India's Country Report

Asia-Pacific Community Mental Health Development Project

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Definitions of key terms:

- *Community*: A group of individuals and families living together in a defined geographical area, usually comprising a village, town or city
- *Community mental health services*: Specialist mental health services in the community
- *DMHP*: District Mental Health Programme
- *MandaI and Zilla Parishad members*: Members of local governance committee
- *NGO's*: Non-governmental organisation including voluntary organisations
- *Taluk*: A geographical administrative area of sub-district level
- *MLAs*: Members of Legislative Assembly
- *MPs*: Members of Parliament
- *ANMs*: Auxiliary nurse midwife
- *Anganwadi worker*: the Anganwadi worker is trained in various aspects of health, nutrition and child development. The duties of the anganwadi worker are: Regular health check-ups, immunisation, health education, non-formal pre-school education.
- *Panchayat*: A unit of local government
- *Safai Karamchari*: A fourth-grade staff for assisting in cleaning etc.

1 Country Background and Mental Health System

1.1 Socioeconomic and cultural context

India is one of the oldest civilisations in the world encompassing kaleidoscopic variety and a rich cultural heritage. It has achieved multi-faceted socio-economic progress during its last fifty-nine years of Independence. India is now self-sufficient in agricultural

production, and is now the tenth most industrialised country in the world. It covers an area of 3,287,263 square kilometres, extending from the snow-covered Himalayan heights to the tropical rain forests of the south. It is the seventh largest country in the world and is divided into twenty-nine states and six union territories.

The country has always been portrayed as a land of spiritual integrity; its strong affinity with religion and mythology has been reflected time and again through various art forms and performing arts, which represent the composite culture of India. Unity in diversity is an important principle in India's national values. Religious tolerance and cultural amalgamation have given shape to a uniquely secular nation, which takes an impressive place in the global arena.

All five major racial types - Australoid, Mongoloid, Europoid, Caucasian, and Negroid are represented among the people of India.

According to the 2001 census, out of a total population of 1.028 million, Hindus constituted the majority with 80.5%, Muslims came second at 13.4%, followed by Christians, Sikhs, Buddhists, Jains, and others. The average annual exponential growth rate stood at 1.93 per cent during 1991-2001.

There are twenty-two National Languages recognised by the Constitution of India, of which Hindi is the Official Union Language. In addition there are 1,576 classified mother tongues and dialects.

The Life Expectancy Rate is 63.9 years for males and 66.9 years for females (September 2005). The Sex Ratio is 933 according to the 2001 census.

Literacy: According to the provisional results of the 2001 census, the literacy rate is 64.84 per cent: 75.26% for males and 53.67% for females.

Economic overview

Half a century after gaining independence, India has overcome all odds and achieved phenomenal standards of economic stability, courtesy of the indomitable contributions of agriculture, tourism, commerce, power, communications, science and technology, which have acted as pillars of the Indian economy. India is today one of the six fastest growing economies in the world. In 2001, the country was ranked fourth in terms of

Purchasing Power Parity (PPP). The business and regulatory environment is evolving and constantly improving. As of September 2005, the GDP per capita of India was US$ 543, and GDP composition by sectors was as follows: Services 56%, Agriculture 22%, and Industry 22%. However, as of September 2005, there was a 9.1 % unemployment rate and approximately 22.1 % population lives below poverty line.

In 2001, 55.85% of total households had electricity, 47.4% of total households had permanent housing, and 62.3% of population had access to safe drinking water.
The mean age of effective marriage for females was 20.1 years in 2003.

The Per Capita Net National Product was Rs. 25788 Crore in 2005-06.

Employment in the Organised Sector in India 2002-03:
Public 18449.0 Private: 8534.2 Total: 26983.2

Distribution of Households by Type of Houses Occupied in India (2001):
Total: 191,963,935, Permanent: 99,431,727, Semi-permanent: 57,664,327, Temporary: 34,815,619, Unclassifiable: 52,262.

1.2 Mental Health Policy

There is no separate mental health policy, however as mental health is an integral part of General Health, it is covered in the comprehensive National Health Policy (NHP 2002). As a result, a separate mental health policy was not warranted.

Section 2.13 of the NHP 2002 acknowledges that Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a significant bearing on the quality of life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith healing. Serious mental disorder conditions require hospitalisation and treatment under trained supervision. Mental health institutions in India are woefully deficient in physical

infrastructure and trained manpower. NHP 2002 will address these deficiencies in the public health sector.

Section 4.13 of NHP – 2002 envisages a network of decentralised mental health services for treating the more common disorders. The programme involves the diagnosis of common disorders and the prescription of common therapeutic drugs by general duty medical staff. The Policy proposes upgrading the physical infrastructure of mental health inpatient institutions at Central Government expense in order to secure the human rights of this vulnerable segment of society.

Equity, accessibility, delivery of services, education of health professionals, public health infrastructure, the role of local self-government institutions, standards for health care professionals, provision of drugs, information, education and communication strategies, health research, the role of the private sector, the role of civil society, ethics and human rights, inter-sectorial coordination, and alternative systems of medicine are covered in the Policy.

In accord with the Policy, the Government is implementing community-based mental health services using trained primary care physicians as the first point of contact for people with mental illness. These physicians are supervised by a psychiatrist at the district level who also serves as the first referral point. Other health workers are also trained to identify mental illnesses. General hospital psychiatry units and psychiatric hospitals provide the tertiary care services.

The National Mental Health Programme (NMHP) was launched in 1982, and reviewed during 2002 for implementation during the Tenth Five Year Plan (2002-2007) with a quantum increase in fiscal allocation from Rs 28 crore during the Ninth Plan to Rs 190 crore. It forms the basis for public mental health initiatives. The redeveloped national mental health programme aims to provide a balanced mix of closely networked services, with dedicated budgetary support for modernisation of the Government mental hospitals, strengthening of medical college departments of psychiatry, implementation of district mental health programmes in one hundred districts across the country in the first phase, focused information, education, communication (IEC) strategies, training and research.

1.3 Mental Health Funding Model

As a percentage of total expenditure on health, Government expenditure is 17.9 while private expenditure is 82.1%.

Public spending on health in India has increased from 0.22% of GDP in 1950-51 to 1.05% of GDP during the mid-1980s, and currently hovers around 0.9% of the GDP. This amounted to about 4.8 percent of the estimated Gross Domestic Product (GDP) at market prices in 2001-02. National health expenditures, when taken as a proportion of GDP at factor cost, were 5.1 percent.

Measured Levels of Expenditure on Health in India 1997-01

S. No.	Selected National Health Accounts Indicators	1997	1998	1999	2000	2001
	1	2	3	4	5	6
1	Total Expenditure on Health as % GDP	5.3	5	5.2	5.1	5.1
2	General Government expenditure on health as % of total expenditure on health	15.7	18.4	17.9	17.6	17.9
3	Private Expenditure on Health as % of total expenditure on health	84.3	81.6	82.1	82.4	82.1
4	General Govt Expenditure on Health as % of total government expenditure	3.2	3.5	3.3	3.1	3.1
5	External Resources on Health as % of total expenditure on health	2.3	2.4	2.2	2.2	0.4
6	Social Security Expenditure on Health as % of general government expenditure on health	NA	NA	NA	NA	NA
7	Out of Pocket expenditure as % of private expenditure on health	100	100	100	100	100
8	Private Prepaid Plans as % of private expenditure on health	NA	NA	NA	NA	NA

Notes:

- N.A- Not Available

Source: World Health Report 2003

Year	Health Expenditure as % of GDP			Per Capita Public Expenditure on Health (Rs)
	Revenue	Capital	Total	
2000-01	0.86	0.04	0.9	184.56
2001-02	0.79	0.04	0.83	183.56
2002-03	0.82	0.04	0.86	202.22
2003-04	0.86	0.06	0.91	214.62

Sources: Report on Currency & Finance, RBI, Various Issues; Statistical Abstract of India, Government of India, various issues; Handbook of Statistics of India, RBI, various issues quoted in Financing and Delivery of Health care services in India, NCMH, 2005

S.No.	Ultimate Source	Total Expenditure (Rupees in crores)	Share in total expenses (%)
	1	2	3
1	**Government**	26702.7	24.55
2	**Central (MOHMFW)**	3311.2	3.04
3	Health	1898.7	1.75
4	FW	1299.1	1.19
5	AYUSH	113.4	0.10
6	Other Central Ministries	2629.8	2.42
7	State	18422.7	16.94
8	Local	2339	2.15
9	**Firms**	1963.2	1.8
10	Public Enterprises	1155.8	1.06
11	Private Enterprises	807.4	0.74
12	**Social Insurance**	2564.6	2.36
13	CGHS	356.5	0.33
14	ESIS	2208.1	2.03
15	**Private Insurance**	756.9	0.7
16	**NGOs**	1768	1.63
17	**Households**	74977	68.96
18	Reimbursements	2218.3	2.04
	Total	**108732.5**[1]	**100**

Source: Background papers, Financing and Delivery of Health Care Services in India, National Commission on macroeconomics and Health, 2005 (depicted in pie chart below)

India spends 2.05% of its total health budget on mental health. The primary sources of mental health financing in descending order are tax-based, out-of-pocket expenditure by the patient or family, private insurance and social insurance.

Government funding for health services is provided both by the States and by Central Government. Services provided at Government health centres are free. Certain industrial and government organisations such as Railways, Armed forces, Government services, and Employees Insurance Schemes provide health care schemes for their employees or beneficiaries.

As mental illness is included as a disability under the Persons with Disability Act (1995) persons with mental disorders can receive disability benefits.

1.4 Mental Health Facilities and Services

Through the District Mental Health Programme (DMHP) funded by the Indian Government, mental health care is part of the primary health care system. Services are provided by primary physicians trained in diagnosing and treating common mental

illnesses, as well as severe mental disorders. Mental health care is incorporated in primary care in 125 of the 607 districts in India. It will be extended to all districts in the next few years.

Under the DMHP, primary care professionals receive regular training in mental health care. Many workshops for sensitivisation and training of programme officers, voluntary agencies, health directorate personnel and mental health professionals, have been undertaken. A range of training materials was developed and field-tested.

Mental health facilities are also available through general hospital psychiatry units of district hospitals and 271 medical colleges. In addition forty-nine mental hospitals and institutions across the country provide tertiary care mental health services. Available infrastructure in Mental Health:

Total psychiatric beds per 10,000 population 0.25
Psychiatric beds in mental hospitals per 10,000 population 0.2
Psychiatric beds in general hospitals per 10,000 population 0.05

1.5 Workforce (medical and allied health specialities)

Number of psychiatrists per 100,000 population 0.2
Number of psychiatric nurses per 100,000 population 0.05
Number of psychologists per 100,000 population 0.03
Number of social workers per 100,000 population 0.03

Number of allopathic doctors in the country is 656,111 (2005).
Total number of registered AYUSH (Ayurveda, Unani, Siddha, Naturopathy, Homeopathy) practitioners in India (2005) was 717,860.

In 2004, the number of people served per government doctor was 15,980
Number of Registered Nurses (2004): 865135 & Pharmacists (2003): 559408

No. of Doctors at PHCs	Total Specialists[1] at CHCs	Health Assistants		Health Workers	
		Male	Female(LHV)	Male	Female/ANM
21974	**3953**	**20086**	**19773**	**60756**	**138906**

Notes:

1 Total Specialists: include Surgeons, OB & GY, Physicians & Paediatricians data from Bihar, Jharkhand & UP not available. Source: Bulletin on Rural Health Statistics in India 2005. MOHFW

1.6 Training and accreditation system

Undergraduate level: Psychiatry is taught as a subject in the MBBS curriculum.
Post-graduate training in Psychiatry: This is available in the form of three years MD-Psychiatry, two years DPM courses in Institutes and medical colleges. The Medical Council of India is the regulatory body.

DNB in Psychiatry is also available and is run in medical colleges as well as general hospitals which have adequate training facilities under the regulation and supervision of National Board of Examinations.

Clinical Psychology: There is a two year M.Phil. course and a three year Ph.D. course in clinical psychology in psychiatric teaching institutions. These courses are regulated by the Rehabilitation Council of India

Psychiatric Nursing: 2 years M.Sc. Psychiatric nursing and 1 year DPN are two courses available at a few institutes. The regulating authority is the Nursing Council of India
Psychiatric Social Work: There is a two year M.Phil. course and a three year Ph.D. course in Psychiatric Social Work in a few psychiatric teaching institutions.

1.7 Role of private hospitals and providers

NGOs provide mental health programs in some parts of the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. They provide counselling, suicide prevention, training of lay counsellors, and rehabilitation

programmes through day-care, sheltered workshops, half-way houses, hostels for recovering patients and long-term care facilities.
Parents and other family members of mentally-ill persons are coming together to form self-help groups.

Private hospitals and private psychiatrists are also important contributors to mental health care.

2 Country Mental Health Strategy and Principles

2.1 Country approach to recommended mix of services by W.H.O.

India has already adopted the recommended mix of services under the National Mental Health Programme (NMHP). Currently operational in 125 districts the programme will be expanded to all districts by 2012 - the end of the Eleventh five year plan.

Long-stay facilities & Specialist services

Under the NMHP assistance is provided to mental hospitals for modernisation of facilities. At present, long-stay facilities are provided by mental hospitals but in consultation with Ministry of Social Justice and Empowerment, efforts are being made for adequately providing for these facilities. Specialist services are provided by mental hospitals, general hospital psychiatry units and clinic-based psychiatrists. The NMHP provides assistance for establishment of General Hospital Psychiatry Units and there is a plan to purchase services from private psychiatrists.

Psychiatric Services in General Hospitals and Teaching Hospitals

Under the NMHP so far 75 psychiatry departments have been upgraded.

Community Mental Health Services: Under the DMHP programme, psychiatrists provide outreach community mental health services. Private psychiatrists practicing in the community also provide a large portion of these services, and it is planned to purchase their services as part of the NMHP.

Mental Health Services through Primary Health Care: Primary Health Care doctors and staff are trained in mental health under the DMHP. They provide free medication, run

Awareness Camps, and are involved in information, education and communication activities to increase service utilisation.

Informal Community Care is provided by faith healers, families, self-help groups etc. They are educated to understand mental illness and manage common difficulties faced by mentally ill people.

Self Care is provided by persons suffering from mental illness who learn coping skills and form self help groups.

Adaptation of International Policies to the local situation

International policies and contemporary scientific practices are followed as much as possible. Due to the shortage of skilled mental health professionals, mental health services are provided through specially trained medical officers, psychologists, social workers and nurses instead of by a team comprising a psychiatrist, clinical psychologist, psychiatric social worker and psychiatric nurse.

To overcome the shortage of psychiatrists, one year certificate courses in mental health are also starting.

2.2 Definition of Community Care

Community care is a decentralised pattern of health care for people, which is accessible, affordable and acceptable. Community-based care is designed to supplement and decrease the need for more costly inpatient care delivered in hospitals. Community care may be more accessible and responsive to local needs because it is based in a variety of community settings rather than aggregating and isolating patients in central hospitals. Community care provides an umbrella of integrated services for a defined catchment area, including prevention, early treatment, and continuity of care.

2.3 Local Principles & Components

Local components are specialist psychiatric services provided by the district hospital, community outreach services provided by the DMHP Psychiatrist, community mental health services delivered by private psychiatrists, primary care by trained medical officers in primary health care, rehabilitation provided by NGOs, and informal care by family and self-help groups.

3 Examples of Best Practice Models

Example One: The District Mental Health Programme (DMHP) based on the Bellary model

Background

Community-based practice services and models came into existence in India following the recommendations of an expert committee of WHO on 'Organisation of Mental Health Services in Developing Countries' which met in 1974 (WHO 1975). The Committee recommended that: "Countries should in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban population". It further recommended that "training programmes, including a simple manual for the training of health workers should be devised and evaluated".

Following this, during 1975-76, major community mental health care experiments were launched at Bangalore and Chandigarh to test the feasibility of shifting the care of the mentally ill from the 'hospital' to the 'community' and from the 'mental health specialist' to the 'primary care physician'.

A programme was developed at Sakalwara near Bangalore and Raipur Rani near Chandigarh. The main aim of the programme was to extend mental health services by integrating them with the existing system of primary health care. For this, the primary health care staff had to be trained in basic mental health care. The objective of the programme was to develop, carry out and evaluate suitable short-term training programmes in basic mental health care for different categories of health care personnel, so that after training, these personnel could provide mental health care in their respective areas of work. These experiments were successful in producing the 'Manual of Mental Health for Multipurpose Workers' and the 'Manual of Mental Health for Medical Officers'. Similarly, the instruments for evaluation of the training were also standardised.

These experiments along with few other projects practically demonstrated that the primary health care system can provide mental health care by trained PHC personnel at the community level. These projects include the "Strategies for Extending Mental Health Care" a WHO multi-centre study with a collaborating centre at Chandigarh and the ICMR-DST (Indian Council of Medical Research - Dept. of Science and Technology)

'Severe Mental Morbidity Project' carried out at four centres - Bangalore, Calcutta, Baroda and Patiala. Other experiments from centres such as Vellore, Lucknow, Jaipur and Hyderabad also added to the growing evidence for successful community-based mental health care delivered by general health staff.

The mental health care could have been improved if the primary health care personnel had better administrative and supervisory support, including supply of a minimum number of essential psychotropic and antiepileptic drugs on a regular basis, provision of a simple recording and reporting method, involvement of all the health care personnel of the PHC district, regular supervision and monitoring of the programme at all levels- PHC, district, division etc, availability of specialist referral facilities, provision of material for public mental health education, and facilities for continuing education of trained personnel (refresher courses), as well as initiatives to improve public understanding and acceptance of primary health care for treating people with mental illness and epilepsy. The field level evaluation of trained PHC personnel highlighted the need for mental health care planning at a district level.

Following these experiments, the District Mental Health Programme (DMHP) was developed over a period of several months during 1984-85 to test the expansion of these projects to a district administrative level.

Programme Prescription (DMHP, Bellary)

The DMHP consisted of three partners, the Department of Health and Family Welfare (Government of Karnataka), District Administration- BelIary and the National Institute of Mental Health and Neuro-sciences (NIMHANS), Bangalore. The joint project was formalised in 1985 and it was agreed that NIMHANS would provide technical input in terms of training, monitoring and evaluation of the programme, the district administration would ensure the funding for adequate and regular supply of drug requirements and printing of records for health personnel and the Directorate of Health and Family Welfare services would implement the programme through its existing infrastructure and personnel. In addition, the directorate also agreed to spare the services of one of its medical officers with experience of programme administration to oversee

the DMHP at the district level (Programme Officer) and meet his transport needs (vehicle, driver and P.O.L.) to tour the district regularly.

Aims and objectives of the DMHP, Bellary

The general aim of the District Mental Health Programme was to extend mental health services to severely mentally-ill persons in the district through existing health care personnel and institutions. The more specific objectives of the Programme were to:

1) Develop and Implement a decentralised training programme in mental health for all categories of health personnel, appropriate to their levels of functioning with least disruption to ongoing general health care activities.
2) Provide a minimum range of essential drugs for treatment of severely mentally ill persons at all peripheral health care institutions.
3) Develop a system of simple recording and reporting of care by health care personnel.
4) Monitor the effect of the service programme in terms of treatment utilisation and treatment outcome.
5) Develop mechanisms of community participation in the mental health care programme through planned activities.
6) Study the cost-effectiveness of the programme.

To achieve these objectives the DMHP had several components:

1.Training of personnel

3.2 Provision of drugs

3.3 Simple recording system

3.4 District level programme officer & his team

3.5 District Mental Health Clinic

3.6 Review cum training as part of visits to the periphery

3.7 Weekly mental health clinics in the periphery

3.8 Monthly reporting, monitoring and feedback

3.9 Community participation, and

3.10 Field training for mental health professionals.

Training of Personnel:

The training for PHC personnel at a district level was as follows:

a) Medical officers: Total training days- 9, in 3 sessions of 3 days

b) Multi-purpose workers: Total training days 4 - in 3 sessions of 1 + 2 + 1 day

c) Health supervisors (health inspectors and lady health visitors): Total training days - 4, in two sessions of 2 + 2 days.

d) Community health volunteers (CHVs): Two days of training preferably during their initial three months training period. The CHVs received two day training at the PHC level to be carried out by trained medical officers, and health supervisors.

e) Block health educators: The block health educators of each PHC (generally, one in each PHC) for 4 days in 2 sessions of 2 +2 days.

In addition to this formal training for larger groups of personnel, informal 'on the job' training inputs were continued for PHC personnel by a district mental health team visiting PHCs regularly once in two or three months, preferably on a fixed day of the week which was designated as the weekly 'Mental Health clinic' day when most of the old and new patients of the PHU/ PHC could visit the centre for their follow-up consultation.

The supervisory officers at the district level were appropriately oriented and sensitised to the mental health needs of the population and the project was regularly supervised and monitored at the district and sub-divisional levels by the in-charge health officer.
Training was carried out by a faculty of two psychiatrists from the community mental health unit of the National Institute of Mental Health and Neuro-sciences

(NIMHANS). Carefully prepared video recordings of interviews with psychotic patients highlighting symptomatology, and clinical presentation were also used for training and discussion.

Provision of Drugs

A supply of five basic psychotropic drugs (Tab. Chlorpromazine 50 mg./100 mg., Tab. Imipramine 25 mg., Tab. Trihexyphenidyl 2 mg. Inj. Fluphenazine 25mg and Tab. Phenobarbitone 60 mg) at the primary health centre/unit was essential for the successful implementation of the programme following the training of the health care personnel. Essential drugs were made available at all peripheral institutions.

Simple recording system

A simple recording and reporting system was designed to be maintained at various levels, which included the Health worker's records, Patient identification cards, and a Record Book maintained by the health workers. This record consists of minimum details of the patients and their symptoms on one side and columns to record the follow-up details on the other side.

Four different proforma were designed for the doctors to collect information about patients with psychoses, neuroses, mental retardation and epilepsy.

District level programme officer & his team

A general doctor with broad experience in the district who was interested in mental health was appointed as the programme officer. He was deputed to NIMHANS for six weeks of training to gain proficiency in clinical psychiatry in order to be able to monitor and supervise the other PHC doctors and health workers. Following training, he ran a regular mental health clinic at the district headquarters in Bellary in addition to organising the DMHP.

He was assisted by a health assistant (MPW) deputed from the health service and a district-level research team consisting of three assistant research officers, a Psychologist, a Social Worker and a Statistician, appointed by NIMHANS. The team assisted the programme officer in running the district clinic, monitoring the programme through

regular field visits, routine data collection from the periphery and data analysis. The psychologist, in addition, certified mentally retarded individuals and assisted in their management. The social worker initiated community participation activities in the district. Later, the programme officer was replaced by a trained psychiatrist when he became available.

District Mental Health Clinic at Bellary

The programme officer and his team ran an outpatient mental health clinic at the district headquarters. During the initial period (first one and half years) this was a daily clinic, but later it was reduced to three days a week.

Weekly mental health clinics in the periphery

A day was designated as mental health clinic day at the PHCs and the bulk of the case work was done on this particular day. New cases were seen every day and were followed up on the mental health clinic day. On this day, the DMHP team visited to supervise and discuss difficult cases. They were required to follow-up cases regularly and refer cases which they could not manage to the District headquarters.

Monthly reporting, monitoring and feedback

A separate monthly report form was filled in by the doctor in which he recorded minimum details of new cases identified in that month, the drug position and the number of drop-outs etc. Reporting, monitoring and feedback took place in monthly reporting, monthly meetings at PHC, and at district headquarters. The progress of the mental health care programme was reviewed every month during the monthly conference of medical officers at the district headquarters.

Community participation

Community participation is vital for the programme and all efforts were taken from the very inception of the District Mental Health Programme to ensure community awareness and participation in a wide range of activities related to mental health care.

Mental Health Camps: To increase public awareness of mental health problems in the community, and of the availability of a treatment facility near their homes, camps were

conducted regularly.

Booklets: Booklets both in Kannada and in English about the District Mental Health Programme were printed to communicate to Youth Clubs, voluntary agency members, staff of Welfare institutions, teachers, MandaI and Zilla Parishad members, MLAs, and MPs and others interested in the programme. This helped them to understand the details of the programme and the scope of their participation.

Films: The District Health Education Wing continued to screen films on mental health in the villages along with other films on family planning and health activities.
Cinema Slides: Cinema slides were prepared with the help of local agencies like Lions Club, Rotary Clubs and Union Bank of India. These were shown in the theatres to create awareness about the features of mental illnesses, mental retardation and Epilepsy and the available services in the Government Hospitals, PHCs and PHUs.

Educating the Educators: Education officers and teachers were sensitised and provided with educational material for discussion and interaction, which resulted in active collaboration with schools and teachers in Bellary District.

Satisfied Consumers: Efforts were made to offer systematic education to family members of the patients, and patients who dropped out were followed-up. Home visits were made and reminder letters were written emphasising the need for regular follow-up. This was given much emphasis and importance to spread the word about the program.

Field training for MH professionals: The program was also used as part of community training for 'training of trainers programme' for mental health professionals from other parts of the country.

Example Two: District Mental Health Programme under NMHP

When the District Mental Health Programme (DMHP) was launched in 1996 under the National Mental Health Programme, the District model of Bellary was adopted.

Objectives

i) To provide sustainable basic mental health services to the community and to integrate these services with other health services.
ii) Early detection and treatment of patients within the community itself.
iii) To ensure that the patient and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities.

iv) To reduce pressure on mental hospitals.

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

vi) To treat and rehabilitate within the community, mentally ill patients who have been discharged from the mental hospital y.

Brief description of the scheme

i) The State began recruitment of suitable personnel for the District Mental Health Team. They took candidates from within the mental health services who were willing to participate in this Pilot Project and provided them the necessary training.

ii) The catchment area was the district and adjoining areas.

iii) The District Mental Health Team was expected to provide the following services to needy mentally-ill patients and their families: daily outpatient service, ten bed inpatient facility, referral service, liaison with Primary Health Centre and follow-up. They were also to carry out a community survey if feasible, and to increase community awareness to remove stigma associated with mental illness.

Components

a) Personnel: A psychiatrist, a clinical or trained psychologist, a trained social worker, four trained or psychiatric nurses, a statistician-cum-clerk, a driver, a nursing orderly, a safai karamchari.

b) Equipment, vehicles and other infrastructure.

c) Medicines, POL, other contingencies etc.

d) Information, Education and Communication components -Print, Electronic media, Health melas etc.

e) Training programmes in identified institutions of various workers up to the grass-root level-Doctors, Nurses, Social Workers, Psychologists, non-professionals like panchayat leaders, ANMs, Teachers, Anganwadi workers.

f) Development of training capsules for various workers and their translation into regional languages.

Release of funds was through the central institution which provided technical and managerial support, however funds for the employment of staff came through the state Government.

Monitoring of the programme was done by the state through the designated institution as well as by the Centre through WHO Consultants in the Ministry.

Category	% of Persons	Duration of Training	Frequency per year
Trainers e.g. Doctors	15-16	2-3 Weeks	Two
Paramedical workers	15-20	2 Weeks	Two
Non- Medical e.g. Panchayat leaders, teachers, parents, ANM	20-25	5 Days	Four

Training was to be completed within three years.

A doctor, a nurse, a driver with one Safai Karamchari started work immediately. The remainder of the positions were filled in a phased manner with the states determining priority. Work commenced with one vehicle and one ECT machine with resuscitation equipment and medicines on O.P.D basis and with field visits.

Achievements/Targets expected

i) By the end of the year, the states will have implemented the District Mental Health Programme and the experience gained will be helpful in further planning and improvement of the services for these and other states.

ii) Training programmes envisaged under the scheme will result in creation of a qualified mental health team to work at the grass-root level within the community.

iii) The scheme is expected to generate an appropriate database for better planning of future services in the District.

iv) Provision of mental health services and integration with general health services will result in " acceptance of mentally-ill people within the community" and also

assist in early identification and treatment, as the community is almost at its "doorstep"

In 2003, the DMHP was modified slightly to decrease the number of staff in DMHP team from 10 to 6 with the provision of outsourced vehicles instead of purchased vehicles with a recruited driver. Other than this, the program components remained the same.

In addition, to address the shortage of mental health professionals a new scheme for upgrading the facilities of the psychiatry wings of medical colleges/ general hospitals was initiated to enable these institutions to develop more training posts. Similarly, a scheme to fund the modernisation of the state- run mental hospitals was launched to make them tertiary care therapeutic institutions with provision for mental health training. Large-scale central level strategies for information, education and communication were also considered necessary and included in the redeveloped NMHP in 2003.

Successes and Difficulties

The DMHP model has demonstrated that basic mental health care delivery is possible in primary care settings. Primary care physicians can be trained to deliver such care. Provision of supervision and support from the program officer and/or the psychiatrist, empowers the public health care system to respond to the mental health needs of the population.

This model of DMHP was implemented in twenty-seven districts in the Ninth plan and later extended to 125 districts in the country. A team of experts from the National Institute of Mental Health and Neuro-sciences (NIMHANS) evaluated the DMHP in the year 2003. Findings from the evaluation were as follows:

- Mental Health Care is available in many States at the District level in the country because of implementation of the DMHP.
- The minimum range of essential drugs is available at the district level in adequate quantities. However availability of drugs at the primary health centre and taluk

hospitals varied. Procurement of drugs was delayed due to various procedural problems.

- Most of the centres had trained doctors in mental health care, however the duration of training and the number of doctors trained varied from centre to centre.
- Some centres kept good records while others were poor. Registration of cases and reporting format were not uniform across the centres.
- Some centres had developed their own material for public education, while others were using material provided. Information, Education and Communication (IEC) activities were not uniform across all the centres.
- More than 50% of the DMHP sites had organised mental health care in the district hospital, including inpatient care, however the number of clinic days varied from one centre to the other. Evidence suggested that the number of persons using the district mental health clinic had increased with time.
- Mental health care both at primary health centres and the taluk level was observed in some districts and the number of patients seen in the periphery varied from few hundred to over thousands.

Current Status of DMHP in India

- The Tenth plan proposed an increase in the number of DMHPs to 100 districts. To date, the DMHP has been extended to 125 districts.
- The DMHP was reviewed by NIMHANS in September 2005.
- Most of the centres had trained doctors, health workers and other paramedical workers.
- The program officer is now a Psychiatrist in many of the DMHP states, which is a very positive development. However instead of providing support to the primary health care team, they are visiting the Taluk and District headquarters to treat people with mental health problems. Medical officers and health workers are responsible for referring people with mental health problems to the Taluk or District location where the specialist visits at periodic intervals. This changes the DMHP from a primary health care team managed mental health care programme to a specialist-operated programme.

Barriers to implementation of DMHP

Based upon National reviews and consultations the following main issues emerged:

1. The DMHP was not becoming integrated in district health planning as in many places, the designated institutions to which funds were released and the district health services where the programmes were implemented were administered by different departments.
2. The DMHPs which were funded were not able to fully expend the funds due to lack of available psychiatrists and other mental health professionals such as psychiatric social workers and clinical psychologists.
3. Under the Programme, similar districts came under the administration of the designated agency against the desired outcome of integration at the district level with the general health system. Most of the states are not prepared to agree that the Programme activities would be taken over by districts after five years, as the programme is currently run by medical colleges which are under a different department.
4. The DMHP has been dependent on leadership from a psychiatrist which has led to the inability of some district programs to commence, due to lack of a psychiatrist.
5. There was lack of delegation of power for procuring medicines and recruiting staff under the programme at the district level.
6. The programme focused on catering mainly to severely mentally ill patients, and many important issues like suicide prevention, workplace stress management, adolescent mental health and college counselling services which could benefit larger section of society were not getting adequate focus.
7. There is a lack of community participation in the programme due to inadequate efforts to stimulate self–help in the community.
8. There is a lack of regular and dedicated monitoring and facilitating mechanisms.

Strategies to overcome the gaps

1. In the Eleventh plan, the DMHP has the following staffing components -one medical programme officer (MBBS), a psychologist (M.A. in psychology), a social worker (M.A. in medical social work), a Nurse and an office assistant. To run the

DMHP short-term skill-based training would be provided to the DMHP staff. This training would be carried out at identified centres using a uniform curriculum.

2. As per demand, new services will be added to the DMHP by incorporating new components. In addition, active participation of credible organisations and private practitioners will assist in providing mental health services and implementing the DMHP.
3. The DMHP will be run by the district administration through the district health society to ensure integration of the program in the district health plan.
4. Training and preparation of the mental health workforce in the district will take place before rolling out the programme.
5. A one-year certificate course in Psychiatry will commence for in-service government doctors to train as sub-specialists in Psychiatry to alleviate the shortage of psychiatrists and provide referrals to the DMHP.
6. In order to develop a skilled multi-disciplinary mental health workforce and establish a training infrastructure evenly across the country, the establishment of regional centres based on the Institute of Mental Health & Neurosciences (NIMHANS) model and in close association with it, is recommended.
7. It was considered necessary to continue upgrading psychiatry wings of medical colleges/general hospitals and modernisation of mental hospitals. The Government medical colleges and State-run Mental Hospitals may be supported during the period of the Plan. The government medical colleges/general hospitals and State-run Mental Hospitals will be entitled to grants in the plan period.
8. A need for strong strategies for information, education and communication (IEC) to enhance awareness and reduce stigma, and promote research in mental health was also recognised.
9. Voluntary organisations and NGOs will become partners in the implementation of the DMHP at district and state level.

A dedicated monitoring and coordinating system will be established at the central, state and district level to facilitate the implementation of DMHP.

4. Extending the Current Capacity of Community Care

National reviews, national consultation with experts, and in-house evaluation of the DMHP have given valuable insights. As a result of the experience gained so far with the District Mental Health Programme some modifications are being proposed for the Eleventh plan.

1. In the DMHP, the psychiatrist will be replaced with a medical officer trained in mental health and programme implementation so that the programme is not curtailed due to lack of a psychiatrist in a particular district.
2. The Programme officer (medical officer) of a district will be trained for three months in mental health at specified institutions using standard curriculum modules. Psychologists and social workers will be trained for three months. Nurses will be trained for one month.
3. All doctors as well as health workers in a district will be trained in the district itself using standardised training modules. Training of doctors would be of six days duration each year and two days duration for health staff each year.
4. A one year certificate course in Psychiatry for medical officers will be introduced to compensate for the lack of psychiatrists to lead the Programme.
5. Regional Institutes of Mental Health & Neurosciences will be established to increase the mental health workforce capacity.
6. Psychiatry wings of medical colleges will be upgraded to enable them to start Post-graduate courses in Psychiatry.
7. State-run mental health institutions will be modernised to transform them into tertiary care teaching institutions.
8. The psychiatry curriculum in undergraduate medical courses should be expanded to increase the competency of the MBBS doctor in treating common psychiatric conditions.
9. Standardised training modules have been prepared for various training courses to be undertaken in the Programme to ensure maintenance of consistent standards.
10. Private sector resources will be utilised for the Programme.
11. The emphasis will be on partnership with credible and ground level voluntary organisations and NGOs for smooth implementation of the Programme.
12. Life skills education in schools will be implemented though training school teachers.

13. College counselling services will be run by the psychology departments of colleges.
14. District counselling centres will be established in the psychology departments of identified college as part of suicide prevention services.
15. Workplace stress management workshops will be conducted by NGOs using modules prepared by national institutions.
16. Rehabilitation services for severely mentally-ill people such as community-based rehabilitation will be operated by NGOs using evidence-based models.
17. Programmes for homeless mentally-ill people will be run through NGOs.
18. Coordination of monitoring will be established at a central office to support the monitoring officers at the designated institutions in each district.
19. A State Mental Health Office will coordinate and monitor the Programme.
20. The Central Mental Health Authority and State Mental Authorities are entrusted with the task of development and regulation of services. Their active participation will be sought for the Programme.
21. There will be a tele-link with each district and state office so that real-time information flow can take place to run the Programme.
22. In addition to regular in-house evaluation, two external evaluations are proposed in the Eleventh plan.
23. Funds for the Programme would be released through the state health societies to overcome difficulties in the flow of funds from Central Government to the districts.

Outcome indicators

- Reduction in incidence and prevalence of mental disorders
- Reduction in mortality associated with mental disorders
- Improved social functioning
- Reduction of family burden
- Prevalence of awareness and decrease in stigma
- Quality of life of mentally-ill patients
- Self-reports by users
- Reply to the question: is the work well done?
- Number of new patients starting treatment

- Percentage of `drug non-compliant cases' of total diagnosed cases
- Case identification rates
- Percentage of those discontinuing treatment
- Increased awareness levels
- Availability of trained mental health personnel

Strategies for funding and resource building

Funding will be provided by the Central Government as grant-in-aid to the States to deliver community mental health services. States will also contribute by providing their workforce and health infrastructure. When these services are established it is expected that states would take over and manage the mental health services as a part of their general health services.

5. Overall Summary/Conclusions

5.1 Implications for India & Other countries

India needs to expand the District Mental Health Programme to include school mental health services, college counselling services, workplace stress management, and suicide prevention.

Community-based rehabilitation is an integral part of community care, especially for those who are severely mentally-ill. It needs to be tested and fine-tuned in more districts with a full complement of regular DMHP staff instead of highly motivated & skilled professionals. In the current plan rehabilitation will be provided under NGO leadership in a public private partnership. If successful, community rehabilitation will be integrated into the DMHP & extended to all districts.

NGOs will be encouraged to provide the treatment and rehabilitation of homeless mentally-ill people.

Family groups and self-help groups will be encouraged to participate in the programme.

At the global level, with its extensive experience in implementing a comprehensive community-based mental health programme covering 125 districts (with a population of approximately 250 million), India could lead in providing technical support to countries with similar socio- economic conditions in developing cost-effective community mental health services based around the existing general health care system. The community-based model of service delivery through the general health care system with hubs of mental health institutions and tertiary care centres, could be replicated in countries with similar socioeconomic contexts as a cost-effective strategy to address the huge burden of mental illness.

As the Asia Pacific Community Mental Health Development Project draws to a close, India is certain that its community mental health model and experiences will be appreciated and generate attention from countries with low resources in mental health. Standing true to its tradition of exemplary international cooperation, India would be happy to provide its technical support in this field to any country or host a collaborative centre for further action and cooperation in this important field.

5.2 Vision for community care

The long-term goal in community care is to ensure the availability of a skilled mental health workforce by increasing training programs in the mental health professions. Improving the infrastructure in rural areas is crucial in order to attract more mental health professionals to work there and reduce the disparity in availability of professionals across various regions. With the availability of more professionals, community mental health services would improve.

Specialised mental health services such as child, geriatric, substance abuse services would be available in the community. Long-term care, residential facilities sheltered workshops, half-way houses, day programs and community-based rehabilitation services would be integrated with the District Mental Health Programme for comprehensive mental health care.

Socio-economic development and stronger intersectoral coordination would strengthen the community-based mental health initiative. Mental health services would be available to all people and promotion of well- being would be ensured.

With its philanthropic nature, diverse socioeconomic and cultural conditions and rich community mental health experience, India would emerge as a leader and provider of support for development of sustainable community mental health services for countries with low mental health resources.

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