Mission as planned.
- o) Number of meetings of user and care-giver groups held at health facilities.
- p) Budget Utilization by individual DMHP districts
- q) no of SHGs and advocacy initiatives launched.
- r) increase in OPD registration to show higher help seeking behaviour

2. Output indicators and Outcome indicators:

- a) The estimated coverage of core MND based on expected number of cases and the number identified and in care.
- b) the types of interventions offered to each case, disaggregated by types of medication

and psychosocial interventions and by levels of care.

c) The number/proportion of homeless persons with mental illness and other socially or economically disadvantaged sections of the community who access the DMHP.

d) The number/proportion of persons from different economic strata, and gender, who are diagnosed with a MND who are treated at the PHC, and the number/proportion who are referred by the PHC to the District Hospital.

e) The number/proportion of persons with MND receiving continuing care services (day care centres, home based rehabilitation and short stay residential continuing care service).

f) The number of women with mental illness referred to the DMHP programme by the RCH programme.

g) The number of children receiving services at each level of care from the DMHP.

h) The number/proportion of persons with alcohol and substance use disorders receiving services at each level of care from the DMHP.

i) The number/proportion of persons with a severe MND in receipt of disability certification.

j) The number/proportion of persons with a severe MND in receipt of disability allowance.

k) The number/proportion of persons with an MND accessing service from the CMHW.

l) The number/proportion of patients reviews conducted at the PHC.

m) The number/proportion of persons with mental illness included in govt sponsored schemes that promote livelihood such as NREGS.

n) The number/proportion of persons with MND disorders receiving any form of psychosocial intervention, disaggregated by diagnostic category, age and gender.

o) Treatment adherence

p) The number/proportion of persons with MND disorders receiving any form of care for co-morbid physical health problems.

q) Relapses in persons who have had contact with the program

r) The number of suicides each year.

s) The number/proportion of persons with a MND disorder who have had a planned discharge/dropped out of care.

VI. Governance & Stewardship (Programme Implementation Teams):

The weak governance and stewardship of the district mental health care programme is recognized as one of the major barriers to scaling up the programme. In many states, the important task of leading the DMHP is characterised by a lack of leadership and accountability, poorly defined monitoring and evaluation systems, inadequate technical skills and competing alternative work commitments. The recommendations below seek to specifically address these challenges in the XIIth plan by laying out a clear plan for governance, monitoring and evaluation and research.

Governance and Stewardship Teams at different administrative levels:

Level	Key Human Resource	Qualifications & Experience	Functions
<i>Central Implementation Team (at the Ministry of Health & Family Welfare)</i>	Executive Director	Civil Servant; experience in Public Health Administration & running national health programmes	Programme in charge at the national level
	Programme Officer (Finance)	Financial management of national health programmes or social sector programmes	Ensuring fund flows to the States and districts implementing the DMHP
	Programme Officer (M&E)	Monitoring and evaluation of health programmes or national social sector programmes	Setting up and implementing monitoring and evaluation mechanisms
	Programme Officer (Operations)	Experience of managing operational aspects of national health programmes or other national programmes	To ensure all components of the programme are implemented. This includes co-ordinating the work of the TSAG, and setting up and implementing drug logistics and delivery systems to ensure essential drugs are made available
	Programme Officer (Training)	Designing and implementing training programmes for health workers	Responsible for planning and delivery of necessary training programmes for health staff
	Programme Officer (IEC)	Experience in IEC for health and/or social sector programmes	Responsible for co-ordinating the implementation of the IEC programme
<i>State Implementation Team (at the State Health Department)</i>	State Director	Experience in public health administration and running health/social sector public programmes	Programme in charge for the State

	Programme officer (Finance)	Financial management of health programmes or social sector programmes	Ensuring fund flows are received from the Centre and timely disbursement of funds to districts implementing the DMHP
	Programme Officer (M&E)	Monitoring and evaluation of health programmes or social sector programmes	Setting up and implementing monitoring and evaluation mechanisms
	Programme Officer (Operations)	Experience in operations and drug logistics and delivery in health programmes	Meeting operational requirements of districts to implement the programme & setting up and implementing drug logistics and delivery systems to ensure essential drugs are made available
	Programme Officer (Training)	Designing and implementing training programmes for health workers	Responsible for planning and delivery of necessary training programmes for health staff
	Programme Officer (IEC)	Experience in IEC for health and/or social sector programmes	Responsible for co-ordinating the implementation of the IEC programme
<i>District (at the District Hospital)</i>	District Programme Manager	Public health management (similar to the district manager in NRHM)	Administrative responsibility for implementation of the DMHP in the district
	District Mental Health Nodal Officer (Psychiatrist)	Psychiatry training or equivalent	Technical responsibility for implementation of the programme in the district

1. At the Central Level: Central Implementation Team

A Central Implementation Team to be established at the Ministry of Health and Family Welfare to ensure implementation of the DMHP. This team will be responsible for overall implementation, monitoring, arranging technical support to districts, commissioning and responding to external evaluations and service related research. The Team will also have overall responsibility for co-ordination of training activities.

The team shall consist of:

- i) DMHP Executive Director (full time): The Executive Director shall be a senior civil servant with substantive experience of public health administration and running large national health programmes. A full time Executive Director is required to fully implement the proposed expanded content and geographical spread of the DMHP.
- ii) Staff: (To be staggered according to number of districts enrolled in the DMHP. Staff may be employed on contract or seconded to the DMHP Team)
 - a) Programme Officers (Finance) (min 2 , max 4)
 - b) Programme Officers (M&E)) (min 2 , max 4)
 - c) Programme Officers (Operations including drug logistics – procurement and delivery) (min 2 , max 4)
 - d) Programme Officers (Co-ordination of Training of activities for all health professionals) (min 2, max 4)
 - e) Programme Officers (Communication) (min 2 , max 3)
 - f) Support staff (junior officers, and other office admin support, upto 8 people).

2. At the State Level: State Implementation Team

Each State shall establish a State Implementation Team within the State Health Department. The State Implementation Team shall be responsible for overall implementation of the DMHP in the State. The number and staff for each State shall be decided based on the number of districts in the state and the population of the state. The team shall consist of the following :

- i) State DMHP Director – Director level
- ii) Staff (may be seconded from other Departments or employed on contract)
 - a) Programme Officer (Finance) - 1 staff
 - b) Programme Officer (M&E) – 1 staff
 - c) Programme Officer (Operations including drug logistics) – 1 staff
 - d) Programme Officers (training logistics -planning & implementing) – 2 staff
 - e) Programme Officer (Communication) – 1 staff
 - f) Support staff – 3 people

Note: In smaller states, some of the above tasks can be combined and fewer programme officers will be required.

3. At the District Level

A full-time District Programme Manager with a background in public health management will have overall administrative responsibility for implementation of the DMHP in that district. The qualifications and experience prescribed for District Programme Manager shall be the same as for a Programme Manager in NRHM. A full-time Psychiatrist (or suitably trained medical practitioner in the absence of a psychiatrist) will provide technical leadership and support for the clinical implementation of the programme.

VII. DMHP Clinical Team

1. District Hospital Level

Sanctioned posts for the DMHP Team staff should be created at the District Hospital Level.

The DMHP team at the District Hospital shall consist of the following :

a) Psychiatrists : All DMHP districts shall appoint two full-time psychiatrists to the DMHP programme. Districts which are unable to get full-time psychiatrists are encouraged to appoint part-time psychiatrists (working half-time and paid on pro-rata basis). The part-time psychiatrists shall be free to work elsewhere after their duty hours with the DMHP Team. Where part time psychiatrists are appointed, it should be made clear to the appointees that clinical responsibility for admitted inpatients will have to remain with designated psychiatrists on a full time basis. It is recommended that Psychiatrists have an MD qualification, but if none are available, the DMHP may appoint Psychiatrists with a DPM qualification, and if not available, the DMHP in the district may appoint a medical doctor who has completed an accredited training program, for e.g. the one year training course at NIMHANS or equivalent. Salaries paid to the DMHP psychiatrists will be commensurate with qualifications and whether full-time or part-time. The salaries for the Psychiatrists and the option of appointing part time psychiatrists have been proposed taking into account difficulties in recruiting and retaining psychiatrists in the DMHP.

b) Nurses –7 Nurses shall be appointed for in-patient and outpatient care. The order of preference for appointments based on qualifications shall be as follows:

- i) Diploma/Degree in Psychiatric Nursing
- ii) Diploma/Degree in General Nursing with at least 5 years experience
- iii) Diploma/Degree in General Nursing.

The State Implementation Team shall ensure that all general nurses receive adequate skills training to work with persons with mental illness.

Nurse salaries will be commensurate based on qualifications as specified above.

c) Clinical Psychologist: Two clinical psychologists will be appointed with the following qualifications :

- i) PhD in Clinical Psychology from a recognized University or
- ii) MPhil in Clinical Psychology from a recognised University and a Masters degree in Clinical Psychology/Counselling Psychology/ Psychosocial Counselling/ Psychosocial Rehabilitation from a recognized University

If a clinical psychologist is not available, in the interim, a psychologist with BA in Psychology and appropriate clinical experience may be appointed. The State Implementation Team shall make arrangements for suitable training of such individuals at the appropriate training institution (Centres of Excellence/Department of Psychiatry at Medical Colleges/any other equivalent training institution). These individuals should also be encouraged and given preference in admission to MA/MPhil courses in clinical psychology on completing a minimum period of service with the DMHP.

Psychologist salaries shall be commensurate with the qualifications as above.

d) Psychiatric Social Worker : Four psychiatric social workers will be appointed with the following qualifications :

Post graduate qualification in Medical & Psychiatric Social Work/Mental Health Social Work from a recognized University,

If a psychiatric social worker is not available, as an interim measure, a social worker may

be appointed, the order of preference based on qualifications shall be as follows :i) Post graduate qualification in Social Work from a recognized University,

ii) Bachelors qualification in Social Work with appropriate experience. The State Implementation Team shall also make arrangement for suitable short-term training of such individuals at the appropriate training institution (Centres of Excellence/Department of Psychiatry at Medical Colleges/any other equivalent training institution). These individuals should also be encouraged and given preference in admission to post-graduate training in Psychiatric/Mental Health Social Work on completing a minimum period of service with the DMHP.

Psychiatric Social Worker salaries shall be commensurate with the qualifications as above.

Note : Recognizing the shortage of available human resources in the country, in the short term and temporarily, flexibility is also provided for inter-changing of the above posts of Clinical Psychologists and Psychiatric Social Workers. Districts have the flexibility to have either both Clinical Psychologists or Psychiatric Social Workers (depending on availability) for the posts as specified above or inter-change the posts depending on the availability fo suitable professionals, subject to approval for these changes from the State Implementation Team.

e) Programme Assistant (1 Nos)

g) M&E Officer (1 Nos)

h) Ward Assistants/Orderlies (4 Nos)

2. At the Taluk Hospital/CHC level

Note : Districts will receive funds for appointments at the Taluk Hospital/CHC only after the DMHP programme is running satisfactorily for at least 2 years at the District Hospital. The criteria used for expanding the programme to the Taluk Hospital will be as follows :

i) All staff in post at the District Hospital for at least 2 years

ii) Outreach programme (fortnightly outpatient clinics at the Taluk Hospital run by visiting psychiatrists from the District Hospital) running successfully for at least 2 years.

Districts which have fulfilled the above criteria, can apply to the State Implementation Team for funds to expand the programme to the Taluk Hospital Level. The State Implementation Team, after evaluation of the situation in the District can apply to the Central Implementation Team for release of funds for additional human resources at the Taluk Hospital/CHC as described below.

Staff at the Taluk Hospital shall consist of :

a) Medical doctor with minimum prescribed training in Psychiatry – (1 Nos). NIMHANS runs a 4 months course for medical officers. It is recommended the new Centres of Excellence should also start this course based on the curriculum designed by NIMHANS. The Central Implementation Team shall co-ordinate with NIMHANS and the Centres of Excellence to start such courses at the Centres of Excellence.

b) Clinical Psychologist (1 Nos) or a Psychiatric Social Worker (1 Nos). Districts have the flexibility to appoint either of the two speciality staff (as per qualifications described above) depending the type of work at the particular Taluk Hospital/CHC.

3. At the PHC level

i) PHC Doctor : All PHC doctors will be trained in recognition and management of common mental disorders, management of mental health emergencies, recognition of persons with severe mental disorders and their referral to Taluk/District Hospital (as may be appropriate in a particular district) and follow up of patients with Severe Mental Disorders as per treatment plan prepared by the Taluk/District Hospital. The training of the PHC doctors shall be co-ordinated and arranged by the State Implementation Team. The training shall be done by the district DMHP Team with support from visiting experts from Department of Psychiatry, Government Medical Colleges and /or Centres of Excellence (in the State if available). The training programme shall be so designed to ensure minimum competencies and combined with on job supervision and support. Training strategy will have to be designed using on-site, distance based and short residential courses to minimize disruption of routine PHC activities.

ii) Community Mental Health Worker (2 to 4 Nos): Community Mental Health Workers (CMHW, or community counsellors) are the 'front-line' mental health care providers based in each PHC. He/She will be a local resident, has studied upto Xth class and will be trained to detect mental illnesses and provide a range of psychosocial treatments for mental illness. These will include screening PHC attenders to detect depression, anxiety and alcohol abuse, brief psychological treatments and psychoeducation, problem solving counselling and adherence management for those taking medication. They will also be trained to detect probable cases of severe mental illness in community settings, and refer them to the PHC for diagnostic assessment, support families and care-givers of persons with severe mental illness, promote inclusion and challenge discrimination against people with MND and help persons with mental illness in accessing social benefits and entitlements. Each PHC will initially have an allocation of two CMHWs, one of whom will be appointed to take overall charge of the implementation of the program in that PHC. PHCs can ask for two additional CMHWs based on work-load justification. The CMHWs will be paid a monthly honorarium for their work. They will be trained by the DMHP Team in a structured training program. The Training programme shall be designed by the Central Implementation Team in consultation with the Technical Support and Advisory Group for Training based on the curricula developed for the tasks cited above. The State Implementation Team shall be responsible for implementing the training programme for these staff through appropriate institutions for training of community health workers. Regular supervision and refresher courses will be provided by the District DMHP Team, which will be combined with mental health promotion exercises for these staff.

VIII. DMHP – Clinical Services

Table of services at different levels of health care system and professionals responsible for delivery of these services

Location	Services	Professional primarily responsible for delivery of services	Professional(s) secondarily responsible for delivery of services
<i>District Hospital</i>	Outpatient services	Psychiatrist	Mental Health Nurse Clinical Psychologist Psychiatric Social Worker

			Programme assistant
	Inpatient services	Psychiatrist District Programme Manager	Mental Health Nurses Ward Assistants/Orderlies Programme assistant
	Child mental health services	Psychiatrist Clinical Psychologist	Mental Health Nurse Psychiatric Social Worker
	Collaboration with RCH services to address post partum mental disorders	Clinical Psychologist Psychiatric Social Worker	Mental Health Nurse District Programme Manager
	Specialist Counselling and Therapy services	Clinical Psychologist	Psychiatric Social Worker
	Availability and Provision of psychotropic medications	District Programme Manager State Implementation Team	Psychiatrist
	Clinical support to continuing care services	Psychiatrist Psychiatric Social Worker	
	Disability Certification	Psychiatrist Psychiatric Social Worker	
	Laboratory Services	District Programme Manager	Psychiatrist
	Interventions for persons attempting suicide	Psychiatrist Clinical Psychologist Psychiatric Social Worker	
	Support and supervision to PHC staff	Psychiatrist Clinical Psychologists Psychiatric Social Worker	Programme Manager Mental Health Nurse
	Outreach outpatients at CHC/Taluk Hospitals	Psychiatrist Mental Health Nurse Clinical Psychologist	Programme Manger (admin and managerial support)
	Capacity building and Training Activities	District Programme Manager Psychiatrist Clinical Psychologist Psychiatric Social Worker	Programme assistants

		Mental Health Nurse	
	Emergencies	Psychiatris Mental Health Nurse	
	Administrative and Managerial support to all clinical services	District Programme Manager	Programme Assistants
<i>CHC/Taluk Hospitals*</i>	Outpatients services	Medical Doctor with 4 mth training in Psychiatry Psychologist/Social Worker	
	Inpatient services	Medical Doctor with 4 mth training in Psychiatry	
	Specialist counselling services	Psychologist	
	Social support	Social Worker	
<i>PHCs</i>	Management of common mental disorders Management of mental health emergencies Referrals to District Hospitals Follow up of patients with SMD with a treatment plan drawn up by District DMHP Team	PHC Doctor	CMHW
	Identification of persons with SMD in community and mobilizing them for assessment to PHC Community based rehabilitation for persons with severe mental disorders Assist in accessing services in the community (eg day	Community Mental Health Worker (CMHW)	PHC Doctor

	care centres) Assist in accessing social benefits		
	Availability and Provision of psychotropic medications	District Programme Manager State Implementation Team	

**these services will only be available in districts after meeting criteria as outlined (VII (2) above).*

1. At the District Hospital

- i) Outpatient services for walk in patients and Referrals from the Taluk Hospital/CHC and PHCs. .
- ii) Inpatient services – provision for 10 beds (short stay admissions) for assessment and treatment. 5 Nurses at the District Hospital will be utilized for the inpatient service.
- iii) Child Mental Health Service - this includes two activities :
 - a) collaborating and training the District Health Team (of NRHM) in identifying and managing mental health problems in school children and
 - b) running an outpatient service for children with more severe mental health problems.
- iv) Collaboration with the RCH Team for post-partum Depression/ psychosis and such mental health issues: to train RCH staff in detecting at least post partum depression / psychosis, bringing these mothers to the PHC/Taluk/DH to see the CMHW/Psychologist as necessary, getting medicines by MO/Psychiatrist and/or counselling by the appropriate personnel and ensuring effective follow up of these patients.
- v) Specialist Counselling services to be provided by the Clinical Psychologist and/or Social Workers
- vi) Regular periodic assessment (at least once in 6 months) of patients in Continuing Care services (see below)
- vii) Making referrals for day centres, medium stay centres and long stay centres
- viii) Disability Certifications to be done by the Psychiatrists at the District Hospitals
- ix) Necessary laboratory services including Therapeutic Drug Monitoring for psychotropic medications.
- x) Training, supervision and support to taluk/CHC and primary health care staff at the PHCs
- xi) Interventions for persons who have survived a suicide attempt
- xii) Alcohol and Substance use disorders : Provide services for inpatient and outpatient detoxification, user/care-giver education, link users with community based alcohol/drug rehabilitation services and voluntary services such as AA/NA.

2. Outreach Services by the DMHP team based at the District Hospital : (average of 6 Taluk Hospitals/CHCs per district) The psychiatrist at the District Hospital, along with one nurse from the district hospital shall visit and conduct an outpatient clinic at each Taluk Hospital/CHC atleast once every fortnight. Districts which have a fewer number of Taluk

Hospitals/CHCs can arrange to conduct an outpatient clinic by the visiting psychiatrist at more frequent intervals (eg. Once a week). Districts may also consider using Telemedicine facilities for linking up with Taluk Hospitals/CHC for providing support and supervision to general health staff in managing mental illness.

3. At Taluk Hospital/CHC

Note : The services described below will become available at the Taluk Hospital/CHC only when appointments have been made at the Taluk Hospital/CHC, subject to conditions outlined above (see VII (2) above). Until then, only outreach services (see VIII (2) above) will be available at the Taluk Hospital/CHC.

- i) Outpatient services for walk in patients and patients referred by the PHC
- ii) Inpatient services with admissions (short stay upto 5 days) for emergencies and assessment
- iii) Medical & Social Care & Support to Continuing Care services in their area.
- iv) Counselling services (for those referred to the Psychologist by the CMHW from the PHC). CMHW may refer patients requiring specialist psychological counselling to the Psychologist at the Taluk Hospital.

4. At the PHC level

- i) Detection and primary care management of common mental disorders and alcohol use disorders
- ii) Continuing care and support to persons with severe mental disorders (SMD): This includes referral to District Hospital (and to Taluk Hospital/CHC when services are available) for SMD patients and follow up based on treatment plan drawn up by the Psychiatrist at the District Hospital (Taluk Hospital/CHC when available)
- iii) Management of mental health emergencies and referral to district/taluk hospitals as necessary
- iv) Provision of medications - All persons requiring long term medications as prescribed by the Psychiatrist at the District Hospital will be able to refill their prescriptions at regular intervals at the PHC for a duration as specified by the Psychiatrist at the District Hospital. This is convenient for patients and their care-givers, reduces opportunity costs in continuing medication and frees the psychiatrist at the District Hospital from the task of writing routine repeat prescriptions. The State Implementation Team and the District Programme Manager shall co-ordinate the drug logistics and delivery to ensure that psychotropic medicines on the Essential Drug List are available at all PHCs.
- iv) Counselling services and help with accessing social care benefits : The CMHW at the PHC will help patients (with support from psychiatric social workers based at the District and Taluk/CHC) gain access to support groups, day care facilities, higher education, vocational skills and employment facilities, certification, reservations and other benefits. CMHW are expected to make home visits for persons with SMD so that the home environment is examined, monitored and made conducive to the extent possible and to provide a range of community based rehabilitation interventions. Caregiver burden is also addressed at this point and entry in caregiver support groups is initiated. CMHW may solicit support from the panchayat groups for this activity. Access to education for children in the family, old age pension for elders in the family etc. are facilitated, to reduce the

overall burden of care and improve quality of life for patients and their families.

v) Pro-active case findings and mental health promotion and literacy activities: The CMHW will sensitise other community health workers (for e.g. ASHA) and other community stakeholders about mental illness and improve case detection of SMDs and mobilize affected persons to seek help from the PHC/district hospital as appropriate.

(vi) Home and/or family based continuing care: This includes activities listed under (ii) and (iv) above.

IX. DMHP – Continuing Care Services

A significant proportion of persons with severe and/or chronic disorders are left with residual symptoms and/or functional impairments which do not necessarily respond to pharmacological interventions. In most instances families and care-givers provide care for these individuals with little support from public health services. The need to provide care to an ill-family member can prevent care-givers from taking up employment and can lead the family into poverty. The functional impairments also contribute to stigma, discrimination and exclusion. Continuing care in the community is therefore an important aspect of service provision for this group of persons with chronic and enduring mental disorders. The DMHP has until now not addressed the needs of these persons. Hence provision for home and/or family based rehabilitation is made under services provided at the PHC (see 4 (ii), (iv) and (vi) above).

There is also a need to try different institution based models for continuing care in different parts of the country to get a better understanding of what is likely to work in different environments.

The DMHP shall therefore include the following in the XIIth Plan to be introduced in 2 districts in States with less than 15 districts and 4 districts in States with more than 15 districts.

Types of institutional continuing care services to be provided in these selected districts include the following:

- (a) Day Centres / walk in / OPD centres with vocation training and
- (b) Short stay (up to 6 months) residential continuing care

1. In the selected districts:

- a) Day Care Centre with vocational training facilities and employment support service will be set up in two taluks of the district with each day centre having a capacity for 25 person places.
- b) Residential continuing care (short stay upto 6 months): One centre each in two taluks of the district each with a capacity for 25 beds/places.

2. Long term residential continuing care: States which have successfully operated day care centres and short term rehab centres should consider establishing long stay continuing care services. These can be done in the public sector or in public-private partnerships.

3. The State Implementation Team shall decide in consultation with the State Mental Health Care Committee (SMHCC – see XIII below) the Districts where the above

continuing care services will be implemented, depending on the readiness and capacity of the districts to take up this activity. The State Implementation Team shall also have the flexibility to implement the programme in all the chosen districts simultaneously or in a staggered manner over time and the flexibility to implement all the 3 components (Home/Family based continuing care, Day Care centres, and Residential Continuing Care) or only selected components based on perceived need and availability of appropriate human resources.

4. The Technical Support and Advisory Group (TSAG- Community Action) will provide technical support to the States in design, planning and implementing the Continuing Care programme.

5. State Implementation Teams are encouraged to try different implementation models including public health run services and public private partnerships (with NGOs and other mental health providers). Each of these rehabilitation services shall receive a capital grant for infrastructure and capital and expenditure grants on capitation (per person) basis.

6. DMHP staff at the District Hospital will provide the psychiatric and medical services to persons with mental disorders enrolled in continuing care services. Medications will be provided by the District DMHP programme. In addition, each of the two facilities (day care and residential) will have dedicated staff comprising a mix of professionals (Rehab professionals, nurses, psychologist) and local persons from the community (appointed after due training).

7. The District Mental Health Care Committee (DMHCC – see XIII below) and the District DMHP team shall monitor the continuing care services in the district.

8. The Central Implementation Team (MoHFW) will commission an independent evaluation of continuing care programmes after they have been running for 2 years. Based on the results of these evaluation, the DMHP Team will propose expanding the programme to all the districts in a phased manner.

9. Training in continuing care – District DMHP teams with support from medical colleges, local colleges with departments with adequate expertise, Centres of Excellence, national educational institutions such as TISS and NGOs with experience in rehabilitation should be encouraged to start one-year Diploma and 3 month Certificate Courses in continuing care.

10. There is a need for recognition of the fact that mental illness, especially severe mental illness, is quite often long term, and that appropriate planning for intervention will need to span a longer course than is envisaged by the five year DMHP cycle. This need to transition from short term care, to well established and administratively supported long term care (that includes appropriate medical, psychological and social work services; both in-patient and outreach) remains one of the aspects that the current DMHP planning still needs to address. We hope that services for the mentally ill will continue to grow in material and professional terms, and expand to answer the complex needs of patients who suffer, and their families, in the future Plan periods.

X. Ambulance Services

108 Ambulance services will be made available to transport patients to the District Hospital in an emergency. These can be requisitioned by the Psychiatrist at the District Hospital or by the PHC Doctor in consultation with the Psychiatrist at the District Hospital. The capital costs for the Ambulances is already paid for through NRHM. Provision for operational costs based on certain number of trips per district will be made in the DMHP. The DMHP Team at the District shall provide training to Ambulance staff in managing persons with mental illnesses

XI. Drugs

Psychotropic medicines from the National Essential Drug List (EDL) will be available at all health facilities from PHC upwards free of cost. Patients should be able to get refill of long term prescriptions from the local PHC once it has been prescribed for them by the Psychiatrist at DH or MO at the Taluk Hospital (where available).

The Central Implementation Team, with the help of experts, will develop standard treatment guidelines and guidelines for rational use of medications and therapies. These guidelines shall be made available at all service delivery points (eg district hospital, taluk hospital/CHC, PHC). These guidelines will also be incorporated in the training of all relevant medical professionals working with the DMHP.

The State Implementation Team will draw up guidelines and make provision for funds for any additional drugs (not on the EDL) which may be made available at various levels of the health service. The State Implementation Team will be responsible for ensuring drug availability by co-ordinating the logistics and delivery of psychotropic drugs to the PHCs/CHC/Taluk and District Hospitals. The State Implementation Team can use the existing logistics and delivery mechanisms for this purpose.

Flexi pools available at each health facility will also be instructed to include psychotropic medicines in their list of local purchase.

XII. Preventive & Promotive Services

i) Mental Health Help Line: The Central Implementation Team will set up a National Mental Health Help line with a toll free number to provide information about the availability of services at public health facilities in their area.

ii) Suicide Prevention Programme: The State Implementation Team shall set up the service delivery components of a suicide prevention programme in the DMHP districts in the state. This programme shall include the setting up of a suicide prevention helpline to provide 24 hr helpline support, telephone counseling, encouraging people to access the available mental health services and provision of post-suicide attempt counselling to survivors. The State Implementation Team may outsource the task of running the helpline to appropriate NGOs with experience in this area. The suicide prevention program will cover components such as training for medical officers, health workers, senior health inspectors, teachers, panchayati raj institution members both at the level of village and district level, bank officers and the police department in the district. The program will include setting up of counselling centres in locations which are at risk in the district.

A national suicide prevention programme focusing on population level interventions, such as addressing methods of suicide, will be coordinated by the Central Implementation Team.

iii) Life Skills programme: Life skills training programme in DMHP districts may either be managed by the DMHP team in collaboration with educational institutions/departments or outsourced to NGO partners for implementation. It is recommended that the Central Implementation Team should look at the Life Skills programme developed by NIMHANS to use across the country with necessary modifications and changes to suit local needs. School based counselling services should also be promoted to provide early interventions for adolescents with mental health problems. The NIMHANS Life Skills programme is a uniform cascading model of imparting life skills education through the school teachers. There are standardised modules and requires the training of master trainers. The master trainers will impart training to the high school teachers who in turn will impart life skills education to 8th, 9th and 10th standard boys and girls as part of school curriculum.

The TSAG – Implementation (see XIV below) shall provide Technical Support to various State Implementation Teams for implementation of these Preventive and Promotive programmes.

XIII. Community Participation

The Central Implementation Team and the State Implementation Teams shall ensure effective community participation and supervision for the DMHP. The TSAG- Community Action (see below XIV) will provide technical support to the Central Implementation Team to suggest processes for initial facilitation and capacity development, implementation of the community participation components and involving civil society organizations in this process.

1. Community Participation

(i) *State Mental Health Care Committee (SMHCC) (to be replaced by the State Mental Health Authority as proposed in the draft Mental Health Care Bill once the Bill becomes Law):*

Note : The draft Mental Health Care Bill provides for an expanded State Mental Health Authority (SMHA) with adequate representation of all stakeholders including care-givers, users and civil society organizations. However until the draft Bill becomes law, the State Mental Health Care Committee (SMHCC) will be constituted to perform functions outlined below. When draft Mental Health Care Bill becomes law, the SMHCC shall be dissolved and all the functions of the SMHCC will be transferred to the SMHA.

The SMHCC shall be chaired by the State Health Minister, with the State Health Secretary as the Convenor and shall consist of the representatives of other relevant government departments, NGOs working in the field of mental health, care-giver representatives, user representatives and mental health professionals. Funds will be provided to the SMHCC to commission independent evaluation of the DMHP in the various districts in the State.

Functions of the State MHCC :

- (a) Monitoring and evaluation of the progress of DMHP in the State
- (b) To provide support and oversight to State Implementation Team and the DMHCCs (see below) as per need
- (c) To determine planning norms and suggested interventions for the State keeping space for innovation
- (d) To commission independent evaluations to assess progress against benchmarks
- (e) To promote convergence with other departments and seek facilitating administrative instructions for effective action across departments
- (f) To promote a culture of transparency, accountability and effectiveness by promoting community participation for example, by involving stakeholders in DMHP review process.

(ii) *District Mental Health Care Committee (DMHCC)* : The District Health Officer/Chief Medical Officer shall be the convenor of this Committee and it shall consist of representatives of the Zilla Parishad, the DMHP Team, representatives of family care-givers, marginalised groups, user representatives, CBR/DDRO, SHGs and other mental health professionals in the district. The DMHCC shall be responsible for the monitoring and mentoring of the DMHP programme in the district and the DMHCC shall meet at least 4 times a year. Specific funds for district level research and for organizing and conducting Jan Sanwads shall be made available to the DMHCC in the DMHP budget.

The DMHCC shall have the following functions and responsibilities :

- (a) Responsible for monitoring and evaluating progress of DMHP in the district.
- (b) Suggesting district specific interventions for example, interventions for suicide in a district with high suicide rates or specific interventions targeted at tribal communities in districts with high tribal population.
- (c) Nurture community processes for effective monitoring and functioning of the DMHP
- (d) Activate women's groups to ensure gender sensitive approach
- (e) Co-ordinate with other government departments and programmes to ensure that persons with mental illness get their social benefits and entitlements
- (f) Organizing public hearings and conducting health facility surveys
- (g) Plan, organize and implement district level IEC programmes
- (h) Setting up at least one user group and care-giver group in the district (see below)

(iii) *User Group*

The development of a user group, , in each district will be supported through the DMHP.

(iv) *Care-giver Group*

The development of care-giver group, , in each district will be supported through the DMHP.

(v) *Jan Sanwad – at District level*

a) These hearings will be conducted at the District levels atleast twice in a year, as events open to all, which will enable the general public and various groups and organisations to give independent feedback about the District Mental Health Programme.

b) The hearings will be announced with at least one month's public notice, with the Zilla Parishad and community organisations being entrusted with the task of publicizing the hearing.

c) Testimonies of possible denial of mental health care can be presented by individuals or groups during the hearing. Similarly testimonies by individuals who received exceptional or exemplary good care, due to dedicated work by any public health functionary can also be presented. Care will be taken to ensure confidentiality for persons with mental illness.

d) The panel for these hearings will include members of the DMHCC and civil society representatives (Community organisations, People's organisations, NGOs involved in mental health). Respondents will be the District Mental Health Team whose presence is mandated as essential.

e) The panel will take note of and recommend action regarding any cases of denial of health care; similarly it will recognize providers whom the public acknowledges as providing exemplary good services. Both kinds of recommendations will be taken up for appropriate action, and will be included in the formal service records and annual evaluation reports of the concerned persons.

f) What issues should public hearings discuss?

- People's perceptions about existing mental health care services.
- Mental Health needs of the community.
- Specific cases of denial of mental health services.
- Problems related to accessing mental health care services, especially problems faced by women or vulnerable sections of the community (for example dalits, adivasis, homeless, poor households and sexual minorities) in accessing mental health services, including possible discriminatory behaviour and lack of home based care for persons who cannot access care in the PHC/CHC/District hospital.
- Suggestions for addressing these problems.
- People's perceptions about behavior/attitude of DMHP team and their availability at the District Hospital and outreach clinics.

2. Audit

The DMHP will have concurrent audits and Joint Review Mission (as in NRHM). Annual audits of service provision (including processes, inputs) will be conducted in all DMHP

districts.

3. Citizen's Charter for Mental Health

A Citizen's Charter for Mental Health prepared by the Central Implementation Team would be prominently displayed outside all the District Hospitals and Taluk Hospitals/CHC (when services are made available there) and PHC. The Charter will include the mental health services to be given at the Hospital/Health centre and their rights in that regard including the procedure for lodging complaints. Information regarding grants received, medicines etc will also be displayed. The outcome of various monitoring mechanisms will be displayed at the District Hospital in a simple language for effective dissemination of this information.

XIV. Technical Support

1. Technical Support & Advisory Groups

The primary responsibility for providing technical support for implementation to the States and the Districts rests with the DMHP Team at the MoHFW. Two TSAGs – one for Implementation (including training and research and evaluation issues) and another for Community Action (including community participation, IEC and continuing care issues) shall be established by the DMHP Team at the MoHFW with the Executive Director as the convenor. The TSAGs shall include a pool of technical experts from the field of mental health, public health, communication and public health administration. The DMHP Team at the MoHFW shall utilise the services of the TSAGs on an as needed basis to provide technical support to the districts as and when required. On average 7 days per district per year of technical support from outside technical experts visiting the district to be budgeted (travel, per diem and honorarium costs).

State Technical Support and Advisory Groups : State Implementation teams can consider appointing a single TSAG at the state level to assist the State Implementation Team for effective implementation of the DMHP in the State.

XV. Monitoring, Evaluation and Research

The Central Implementation Team at the MoHFW will commission regular programme evaluation (audit) of the DMHP. The Central Implementation Team at MoHFW shall also commission independent outcome (impact) evaluation (illness outcome, social outcomes, economic outcomes, care-giver burden outcome quality of life outcomes) at least twice during the 5 year Plan period.

There is provision for funds, under the control of the DMHCC, for district level research and evaluation. These research funds will be utilised to conduct local district level research and evaluation on issues which are specific for the district. These district research and evaluation funds can also be utilized for district level surveys if required.

The TSAG- Implementation shall advise the Implementation Teams at the Central/State level and at the District level for planning and implementing the research and evaluation strategy.

Monitoring and evaluation is an integral component of all public health programs. These need to be carefully designed so that they are realistic, provide reliable and timely information, and can be acted upon to ensure that program goals can be achieved. Two distinct types of monitoring and evaluation activities for the DMHP as shown in the table below.

Characteristic	Audit	Impact evaluation
Goal	To monitor the progress of implementation	To evaluate the impact of the program on health outcomes
Frequency	At least quarterly; preferably monthly	At least mid-term and end-term; preferably annual
Data sources	Routine mental health information systems	Individuals concerned with the program, including health care providers, patients, family care-givers and community informants
Sample indicators	Process- number of PHC medical officers trained; number of community mental health workers Output-number of patients with different types of mental disorders registered	Return to work for persons who were unemployed due to mental illness Number of old patients, new patients, their duration of illness and number of patients who have remitted, or improved Symptom severity Incremental cost per DALY averted
Key outcomes	Coverage of services	Impact on health outcomes Cost-benefit analyses
Responsible agency	DMHP implementing agency	Independent/external evaluators

Research

The primary role for research in the context of the DMHP is to generate knowledge which will ultimately lead to achievement of the goals of the program, viz., to reduce the treatment gap (and thus the burden of mental illness) and to strengthen the human rights framework for mental health care in India. ICMR already supports clinical and epidemiological research and the DBT supports aetiological and basic science research and therefore it is recommended that the DMHP (or NMHP) should support health policy and systems research in order to provide guidance about how to increase access to cost-effective treatments. In particular, the emphasis in these priorities is to better understand how to deliver what we know works in an affordable manner, what has been referred to as 'implementation' science. Examples of key research questions include:

- To develop and evaluate mental health interventions for delivery by non-specialist health workers, a strategy referred to as 'task-sharing';
- Quantifying the treatment gap in different states and populations to enable states to prepare annual plans with realistic goals and objectives which can be reviewed regularly;
- Evaluating the effectiveness of different approaches to enabling health worker achieve, and maintain, basic competencies/skills in mental health care;
- Evaluating the effectiveness of various forms of IEC methods aimed at improving community awareness about mental illness and reducing stigma;

- Community based research from diverse stakeholders, in particular from PwMI, family members, care giver groups etc to enable states and districts to fine tune the work done by the DMHP.

The research projects should offer insights as well as pathways for change. Research questions should be further developed through a consultative process and research partners should work together through the period of the XII plan. A key challenge to implement these research priorities is that of capacity and resources to implement research. It is recommended that linkages between Centres of Excellence for Mental Health and Medical College Departments of Psychiatry with the DMHP and with technically skilled NGOs should be strengthened to ensure that priority mental health research is implemented.

Adequate budgetary provision for health services research should be made in the DMHP/NMHP programme.

XVI. Training

A rights based approach to training should be adopted. Professionals should be sensitized to rights issues of persons with care givers and family members during the training process. Training should not just happen at tertiary centres but should also be conducted at primary and secondary centres to ensure that trainees are trained in issues of relevance at the primary and secondary care level.

The Central Implementation Team at MoHFW and the State Implementation Teams will be jointly responsible for the overall co-ordination and implementation of the Training Programme. The TSAG–Implementation will provide technical support in the development of the training curriculum. Training should be provided in a decentralised manner near to the trainees usual place of work. Preference should be given to on-job training through a model of collaborative care. The District DMHP Team can play an important role in this process of training through collaborative care.

Training Modules should be developed jointly by the National Institutions in collaboration with the Centres of Excellence and a uniform set of training Modules to be used.

Training modules will be developed for the following :

- i) Medical Officers at PHC/Taluk/CHC hospitals
- ii) Community Mental Health Worker (CMHW)
- iii) Programme Managers and Programme Assistants
- iv) Psychologists and Social Workers with Bachelors' degrees recruited in areas where masters level professionals are not available
- v) Village Health and Sanitation Committee (VHSC) members, Pachayti Raj Institution members and Urban Local Bodies members and members of the District Mental Health Care Committees.

XVII. Communication Plan (IEC)

The primary purpose of the communication plan is to increase community awareness of mental health problems, rights of persons with mental illness, awareness about legislation and the availability of appropriate treatment and management of mental health problems.

The Central and State Implementation Teams will prepare National and Regional IEC plans in collaboration with the TSAG – Community Action. The District IEC plans (for the District IEC budget) will be prepared by the individual DMHCCs with support of the State Implementation Teams and the TSAG – Community Action.

Some examples of communication strategies are outlined below :

i) At the State/ Central level : Links with an ad agency (like the PSI campaign for HIV AIDS), besides Radio/ TV ads, Community radio.

ii) At the District level : Awareness /sensitization campaigns also to be conducted with the Judiciary, the police, Panchayat leaders, SHGS etc. street theatre, through faith healing centres, in PHCs etc.

XVIII. MHIS

The Central Implementation Team (MoHFW) shall commission the development of a mental health information system clearly defining the indicators, data sources and reporting protocols and this system should be fully integrated with the IDSP or other health surveillance systems. Any such information system should address the privacy and confidentiality requirements of persons with mental illness and their families and caregivers.

The Central Implementation Team (MoHFW) shall commission the development of a Telemedicine solution to be implemented for communication between the PHC and Taluk Hospital staff with the DMHP Team based at the District Hospital for referrals, discussing 'difficult' cases, getting a quick second opinion of some of the cases and training and updating health professionals.

XIX : Standards

The Central Implementation Team along with the State Implementation Teams and with support from the TSAG-Implementation shall develop standards for mental health care at various levels of the public health system.

XX. Local level Flexibility

Given the diverse needs and the variability in availability of human resources in different parts of the country, local level flexibility has been built into the programme. The local institutional mechanisms such as DMHCC also have Flexipool funds at their disposal to utilize for specific areas of local concern.

XXI. Detailed Costing

To be worked out by the Ministry of Health and Family Welfare

XXII. Programme Guide Preparation

A programme implementation guide will need to be prepared once the final DMHP plan is approved. The DMHP Team at the MoHFW with the assistance of the TSAG-Implementation can prepare this guide. The guide will assist the State DMHP Teams and also the District DMHP Teams in implementing the programme.

APPENDICES

Appendix I

Order of the Ministry of Health and Family Welfare constituting the Policy Group and Members of the Policy Group (uploaded separately on the website)

Appendix II

Summary of DMHP Regional Review Meetings organized by the Ministry of Health and Family Welfare in 2010 (uploaded on the website as a separate document)

Appendix III

Field Visit Notes

1. Vandana Gopikumar

The method and need to engage in a fact finding mission:

Somehow, I felt that all of us had similar information and knowledge based on exchanges, research studies, our own work etc. And there was something that was just not adding up. 30 years of the DMHP and some very obvious facts were being cited and recited, much of which has been consolidated in the first 2 pages of the document that Soumithra and I had circulated. Now, maybe that's all that there is or maybe we are looking only for issues around integration, human resources, lay counseling, global trends, standards, guidelines and norms resulting in inputs that are meaningful, yes, but not wholesome and robust enough to make a concrete difference.

So what was the plan?

To engage in a fact finding mission with different approaches by different people, in a random yet purposeful fashion to see if we picked up ideas, feedback different from the obvious and oft repeated. This attempted to be a serious, planned, strategic initiative but lacked the research rigor one may expect. The method was to meet different cadres of human resources, visit different sites: PHCs, CHCs, Sub centres, District hospitals, Rehab homes etc.

Without discounting what some very useful research has brought to us about a few key areas including that of Lay counselors (MANAS), the gaps in the current DMHP: reviews by Dr. Kishore, Murthy etc., the experiences of PPPs: the review of Karuna Trust, other research on incidence, interventions, CMD vs. SMD, the need for wholesome rehab: RFS, SCARF studies: this task focused on a few other areas as well.

How did I go about my visits/ interactions?

Since there was far too much to be done, I focused on studying what I could access easily

and quickly based on our current work:

- The role of panchayats/ CBOS in implementing programmes at the grassroots level.
- Activity at the sub centres, PHCS, CHCS, DH in the block, panchayats we worked in. (how well or badly does the DMHP work?)
- The role of VHNs, ANMS, Docs, DMHP teams in these areas. (Human resources)
- The need for holistic services- from emergency care to rehab to long term care: based on the Banyan's own experience, interactions with clients, caregivers and various other stakeholders including NGOS from other states.
- The role of the PH system.
- The role of administration and effective management, monitoring.
- The role of tertiary care centres.
- The role of NGOS in the implementation of the DMHP.
- The role and nature of training.
- The focus on quality of care as an outcome: collaboration between different departments.

The panchayats, PHCs, villages, districts covered include:

Kangamachatiram PHC, Thiruvalluvar District

Poonamangadu PHC, Tirutani Taluk, Thiruvallur District.

Kedar PHC, Kakanur, Villipuram District.

Mangalapuram village, Kakkanur village, Kakanur Panchayat, Villipuram District.

Annaiyur PHC, Thiruvallur District.

Kanai PHC, Villipuram District.

District Hospital, Thiruvallur District.

CHN , Thirivallur District.

Kuttambakkam PHC, Thirvallur District.

Thiruvelangadu PHC, Thiruvallur District.

Harishchandrapuram village, Thiruvallur District.

DMHP draft dated 29th June 2012

Kelambakkam PHC, Kanchipuram District.

Poonjeri PHC, Kanchipuram District.

Thiruporur PHC, Kanchipuram District.

Kanchipuram DH.

Thirukazhikundram PHC.

CHengelpet Medical College.

Uttaramerur PHCs and subcentres. Kanchi Dt.

Gudavancheri PHC, Kanchipuram Dt.

Madhurantakam PHC.

Kovalam Sub centre.

Villipuram GH.

MADURAI meeting facilitated by Dr. CRS, the State Nodal Officer.

PHC docs (30) from Dindigul, Kanyakumari, Thirunelveli, Madurai, Ramnad, Virudunagar Districts.

DMHP teams / psychiatrists from Ramnad, Madurai, Dindigul, Usilampatti, .

Rajaji hospital (DH) Madurai. Met with the Dean, head of Dept. of Psych, Other Profs of Psych, the psychologist etc.

Madurai Medical College.

Training college Madurai.

Vocational Training centre (state run, Madurai)

Erwady Dargah and PHC

Besides this my opinions are also based on my visits/ work with IMH, Chennai, NIMHANS, Beggars Homes, B'lore and Mysore, Gumballi PHC, BR Hills, Karuna Trust, Manasa Trust, Pavlov hospital, Kolkata, Anjali, Bapu Trust, Koshish, Thane Mental Hospital, Beggar's home, Mumbai, IBHAS, Cuddalore VKP, CMC, Vellore, VKP, Vellore, ASHA, Ashadeep, AIFMI, SAA, ICTPH, Tanjore GH, Tanjore PHCS in Allakudi, Karmabayam, MH, Ahmedabad and Baroda, Yerwada, Goa MH, Missionaries of charity, Kolkata (who house the largest number of homeless people with MH issues) and quite some home / client/ family visits.

An important lesson:

What works in our environment, workspace doesn't necessarily have to be the same in other areas. So no single finding can be generalized, unless proven workable in other areas as well. Some of my earlier recommendations, particularly that of working with panchayats needs a relook. Quick visits and interactions were substituted by longer term interactions, substantive spending of time that gave us a far more detailed understanding of some real issues at the grassroots.

NOTE: While most of my recommendations/ suggestions are based on the Chennai, Thiruporur, Madurai, Panchayats, BANYAN experience, (TN based) some of my comments have also been influenced by my previous visits, interactions, meetings conducted over a period of time.

Key observations:

1. Public Health System and Integration:

Now this is primarily based on my TN knowledge/ experience. The health and development indicators are supposed to be one of the best here. Many aspects work well here. The DOTS (TB) programme works well, Malaria, Diabetes programmes are taking off fairly well. Most of the PHCS have docs between 9am and 2 pm with some of the better functioning PHCS, particularly the Block PHCs having attending docs between 8 am and 4 pm and in some cases on a 24-hour basis. The idea is that any PHC should have a 24 hour doc / VHN on call. This of course doesn't work. Common cold, fever, poisoning, and snake bites, viral infections, diarrhoea etc. are also handled at the PHC level.

However, RCH remains the priority/ focus of the PHC with clear targets being laid out for deliveries and abortions!! (1 each a day, per PHC). Maternal Mortality has decreased significantly as has Infant Mortality. The PHC primarily fulfills this obligation with the entire task force of the PHC (Doc to staff Nurse to ANM to staff nurse) contributing towards this goal.

Other problems, particularly the NCDS/ chronic ailments (CVDs, Renal problems, Road accidents/ Trauma are not looked at all with referrals to specialist hospitals / District Hospitals being the only treatment option.

In terms of infrastructure the CHCs and the PHCS are fairly clean and adequately equipped in terms of the very basics for deliveries / emergencies/ common ailments. Every 30,000 population does have a PHC. Every block usually has one main / block PHC and 3 to 4 additional PHCs depending on the size of the District/ Block. Kanchipuram for eg. Has 13 blocks. (30 lakh population) Thiruporur block where we work has 50 panchayats and 247 villages. The District has 50 PHCs, 8 Taluk hospitals and 298 sub centres in all, besides a teaching college in Chengelpet and a District Hospital in Kanchipuram.

Of course, we do realize that the PHCs are not uniformly accessible to people from a geographical point of view. Some are in areas that are well connected by transport and roads while some blocks of the same district could be remotely placed. Eg. Both in

Thiruvallur and in Kanchipuram, there are reserve forests and people in these areas need to walk at least 3-5 kms before they access a Public Health facility. There are usually only two buses that ply on these routes at fixed times. So nearly a day is lost if one has to access the clinic. Ambulatory facilities are also not available on an emergency basis. Strangely, Villipuram, Erwady (Ramnad) also have similar issues of connectivity. Only a few districts are uniformly well connected. So, accessing a health facility in the first place could be a problem in many parts; this in a state like TN.

Perception of the govt. health system fluctuates between good and bad depending on one's experience. It is rarely uniformly one or the other. One huge grievance that people have is that they are not given more than a minute each most times by the Doctor with not even as much as the BP, pulse checked. The medicines are often the same for most patients. The dignity of the client is not really preserved with not as much a seat offered. So a subtle hierarchy, attitudinal barrier is already established. This is not because one relishes this approach but because of a combination of an excessive workload, apathy and age old practice. Clients attending clinics range from 100 a day to 600, in some rare cases even 800.

There is reasonable out of pocket spending, regardless of one's socio economic background as a result of this, leading to debt and ill health related poverty traps. This obviously has an impact on one's MH as well.

Most PHCs do not treat CMDs including anxiety disorders or Post Partum Depression including those that have completed 2 DMHP terms like Madurai and Ramnad ones. They refer clients to the Taluk hospital to access the satellite / mobile clinic that the DMHP team offers and clients seem to be quite happy utilizing / following this system. While most PHC staff including VHNs and Docs are aware of repeated complaints of KKK(Kai Kaal Koduchal)/ Psychosomatic disorders, they feel paralysed by the lack of time to confirm a diagnosis and the lack of medication to treat it. PHCs are randomly picked and stocked with Psych drugs. Eg. none of the PHCs in Madurai stock Psych drugs; only the Taluk and District Hospitals do. In Thiruvallur, some of the PHCs stock drugs while most don't. In kanchipuram, many stocked drugs even a while ago, but now even those in Thirupurur Block don't supply drugs. In Ramnad, only the Erwady Duragh PHC supplies drugs. So the organisation and supply is reasonably sporadic. Many have Chlorpromazine, some have Haloperidol, very few have Risperidone, most have Diazepam, and almost none have trihexyphenidyl.

We had conducted a test survey as part of an advocacy move close to 8 months ago and had moved 60 clients from our Kovalam OP to PHCs close to their homes. At that point medicines were available. Today, 26 of those clients have returned to the Banyan clinics due to unavailability of those drugs.

This discourages a patient from using / trusting this system as it unreliable/ inconsistent and hence diminishes the patient's confidence levels as well and deters them from continually using the system.

If you look at the profile of districts I'm looking at, it's a combination of DMHP (Kanchi, Thiruvallur) – introduced recently, Madurai, Ramnad (OLD DMHP), Villipuram, Dindigul, Tanjore (No DMHP) etc.

Some of the better feedback came in from Madurai, Ramnad and Villipuram, Tanjore and Dindigul; all of who had dynamic leaders (CRS in the former two and DIndigul leading a team/ Psych appointed by him and a good HOD/ District Psych in Tanjore and Villipuram.)

The Sub centres are hardly used and many of those that we visited were locked, located in a crematorium, dilapidated, tucked away in a corner and unapproachable and are naturally very minimally used.

HUMAN RESOURCES:

Most of the PHC doctors had not heard of the DMHP! An exception was the Kelambakkam PHC, the Thiruporur PHC and some of the Doctors trained by by Dr. CRS's team in a few of the PHCs in Madurai, Ramnad, Virudhanagar and Erode. Most others didn't know of the existence of a MH programme, leave alone identify and treat.

Most of the PHC docs felt that MH care should be provided in IMH or in District Hospitals wherever possible. But IMH seemed to be the more used facility.

" I referred a case of substance abuse to IMH", said the PHC doc from POONmangadu. Most cases referred to IMH besides 'psychosis' was for Substance Use Disorder.

' It is unprofessional for me to prescribe psychotropic drugs'. He added.

' I don't remember clearly, but I think I had undergone a PHC training 3 years ago' said a PHC doc from Thiruvelangadu, who felt that treatment for PLMI should be provided in medical college – Psych OPS.

A lady Doctor from Kanai PHC who was aware of cases of PPD, while recommending that the DH would be the best place for treatment at the moment, felt strongly that the PHC should ideally at in the future be the point of treatment as care had to be taken to the doorstep of the client. But few were as motivated as her.

' Lack of training', ' Psychiatry not an examination subject in MBBS', ' Not our work,' ' Too much workload', " Scared of administering drugs", ' we are given 25,000 for a years medicines, we cannot buy psychiatric drugs within this.' ' We don't have simple crocin at the moment, how can we think of psych drugs' – these were some of the responses on integration, treatment at the PHC with most seeking specialist services.

Many declined seeing clients with MI and some accepted that they didn't know what to do and hence referred them to the GH in Chennai or to IMH.

The group of PHC docs I met through Dr. CRS was very articulate about some points. There were two groups, one being trained by DR. CRS (10) and the other at the Govt. Training College, Madurai. (30). While the first group though smaller in number seemed to be more inclined to identify and refer, the latter seemed quite frustrated with the current scenario. Right from unavailability of medicines to work overload to poor work conditions (accommodation, poor educational facilities for their children, no family living quarters, poor transport facilities), there were many grievances that they voiced. "

How will we take care of others when we are so poorly taken care of', they asked!

A huge roadblock not just for the docs but for the VHNS as well was the administrative work that they are bogged down with. They have to enter the same statistic in 3-4 registers and then online. They feel they spend less time on the field and on clinical work and more on their administrative duties.

On the positive side, most of the docs and the VHNS felt that in the absence of these time consuming activities, with adequate training and with better facilities, they would be able to identify and treat CMDs and PPD but over an extended period of time. For the time being most felt comfortable with referrals to the special clinics/ mobile clinics/ Dhs/ GH/ IMH. They seemed comfortable with reviews and follow up.

Interestingly Dr/ CRS 's group of 30 docs were very vocal about the importance of counseling and requested for the appointment of counselors in the clinics. They didn't feel that the VHN could take on this role as she was already overloaded.

They also mentioned that many times clinics didn't have pharmacists and the ANMS in some places played multiple roles of a nurse, pharmacist, helper etc.

Both the VHNS and the DOCS recognized the role of the family/ caregiver in identifying the illness and offering continued support and hence felt that the family needed to be empowered/ supported/ educated. They were not entirely averse to ritualistic beliefs and faith healing and advocated for an integrated approach.

They also cautioned that referrals in some cases didn't work, as the referring centres were 50-60 kms away like in the case of Kanyakumari or Dindigul. It would take a very motivated client / caregiver and care provider to ensure this happened.

Just so you are clear, a PHC doc holds various special clinics in a week on fixed days and in addition travels out to the Schools once every week to screen children.

The VHN is the community nurse and identifies pregnant women, ailments, and patients and brings them to the hospital. Her focus is also the RCH prog and she is responsible for pre natal and ante natal care, follow up, diet management, immunization and now is also responsible for follow up on eye, TB, Leprosy, communicable diseases, school health etc. Most of the VHNS are women from the community and are hence respected a lot by the comm members. There seems to be a subtle VHN/ DOC conflict in some PHCs. After 20 -25 years of service they draw 25 k which is quite a good salary in a village. The SHNs and the CHNs draw a little more. They feel that there is a lot of responsibility / work load that they carry since they are now responsible for almost every condition in the community. Entry point for a VHN is 12k. They recommend that a data entry operator take over their admin tasks. Almost all VHNS I met (close to 30) had a real issue with Admin tasks. They also spoke about how something as basic as medicines could sometimes be a problem where they would be forced to suggest the patient procures the drug from the market.

They seemed to suggest that there was unequal distribution of work between the Health Inspector (male) and them. The health Inspector who is responsible for chlorination, sanitation almost always is free most of the time and underutilized. The

tasks are also unevenly and 'unfairly' divided with more dignified tasks for the men and more laborious being handed over to the women.

I met a group of 40 to be young health inspectors, all energetic and wanting to 'serve the nation', 'procure a safe job', 'earn a Govt job/ placement' etc. There is potential here that is untapped.

The ANM is placed at the PHC and not at the Sub centre. The VHN visits the Sub centre most often for follow up.

The DMHP team: This is probably the most marginalized team working on the field. The Psychiatrists appointed in many of the districts I visited are quite dynamic, particularly in Madurai (Dr. Shivashankari), Dindigul (non DMHP) – Dr. Mahalakshmi, Ramnad- Dr. Lenin etc. Besides the psychiatrist none of the teams had a social worker. In fact the Psych OP in Rajaji Hospital that sees 30 new cases per day and has 300/400 visits over all per day has only one clinical psychologist and no social worker for the past 25 years. The psychologist of the DMHP team in Madurai and Ramnad were drawing 8, 000 Rs. which now after a huge battle is slowly being raised to 13,000RS. The social worker gets paid Rs. 5,000 and is lying vacant. Who would be willing to work under these circumstances?

ADMINISTRATIVE HURDLES:

1. The fund flow seems to be a huge issue in TN with funds flowing from the DPH (Directorate of Public Health) to the PHCs for psych drugs being of paramount concern. The DPH find MH a low priority area.
2. The DMS (Directorate of Medical Services) provides all the funding for the DMHP team. In the case of the DMHP prog that was funded by the Central Govt and has now been taken over by the State Govt, Psych posts are paid for but the posts of the psychologist, Social worker still dangles in uncertainty making it a medically skewed programme. This despite the fact that doctors and others accept and endorse the role of psycho social stressors as a prime reason for ill mental health.
3. Most of the time of the State Nodal Officer is spent chasing the JD for funding, other admin tasks. In this case the State Nodal Officer has been working without a salary for the past year.
4. Budgets from training in State Govt funded DMHP is negligible, making awareness, sensitization and refreshers almost impossible. 'The food allocation for 3 meals is Rs 70. What does anybody get for that these days for tea and three meals? So we have to raise sponsorship amounts as well', by ourselves, says a team member.

5. While some admin difficulties seem inconsequential they affect the programme hugely. ' Petrol rates have gone up. We had a ceiling of 125 litres; now with that amount we can do only 75 kms. So the number of our mobile clinics has decreased. Also since MH is a low priority, our vehicle could get taken for polio campaigns, elections or other admin tasks. What happens ultimately is that people get let down and lose faith in the system and stop accessing it'. Said a District Psychiatrist.

INNOVATIONS and Programmes that work well:

1. Ramnad has initiated many programmes including a PHC in Erwady to support the huge mental health need emerging out of the nearby dargah. We visited the PHC, which had all the medicines and a bright young doctor. Every Friday Dr. Lenin conducts Psych Clinics there. People still are found in chains in the Durgah, but there's some sort of an understanding that the authorities refer cases that they feel need medical help.
2. They have also started 11 Vocational Training Centres for the District. Interestingly these are placed in the DDRO's office as well. This works very well since the certification of disability also takes place here. It is here that many are certified temporarily so they can begin availing benefits. After a 3-year period, their status is reviewed and they are accordingly given a permanent certification if required. Clients access this centre, but what's more interesting is that Family Federations have also been formed that focus on livelihood creation in Madurai and Dindigul, besides Ramnad. This is quite like The Banyan, AIFMI, SAA, ASHA, and ACMI models. The Banyan of course caters to the most deprived (homeless and BPL), as does Ramnad.
3. Ramnad District Hospital has close to 150 new cases a month and 2000 cases in all. Like Thiruvallur, Madurai and many other districts, the SSA is very active here and the special clinics they have are well utilized by persons with Downs, CP and ID, besides other disabilities. We visited one centre in Thiruvallur, which was being run in collaboration with SPASTAN/ LIFE AID CENTRE. The special educators were very good and lots of children were present at the centre that is located within the school premises. Referrals from the PHC work well in Ramnad and Madurai but not so much in Thirvelangadu though Comm awareness campaigns have been launched. Most blocks have a SSA rehab centre being run usually in collaboration with an NGO.
4. Madurai under the leadership of CRS and Sivashankari, a bright, young Psych has started family fellowships and 22 SHGs of PLMI called Nambikkai. They have conducted awareness programmes for 3000 shgs in collaboration with DHAN foundation. They have also trained 300 Corporation schoolteachers who will focus on positive mental health, parenting and coping with stress/ life skills training for

children. This is part of larger Suicide prevention programme in Selur in collaboration with The Madurai Institute of Social Work.

5. With support from the Collector, Rehab centres for homeless people with MH issues have been initiated; but this has to comply with the MHCB, which it doesn't at the moment. However, land / building has been allotted by the corporation and the collector. So, a proactive collector can offer a lot of support. He is also encouraged to review all MH progs/ DMHP once a month.
6. A MH prog inside the prison has also been initiated like the one The Banyan runs inside Puzhal.
7. Dr. Mahalakshmi has initiated a programme for children with developmental disabilities as well as a school Adolescent MH programme in Dindigul. She has trained 300 higher secondary schools on disabilities. 210 children identified as needing psychological support out of an 89,000 population receives counseling support in schools. Various issues just as gender, alcoholism, and violence at home contribute to a disturbed state of mind. Many children move into hostels provided by the Govt to move away from a destructive environment.

EMERGING ISSUES:

Suicide is beginning to seem like an issue that one needs to pay attention to. Hanging, poisons are most common methods of dying. Besides poverty, love affairs, conflict at home, stress at school etc. are emerging as important reasons.

Alcohol and substance use disorder are the most common problems encountered by the VHNS, PHC docs, DMHP teams and certainly need a closer look. The age has come down dramatically and is now a problem that 14 year olds face. Villipuram, Madurai, Ramnad, and Thiruvallur – all face this problem and related issues. There is a close link between alcohol, violence and suicide as well. Glue sniffing, cough syrups etc. etc. are also being widely used.

Suggestions:

1. Clearly, the PH system is burdened and deficient in some ways and needs to settle down itself. Loading MH as another point on the agenda for the time being may tire the system and in the process kill the MH initiatives.
2. Maybe, we start our work in a phased manner: so set three models / approaches and suggest that the District chooses and grade it? Depending on how mature the programme is: in some cases to test something new in a fresh district may also work well. So select one district per State that will work on integration in the truest

form and check outcomes against set indicators over the next 5 years to see whether it works and what the challenges are. In TN, for e.g. it could be Madurai, which has most potential, considering CRS's presence.

3. The other two approaches could be that of the CHC/ Taluk hospital based care/ Mobile/ satellite clinic and District Hospital based care. So clients are identified by the VHN if in the community and by the PHC doc if in the clinic and referred to the CHC/ DH based on need/ urgency. For emergency care, maybe the DH / GH-PSYCH DEPT/ IMH may work better and for regular referrals the CHC may work well. All mobile clinics take place at the BLOCK PHC/ CHC. All PHC doctors and VHNS seem happy to follow this model.
4. It is my opinion that the DMHP should strengthen two areas of care while testing the third (one district in the State working on the full and complete integration model); the areas of care / intervention being the DH / CHC and the MH. If we lose this opportunity to reform the M.Hospital and don't create protocols on numbers, nature of care, culture, ethics, values, staffing, rights, infrastructure etc. we would have lost a huge opportunity. This will also influence future health seeking patterns. Remember, MHs besides providing emergency care for a period of time also offer OP services for a large number of everyday. A good way to initiate these reforms is to set tough yet realistic protocols with close monitoring, training etc. being available. The only way to do it is to initiate immediate large-scale changes on a mission mode. If this change doesn't take place, larger images / symbols will not change. And one isn't talking about being drastic and intolerant/ extremist. Also, one needs to ensure that the need of homeless people with MI is built into this. Either to be integrated into MHs or to be initiated as a separate programme under the homelessness banner. NGO participation in a formal manner in MHs should be encouraged. Similar protocols / criterion applicable to MHs should also be applicable to NGOs like The Banyan that offer similar services, so the standards are uniform.
5. Long-term care should be offered in the community and out of the MH. It is sufficient to start out with one/ two such centres per district; otherwise a parallel structure might be created unintentionally.
6. However, effort to get the SHG model of care (like the community living model of the banyan in KOvalam) should be encouraged wherever possible with no effort to forcibly stretch targets. SHGS, family federations should be empowered.

7. The Skills Development centres should operate out of the DDROS offices, SHGS, land donated by the panchayats etc. and should be extended to clients are caregivers and in an ideal world to others as well, so true integration is possible. This also destigmatises the movement and ups overall potential etc.
8. The Panchayats should not handle money. Most people (villagers, clients, caregivers, ANMS, VHNS) are not in favour of the Panchayat monitoring a home/centre. The BPL certification, NREGA access itself is apparently misused by most panchayats. We don't want the same to happen to the MH prog and people being forced to bribe them for an admission.
9. The concept of counseling: Somehow, the PHC docs were not in favour of the VHN counseling. So we have to debate over this for a while. But a counselor at this point where the focus is positive and promotive MH needs to be introduced. This should not just enable the lay counselor pick up signs and symptoms of CMDs or SMDS but should help the community focus on health eating and living, women's and children's Mental Health etc. This is an absolute necessity if we want to do anything beyond identify illness, pop pills and dole out entitlements. This can also be initiated as an outreach prog from the Block to the Panchayat village level. This can be managed by the Social worker with focus on improving the quality of life of individuals and communities. The social workers should bring together the community by creating awareness on an individual's rights to a dignified life, happiness, health and well being. This programme should run with support from the CBRW who could bring in the VT/ employment /livelihoods aspects . So the focus is to live a good life, to aspire for a full life, to foster a sense of community etc. Issues such as marital conflict, childhood trauma, gender bias, violence etc. can be handled at this point, so in a sense one battles suicide, alcoholism differently. To change the complexion of how MH operates today, one needs to introduce these counselling, good living promotive hubs. This should be tied up with the Social welfare department , the Disability Dept. the education department as well as the NREGA and ensure holistic living standards. This may seem out of the way and radical for a Health Department to initiate but will pay off hugely in the long run.
10. The NCD ASHA I feel may have quite little to do. I don't think people are going unidentified, I think the treatment is inadequate. Unless follow up also rests with her. Or a VHN where an ASHA doesn't exist ? A VHN has all details of every family and this really helps. She is also held in high esteem.
11. Awareness programmes that we initiate have to be of a different sort: while some can focus on mental illness, stigma in the conventional sense, others should focus on principles of honesty, brotherhood, unity etc . We have to go back to just speaking about such values again.

12. As of now 108, the ambulatory service doesn't extend itself to psychiatry emergencies. We should lobby and have them include this.
13. The administrative structure needs to be educated, sensitized etc. beginning from the DPH, DMS, DME to the Collector to the Judiciary, the Police and the DMHP teams, JDs, DHOs, PHC staff, VHNS etc. and this needs to be systematically organized, preferably by third parties/ NGOS etc. in collaboration with Institutes such as NIMHANS, TISS and others. This will help inject some innovation into the prog and over a year, one should be able to see changes in attitude / intent at multiple levels.
14. School Mental Health Programme should be viewed as a key area as by doing so, we are investing in our future. It should be revamped to address current concerns . Counsellors in schools should be made mandatory.
15. PHC staff should be trained to review clients periodically with at least a few essential medicines being available at the PHCs? This cadre could be trained in MH first aid.
16. Can we use technology better in training, handholding as much as in tele-medicine ? Skype trainings etc. can be initiated?
17. Like I have said earlier, leadership seems key. As does a technical hand holding, problem solving expert comm that is active and not just playing an advisory role. We need to build human resources on a mission mode and place them strategically. The younger staff seem to be more likely to deliver in the case of MH.
18. TISS are initiating skills development centres across the country. Maybe there is some synergy between what we are proposing and them. Some costs can then be saved.

So, in an ideal environment, schools offer counselling for those in need and offer life skills training for the children. The MH programme integrates diet, exercise, high ideals and values and positive thought into one's lifestyle as part of it's promotive programme through the counselling hubs – VHNS, CBRWs, Panchayats, SHGS led by the Social Worker placed at the Block/ District?

If a person is identified with PPD or a CMD, she is identified by a VHN, referred to a PHC doc who if in the model prog will treat, else will refer to the mobile / special clinic at the Taluk HQ or to the DH where he/ she will get treated, meet a counsellor, psychologist, social worker if needed. This is documented into a book which the client carries back , gets better over a period of time, goes to the PHC for a review and has the VHN following up / offering basic counseling, problem solving etc. The CBRW will then help her / him join a VT centre or an SHG and over a period of time be gainfully employed. He/ she will also be part of a peer support group and the caregivers , part of a family group.

If emergency care is needed, it could be provided either at the DH or at the MH. If admission is required for a briefer period, it could be provided at the CHC. The CBRW / VHN will ensure that the family is looked at as a whole and referred for suitable schemes such as the DA, Old age pension, NREGA etc. with support from the panchayat. The client can access the VTC at the DDRo's office if he/ she wishes to. The VHN will be substituted by a Health Inspector in case of substance use disorder. 108 will be utilized for emergency transportation.

In case of long term needs, one can access the Block level rehab centre in the community. In case the client desires to join an SHG and live in the community , that option is also available.

Wherever possible integration with other programme such as the VKP(Now Pudhu Vazhvu) is also suggested. This operates in the poorest blocks and hence helps the most vulnerable. The Police, Judiciary are sensitised and hence equipped with skills to deal with homeless people with MI, legal enquires and offer justice.

Tertiary care centres are no longer perpetrators of violence. They are treatment centres with clear and strict protocols that are balanced.

Trainings are provided on both the medical and social aspects with a lot of stress on culture and ethos.

The collector reviews the programme in his monthly review and the JD in his weekly reviews at the CHC/ DH.

The MHRC/SMHA are sensitized adequately and are empowered to engage in surprise checks, grievance redressal etc.

DMHP draft dated 29th June 2012

IEC material instead of carrying 20 year old details about the illness alone will also carry information on the rights a consumer has to access dignified care that he/ she is briefed on.

The VKP Model : How it works:

It is a poverty alleviation model with recent focus on disabilities. The Community Disability facilitator is a person with disability and is usually highly motivated. He/ she ensures that she identified people with disabilities , offers them training, opportunity to be a part of an SHG, seek employment either as part of the SHG or independently and also goes all out to ensure they can access all welfare measures. This group is now strong and has reached the most remote, poor areas. The CDF is incentivised for his/ her work additionally. This goes to show that the client/ caregiver SHGS may actually support this movement strongly.

2. Alok Sarin, Anirudh Kala and Sanjeev Jain notes

Route: Delhi (AS/SJ)-Ludhiana (AK) - Hoshiarpur- (name of CHC)-Ludhiana-Sangrur-(drug rehab)-Bhowanigarh-Chandigarh (PGIMER; GMC)-depart Delhi (AS/SJ) and Ludhiana (AK)

30 October 2011

CIVIL HOSPITAL, HOSHIARPUR

Dr Raj Kumar: trained psychiatrist, salary paid by Punjab Govt, not DMHP

Dr Garg: psychiatrist in Amritsar and nodal officer, also OST officer

Very poor records with just names and prescriptions

Patients are given a number that is valid for one month. This seems to be the practice across Punjab. Next month they are given a new number. Thus there is no continuous reference number and patients are counted several times. No continuous record is possible.

No medications are available

Several posts are lying vacant

There is a 12-14 bed unit (10 in psychiatry and some in de-addiction). 5 patients were there, including addiction, psychosis and depression.





OST: under NACO

High prevalence of injectible opiate use

Harm-reduction main focus, not addiction per-se

Has elaborate staff: outreach workers, doctors, monitoring and follow-up maintained. What is interesting is the fact that the OST programme does not seem to have too many difficulties in staff recruitment despite low salaries. So for the post of a counselor at 7000 Rs. Pm, there were 60 applicants for the interview in Hoshiarpur. Also, the momentum and energy in the OST programme was significantly different from the DMHP programme.

HOSHIARPUR CHC (NAME (Bhunga)

Doctors (lady doctor in PHC)

Does not see any patient with depression, drug dependence, substance abuse or psychosis

No psychiatric training

According to BEE Mast Ram 20 MPW, 30 ANM and 144 ASHA workers; total staff of 300 in PHC/CHC

At best they can recall about 20-30 patients who continue treatment (ever)

Also spoke to Dr Gurdarshan Singh, employed as homeopathic pharmacists at rs 8000/pm though he is an MD in homeopathy; and he also runs a practice in Hoshiarpur in the evenings.

Earlier: service provider contract for 30,000 pm, from which they are expected to employ all ancillary and support staff. This 'de-centralization' has proved very corrupt and inefficient and is being replaced by regular cadres at every level in Punjab.

ASHA roles: RCH. Immunization, birth/death registry, DOTS, cataract, family planning.

Max an ASHA worker has earned ever is 8000 in a month, usually much less.

Some ancillary staff had benefited from MH training, and had successfully sought treatment for their family members and neighbours. Folk beliefs were quite rampant, and Baba Vadhbag Singh near Una in HP was a popular destination for the mentally ill. Spoke to pharmacist Jagdish Kaur who had attended the training, and who felt clearly benefited by it and an individual level. She had been able to help a few people. As far as awareness building is concerned, the brief training certainly helps, but may not be enough to change health delivery systems in the PHC.

1 Novemebr 2011

Sangrur: population 88,000 town; 16 lakhs total

DMHP draft dated 29th June 2012

Met Prof BS Sidhu, Prof and HoD, Dept of Psychiatry, Medical College Patiala and nodal officer, took over a few months ago.

This was his first visit to the DMHP site.

It has a 14 bed psychiatry in-pt unit, but has no patients as the psychiatrist has been transferred.

In the area, there are 13 institutions (3 PHC, 4 hospitals, 6 CHC) and 20 medical officers of various specialties

The medical staffs are all full time employees of the Punjab Govt

No specific appointments under the DMHP. The psychiatrist was also a Punjab Govt employee. The other posts under the DMHP were available, but none have been utilized.

In 2008-09, there were usually 7-8 patients in the in-pt unit all the time (when the full time psychiatrist was there), and over the year more than 150 patients had been seen in the 10 bed unit.

Some records were quite detailed, and diagnosis entered included bipolar disorder, schizophrenia, OCD, trichotillomania, dissociation, recurrent depressions, delusional disorders etc. It was felt that the range of conditions required a full time specialist psychiatrist and there was enough work for this.



There are two psychiatrists in private psychiatrists' near-by who have a steady practice

NAVCHETANA DEADDICTION (near Hoshiarpur)

Displays a certificate by Dr satyendra Sharma, psychiatrist and Dr Ranbir Rana , physician as consultants available

No detoxification in-house

Operate under a two-tier system wherein acute detox is ostensibly done in a medical setting for 3 days, a certificate obtained and then admitted into the rehab facility on a voluntary basis.

No govt run detox facilities available in vicinity

Had 40 patients, some voluntary, and some 'brought', usually from a radius of 60-70 km.

License issued by social welfare and health departments, Chandigarh



BHOWANIGARH

This is a CHC, population 120,000

30 beds, total staff has 94 ASHA, 24 ANM, 14 MPW, 12 pharmacists, 10 class IV employees, 5 operation theatre assistants, 2 drivers, 11 nurses, 10 medical officers posts (2 unfilled; 4 'allopathic', 2 homeopaths, 1 ayurvedic)

None of the doctors and no ANMS or ASHA workers had any exposure to psychiatry
Two years ago, 10-12 people were trained

Many of the ASHA workers have resigned and been replaced by new ones at the moment only 72 ASHA workers were on the field. Very few referrals are received through ASHA or primary care doctors.

There was little awareness

Lack of a 'responsive' health care professionals

Sangrur: reported NIL suicides officially (apparently whole of Punjab too?!!) though everyone knows this to be inaccurate



However: ASHA workers coverage of pregnancies, benefits and care, ensuring diet supplementation, follow-up of delivery and post-natal care, including breast feeding

DMHP draft dated 29th June 2012

education; family planning as also village sanitation committee, and also DOTS and HIV/AIDs program: hospital based deliveries are sometimes several hundred in a month. In total more than 1000 ASHA workers had been trained.

Physicians complained of erratic work hours, emergency duties, having to do tasks which eg post-mortems which they are ill equipped for and lots of 'interference' and 'politics' in day to day work.

2 NOVEMBER 2011

Reality Centre: Kharadayvillage Lakhanwal drug rehab centre
Dr Harmeet at civil hospital Mohali for backup and a 3 day detox
Run on AA and NA lines

There were 65 patients, 70% willing and 30% unwilling
4 counselors available (details not very clear); usual stay 2-3 months

Was a single large room with lots of beds, completely regulated, no access outside, described the daily routine and therapy which used lots of AA principles (one day at a time; realize the rock-bottom that you have/could fall into etc)



Freedom Foundation, Charnali village, Mohali

Counselor available: had an MD in electro-homeopathy but has been working in the field for 8-10 years and had experience

Average stays 2-3 months

Is an expanding facility over several floors, communal shower rooms and toilets screened by curtains.

There were 50 people in each room/hall

Interviewed a few: one had schizophrenia and had no idea why he had been 'picked up' as he never used drugs (was on request from family was the reason); another was a physician with alcohol dependence who was also depressed following personal stressors (separation); was not on treatment for depression or any counseling for this aspect, several young 16-18 old with glue sniffing and opiate use.





The staff felt that the new street 'cut heroin' which was very expensive (1800/gm) was causing more damage.

Were told about Dr Raju (a rubber/plastic pipe was named as such) who was called upon to administer therapy when needed.

All three centres were run by ex-addicts under NA principles. The paperwork was rudimentary, and completed with an eye to licensing. For example, statements of no complaints at time of discharge were actually signed at time of admission. Also, while all files carried detox certificates, clearly detox seemed to be happening at the rehab facility.

3 NOVEMBER 2011

Brief meeting with Prof S Malhotra, PGIMER

In general sceptical about inadequately and briefly trained lay workers (washing the leaves of a tree will not improve it until you improve the roots), and felt that previous plans were relatively superficial and offered only transient benefits if at all.

Also, child services had not been covered at all, and strongly suggested increased attention to this. increasing the specialists cadre (DM, PDF) ; briefer training for 6 months or so, increasing liaison with pediatric training and making exposure to child psychiatry as part of curriculum (just like a 3 month psychiatry exposure was considered necessary for MD medicine at PGIMER).

Integration of psychiatry into health care should also occur at the level of specialists training to become effective

Other methods could include improved exposure during teachers training eg screening for development disorders, handicap etc, and include psychological ideas at every level in the education of teachers, psychologists and other professionals.

As far as the DMHP at Raipur rani was concerned: Dr Mattoo was involved in the initial period, it never took on the role of treatment for the mentally ill and after the department withdrew, it did not sustain itself in any way.

Broad agreement between Prof Malhotra and Prof Mattoo that brief training did not improve skills to improve health care in psychiatry

DISCUSSION WITH Dr D BASU ABOUT MH-GAP

Involved in adaptation of mhGAP for use in India and field trial of the same. Only

DMHP draft dated 29th June 2012

adaptation, not implementation

This was an instrument to be used only by medical staff and was not usable by non-medical staff at all

Was very sceptical about the decision trees and algorithms being used by non-medical staff in an effective manner.

What emerged in discussion was that it was likely that the impact of the tool was going to be dependent on the extent and nature of the training imparted.

(needs to be highlighted).

PROF MATTOO

Had recommended that drug deaddiction services be of two kinds: in-patient and out-patient.

However the licences have been issued as detox centres and rehab centres (as the above was interpreted]

This is quite interesting. The recommendations of the Mattoo committee and the final shape of the guidelines seems to be actually dramatically different. We need to be able to document this.

Dr RUCHIKA SHAH: TELEMEDICINE

Developing a tool for structure interview which is not symptom based, and used a machine-based diagnostic process to arrive at the diagnosis, offer interventions and treatment plans. This is a DST project. Not linked to the mh-GAP which also has similar design components.

Meeting at GMC, Chandigarh with PRAYATAN, a carer NGO

They run a daycare center, was previously permitted to run a halfway home. Project report was submitted but a 30% bribe asked for to get grant. Lack of public awareness and participation (very poor public response to mental health week or Erwadi memorial march: visiting delegation from Pakistan only supporters)

A long list of complaints from users and carers (will be sending a list later) about little face-to-face time with psychiatrists, ill trained professionals,

Why is NT act not applicable to MI

What after us??

Is HIV AIDS can be a focus for state intervention, why not SMI

Stigma of MI is quite intense

No activities in Chandigarh under the DMHP

Very poor levels of satisfaction with mental hospital, Amritsar (refuse visits on Sundays, threaten discharge if confronted, superintendent on 3 month extension cycles so no long term plans or services being developed, entirely custodial) and with PGIMER (developed a half way home but converted to cardiac centre; no interest in looking at problems of the chronic ill or family strains)

The day care centre run by the families themselves is quite useful. Offers respite, better quality of life and economic welfare

A halfway home constructed under NMHP funds was converted to Ashraya Home for destitute children, though 35 lakhs were given by DMHP

Various states differ in pension for MI of govt. employees. Himachal Pradesh does not offer this, while Punjab and Haryana do.

3. Discussion meeting with members of the National Mental Health Policy Group held on 9th November 2011 at the Richmond Fellowship Post Graduate College for Psychosocial Rehabilitation, Bangalore

Present:

- 1) Dr S Kalyanasundaram
- 2) Dr H Chandrashekar, Secretary, State Mental health Authority, Karnataka
- 3) Mr Vasudeva Murthy
- 4) Ms Dechamma Banerjee
- 5) Dr T Murali
- 6) Dr Sudipto Chatterjee
- 7) Dr Pratima Murthy
- 8) Dr Dharitri Ramaprasad
- 9) Dr Swaminath
- 10) Dr Mathew Varghese
- 11) Ms Niveditha
- 12) Dr Thelma Narayan, member, National Mental Health Policy Group
- 13) Dr Alok Sarin, member, National Mental Health Policy Group

Regrets:

Dr Jagadisha T; Dr Vivek Benegal; Dr Nirmala Srinivasan; Ms Lata Jacob, Dr Ravishankar Rao.

A meeting was convened by Dr Alok Sarin, member of the NMHP Policy Group as part of the Policy Group's review of the existing District Mental Health Programme.

The objectives of the meeting were:

- (i) sharing of the thoughts of the policy group regarding the development of appropriate rehabilitation facilities both for people living with mental illness, and for people with substance use issues in the context of the DMHP, and
- (ii) elicit feedback and suggestions on the same from the experience and expertise of people working in this field

Dr Alok Sarin chaired the meeting. The main points that were brought out in the interaction were as follows:

- Human rights violations do occur in the name of treatment of mentally ill and those with substance abuse and these are both rampant and extensive
- Practice of obtaining licenses under the Ministry of Health and Ministry of Social Justice and Empowerment creates loopholes for violators to get away
- Separate licensing for substance use treatment centres - for detoxification centres, and for rehabilitation centres is not required, this must be changed
- Getting a license is no guaranty of quality of care - there are licensed centres that provide abysmal care

- Exemplary models of care are available in the country, but the question is how replicable are these across the country
- States have no uniform rules regarding licensing procedures, manpower requirements, staff qualifications, Board of Visitors composition
- Whether distinction between deaddiction and mental illness rehabilitation centres is warranted at all
- It is important to utilize the opportunity of such consultative meetings and cash in on the global trend of more awareness regarding mental health, in order to initiate reforms in care
- Manpower shortage is a stark reality - this can be bridged by short-term training courses offered by NGOs in the rehab sector eg. Richmond Fellowship
- Training programmes need RCI (rehabilitation Council of India) approval and recognition
- DMHP - there are unutilized funds, varied performance across states/districts - a review will help to identify what has worked and introduce models of rehab care - what has had a positive impact is the felt needs of families/local communities, community involvement, training of personnel, supervision and monitoring
- Integration mental health care with primary health care is dogged by health personnel's negative attitudes to mental illnesses
- It is important to have a range of rehab care services - community-based services, day care, short-term stay and long-term stay options
- Private-public partnership must be effected - need to work out models of the partnership - example, funding from the government, centres managed by NGOs, guidelines/norms are given by the Ministry of Health, monitoring by a group of stakeholder representatives especially families and community representatives - need to work out who the monitoring group will be accountable to - make this uniform across the country
- It is paramount to have better coordination between the Ministries of health and SJE to plug the loopholes
- Whether there is a felt need for residential rehabilitation centres in rural areas
- Should there be a ceiling on the number of patients taken in at psychiatric rehabilitation centres
- With mentally ill persons, sometimes long stay institutions are misused by families to abdicate responsibility of caring for the ill person - become 'socially approved' centres of confinement

Consensus was regarding the following points:

- The learning from the existing rehabilitation facilities for drug abuse treatment, or the model of the old age homes or orphanages, is that human rights abuse is rampant, and that replicating this for people living with mental illness is certainly not desirable.
- Rehabilitation training, however, is vital, and the DMHP must be address this
- It is not essential for every district to have a residential rehabilitation centre, but some form of rehab services must be available in all districts
- The thrust is on universal coverage for basic psychiatric treatment, but the policy should not neglect rehab needs -
- Understand unmet needs in the community and then build service components to address the gap - this way, competencies can be identified and built up accordingly

- A range of rehab services can be envisaged - drop-in resource centres, out-patient facilities, day care, short-stay facilities - the idea is to extend support to families who are the ultimate caregivers in the Indian context
- Explore new and innovative models in a few pilot districts then review and replicate in other districts
- Minimal institutionalization must be allowed - the policy must limit institutional structures to being transient facilities
- Discourage long-term institutions in case of both deaddiction as well as mental illnesses
- Integrate detoxification and rehab centres in deaddiction
- The consensus within the group supported the need for separate centres for drug abuse and mental illness, while understanding that the division, was, in many ways, artefactual
- Improve existing centres and strengthen linkages instead of creating new infrastructure
- Explore the possibility of creating District Rehabilitation Centres – keeping in mind that community support and participation is essential
- Need public-private partnership - model of govt funding and NGO-run establishments, with monitoring

Monitoring mechanism needs to be well thought out.

Appendix IV

Summary of Discussions in Policy Group Meetings

The policy group has had the following meetings

Regional DMHP reviews at Goa, Srinagar, Bangalore, Ranchi and Tezpur, which were attended by PG members.

Five PG meetings at Delhi, (2) Bangalore, Ranchi and Chennai.

Five Tele meetings.

Field visits

Evidence/Information/ data -gathering, synthesis and review.

Interactions/ meetings with stakeholders – This included gathering of information from several civil sector organisations and individuals.

Besides this, the PG also invited Ms. Ratnaboli Ray, Dr. Mohan Isaac, Dr. K.S Jacob and Dr. Thirunavukarsu (President, IPS) to its meetings for guidance and expert advice. Many others have been actively contributing to the PG by sending us mails expressing concerns, offering suggestions, much of which has been systematically documented and taken up for discussion in meetings, subsequently.

The focus areas of the PG:

DMHP Plan:

Since the most critical aspect of mental health care is service provision, much of the focus of the PG is to develop a workable, implementable, mental health plan that will ensure that care is affordable, accessible and of good quality. This is very much in keeping with the vision of the original NHMP plan drafted in 1980. Despite that, even today, nearly 2/3rds of our population does not receive mental health care. As a nation, we have achieved quite some progress in terms of improved resource allocation (28 crores in the 9th plan to over 400 crores in the 11th plan.) However, inadequate (both in terms of numbers and quality) human resources and poor general health services coupled with poverty and large numbers (population) compounds the problem of mental health service delivery.

Almost all the regional reviews informed the PG that mental health services were not integrated entirely in most of the districts and that much of the interventions were provided at the District Hospital, if at all. Also, different approaches had been adopted in different regions and it was learnt that there was no one size that would fit varied and

diverse needs and contexts. While community participation was high in Kerala through the engagement of the PRIs, Tamilnadu seemed to perform better than many states because of its better overall health and social indicators. Training or the lack of it seemed to be a huge area of concern in most regions. Most of the human resources used for the implementation of the DMHP was medical in its training with allied professions of social work, psychology, counselling and even the essential community, link workers not being tapped appropriately. Also focus was primarily on hard skills, with soft skills being almost ignored. Psychosocial interventions were almost always underutilized or completely ignored. Symptom reduction and medical support seemed to be the only focus area, wherever care did exist. Linkages with other sectors such as employment, disability, education etc. seemed minimal except in a few cases such as the World Bank funded Poverty Alleviation Programme in TN and AP, which integrated the needs of people with disabilities as a thrust area. Integration/ convergence with other programmes such as the RCH seemed minimal, across most states. The tie in with tertiary centres of treatment and care was almost always absent, as they continued to be viewed as places that violated human rights grossly. Very few hospitals managed to introduce reforms and make their systems friendly and transparent. Noteworthy amongst those are Gujarat, IHBHAS and Goa. Negligible or nil technical support was provided to the DMHP teams by way of telephonic support or continued hand holding, which ideally should have emerged as an extension of the training programme. Administrative delays in transfer of funds between the centre and state Governments was also cited as a reason for delay in procuring medicines, appointing staff etc. Leadership was clearly flagged off as an issue that could make or break the programme.

So, what does the PG propose?

Much of the visioning and reviews have already indicated the areas that need focus and they can broadly be listed as:

Adequate training and continued hand holding at the work site by Centres of excellence and other such training experts/ groups/ institutions.

Focus on improved quality of life of the client vs. mere symptom reduction.

Focus, thus on inter and intra sectoral linkages, including with the departments of social welfare, disability, schemes such as the NREGA etc.

To ensure the availability of medicines in all centres and to encourage enhanced focus on counseling, befriending as themes: in order to create an environment that supports and promotes a state of overall wellbeing – i.e. focus on psycho social interventions that hinge on principles of unconditionality.

To strengthen the participation of users and caregivers in the process of recovery.

To clearly etch out roles for members of the DMHP team and to ensure greater coordination between members of the team at different levels and between the DMHP team and other health/ welfare teams.

DMHP draft dated 29th June 2012

To focus on the provision of a continuum of services and keep in mind not just treatment, but rehab needs as well.

To focus on the needs of vulnerable groups of people including women, children, the elderly, the homeless, migrants, people living in strife prone areas etc.

To address complex and difficult issues revolving around long term care etc.

To create clear protocols of operation in each location: Community, PHC, CHC, DH, Mental Hospital and Rehab centres.

To encourage civil society participation and develop criterion/ protocols to do so.

To build a clear monitoring and evaluation plan with scope for mid course correction.

To constitute a Technical Advisory team.

To influence other areas of life that influences well-being: eg. BPL status etc.

The Good News:

Based on the reviews and discussions, a broad plan was submitted to the Planning Commission for a significant increase in budgets. Mental Illness, as a result of its high disease burden and sometimes-chronic nature; and in keeping with global trends has been classified as a Non Communicable Disease (NCD) and included in the same bracket. The Ministry of Health and Family Welfare has asked for an increased outlay for the DMHP to ensure at least basic services in almost all the districts (at the moment, only 123 districts have the DMHP operational) and improved and specialized, holistic services in those regions where the programme has already proved successful. The note also summarized the need for a holistic range of services, which attempted to improve the client and caregiver's overall quality of life and ease his or her burden considerably, such that they could enjoy a full and productive life.

The Socio Political Climate:

India lobbied hard and influenced the passing of a WHO Executive Board Resolution (with U.S.A and Switzerland) that advocates for a holistic approach to mental health care and emphasizes the 'need for a comprehensive, coordinated response from health and social sectors at the country level' to deal with the Global Burden of Mental Disorders.

This resolution asks countries to increase resource allocation, focus on wellbeing, care in the community and for 'equitable access to effective programmes and health care interventions' such that persons with mental illness and disabilities can enjoy 'full and effective participation in society on an equal basis with others'. This also focuses on the need for social protection and effective poverty reduction policies.

The World Disability Report:

The World's poorest are also those with disabilities. This report establishes a clear link between poverty and the needs of people with disabilities and again stresses the need for a broader vision and focus in addressing issues of persons with disabilities.

Future Course:

Once the DMHP plan is prepared, it is the plan of the PG to engage with multiple civil society players, DMHP teams, Centres of Excellence, Users and Caregivers, thought leaders and other stakeholders (through consultations and meetings) to get their feedback and then work towards fine -tuning and finalizing the blue print for the next plan. Alongside discussions around what goes into the Policy document will begin. Much of what the UNCRPD and other such resolutions prescribe is reflected in our plans; ensuring at the same time that our reality and uniqueness is also kept in mind at all times.

Our Guiding philosophy:

We aspire to prepare a document that will reach the person at the bottom of the pyramid and provide him/ her with all the care that he/ she needs and is entitled to, as a matter of his/ her constitutional right. While care is being taken to ensure that details such as protocols, points of convergence etc. are in place; utmost care is being taken to ensure that the ethos and this philosophy is upheld. In doing so, we will leave no stone unturned to ensure that the link between a blue print and implementation are established clearly. We understand the suffering and pain that many Indians have gone through and the need to be a part of the solution. In doing so, we understand also the need to listen to the voices of all those who can contribute. We are determined to make this plan the consolidated work of multiple stakeholders.

Appendix V

Publications related to the DMHP and its evaluation

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Appendix VI :

Publications related to mental health intervention programs and projects in India

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Appendix VII

Consultations :

Persons consulted by the Policy Group

(In alphabetical order)

Mr O P Asija
Mr J S Bajwa
Dechamma Banerjee
Dr Debashish Basu
Dr B S Chavan
Dr H Chandrasekhar
Dr Sudipto Chatterjee
Dr Nimesh Desai
Mr P D Garg
Dr Nadja van Ginneken
Mr Milesh Hamlai
Dr Mohan Issac
Dr Sushrut Jadhav
Dr K S Jacob
Dr Sumit Jain
Ms Vaishnavi Jayakumar
Dr Kalpana
Dr Kalyanasundaram
Mr R P S Kapoor
Mr Krishna Kumar
Dr Savita Malhotra
Dr Manjula
Dr S K Mattoo
Col Mendiratta
Dr T Murali
Dr Pratima Murthy
Dr R S Murthy
Dr Rajesh
Dr Raju
Ms Ratnaboli Ray
Dr C S Ramasubramanian
Dr Roopali
Dr Perminder Sachdev
Dr B S Siddhu
Mr Rajbeer Singh
Dr Ruchita Shah
Dr PVSN Sharma
Mr Deepak Srivastava
Dr Satish Thapar
Dr Thara
Dr Thirunavakarasu
Ms Girija Vaidyanathan
Dr Mathew Vargehese

DMHP draft dated 29th June 2012

Dr Vijayakumar
Mr Elango
Ms Lakshmi Narsimhan
Mr Anil Vartak

Many PHC doctors, District Psychiatrists, VHNs, Service Users, Care-givers were also interviewed and offered valuable inputs