District Mental Health Program: Inception, Evolution and Challenges

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Abstract
In 1982, National Mental Health Program (NMHP) was launched in India. In order to suffice its aim and objectives and effective coverage of mental health care, a district level program was suggested and for which NIMHANS did a pilot project in between 1985-90 and finally District Mental Health Program (DMHP) was started in Bellary district of Karnataka. Since then, the DMHP has been running in entire nation for fulfilling its aim and objectives and delivering mental health care services. In the span of almost three decades, the program has been monitored and assessed periodically in terms of its effectiveness by keeping the vision of fulfillment of its goals. In this article we are reviewing the achievements of DMHP and how far we have reached to achieve the goals.

INTRODUCTION
As per WHO’s community-based epidemiological studies, the lifetime prevalence rates of mental disorders in adults vary from 12.2 – 48.6%. Mental, neurological, and substance use disorders constitute about 14% global burden of disease, measured as disability-adjusted life years.1

In 1985, National Mental Health Program (NMHP) proposed a district-level program to fulfill its goals and objectives. NIMHANS, Bangalore, did a pilot study between 1985–90 and after the successful model of Bellary district, in 1996 a new program called the District Mental Health Program (DMHP) came into existence. DMHP was framed with the objectives such as a decentralized training program for mental health care personnel, provision of essential medicines, recording and reporting, monitoring the efficacy of the program, and reducing stigma related to various mental illnesses.1 DMHP has evolved and undergone multiple modifications in the span of almost three decades since its beginning. The last 15–20 years were crucial for DMHP to face various challenges to achieve its goals and objectives. Various issues such as at the administrative level in terms of coverage and functioning of DMHP, manpower shortage and financial issues, training and monitoring related issues, poor public private partnership model, community participation, and IEC activities, were encountered.1 Lacunae in providing efficient coverage and treatment have been observed. In 2015
DMHP was incorporated into NRHM to overcome these shortcomings. India spends less than 1% of its total health budget on mental health. It also faces a severe shortage of mental health professionals, with only 0.3 psychiatrists per 100,000 population and with most of them concentrated in the Southern and Western regions of the country. As per the Indian mental health observatory, the budget for mental health for 2021-22 is 932.13 crore INR, out of which 597.14 crore INR is for MoHFW and the rest 334.78 crores INR for the Ministry of Social Justice and Empowerment.

**NMHP: Beginning and Evolution**

Concerned with the mental health burden and treatment gap, WHO’s mental health advisory group in 1979 urged its members to develop their own National Mental health program to provide compulsory mental health care and in compliance with this, India launched NMHP in 1982. As a part of WHO’s multi-country collaborative study, community health projects were conducted at Sakalwara, a rural area of Bengaluru district, and Raipur Rani block of Chandigarh. Indian council of medical research (ICMR) and the Department of Science and Technology further substantiated these pilot projects which revealed that as much as 20% of mental illnesses can be identified by PHC staff under the vigilance of a psychiatrist. This study created a base for the development of NMHP. The then leaders of psychiatry worked incessantly to form a draft of NMHP in 1981, which finally came into existence in 1982.

With the initial funding of 10 crore INR and with the following aims, the NMHP was begun:

- To ensure the availability and accessibility of minimum mental health care for all in the near anticipated future, particularly to the most vulnerable sections of the population
- To encourage mental health knowledge and skills in general healthcare and social development
- To promote community participation in mental health service development and stimulate community self-help.

This model had many flaws, such as:

- Management and implementation
- Lack of clarity of fund responsibility
- No budgetary estimation
- Limited-service delivery
- Response from psychiatrists were not favorable.

**DMHP**

To overcome the drawbacks of NMHP and to raise its scale, it was perceived as the district should be the administrative and implementation unit of the program. In the Bellary district of Karnataka, a pilot project was conducted from 1985 to 1990 by NIMHANS. It demonstrated that it was feasible to deliver basic mental healthcare services at the district, taluk, and PHCs by trained PHC staff. The successful Bellary model proved to be the foundation stone for the development of DMHP. This, later was launched in 27 districts in 1996 with a budget of 28 crores INR.

**Objectives of DMHP**

- To develop and implement a decentralized training program in mental health for all categories of healthcare personnel in a way that would be least disruptive to ongoing general healthcare services.
- To provide a range of essential drugs such as antipsychotics, antidepressants, anticonvulsants, and minor tranquilizers for the management of People with Mental Illness (PwMI).
- To develop a simple system of recording and reporting care by mental healthcare personnel.
- To monitor the effect of the service of the mental health program in terms of treatment utilization and outcomes.
- To reduce the stigma by bringing about a change of attitude through public health education.
- Treatment and rehabilitation of the patients within the community by adequate medicines and strengthening the family support system.

**DMHP in Kanpur**

Kanpur Nagar was among the first few districts in the country where DMHP was started with a Nodal Office at the Department of Psychiatry, KGMU, Lucknow in 1998. The initial activity of the program was:

- Establishment of an outpatient clinic at the Ursala Horsman Memorial (UHM), District Male
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Hospital, Kanpur Nagar in November 1998, on Monday, Wednesday & Friday
- Outreach clinics at CHCs and PHCs of the district on Tuesday & Thursday
- Training of health personnel
- 10-bedded inpatient unit at the District Hospital
- IQ test of Mentally Retarded patients
- Kanpur Jail visit
- Medicolegal cases of Kanpur and adjoining districts

Staff details were as follows:
- The Uttar Pradesh Government provided a psychiatrist.
- Clinical psychologists, social workers and clerks cum statisticians were appointed on a yearly contractual basis under DMHP funds.
- The District Hospital staff provided driver, Peon & nursing staff.

Experiences of DMHP:
- The increased attendance of OPD patients at the District Hospital showed the utility of setting up mental health clinics at district hospitals
- As seen in Raipur Rani’s experience by Wig et al.,
- it took some time to build trust and relationships with colleagues in the district hospital & PHC/CHC.
- Training programs helped a great deal in increasing awareness on mental illnesses.
- At CHC & PHC levels there were serious difficulties in convincing the local health staff to take over the tasks and activities of DMHP.
- The extensive house-to-house survey shows that the treatment gap can be significantly reduced in any mental illness.
- It was felt that there is a need for proper IEC activities, as villagers still spend a significant amount of time and money appeasing supernatural powers.
- “The Pill” has a significant effect on the attendance of patients in outreach mental health clinics.

Evolution of DMHP

DMHP has evolved greatly over the last 15–20 years under the 10th, 11th, and 12th five-year plan and has been assessed periodically by various government agencies and independent bodies.

In the 10th five-year plan (2002-2007), DMHP was extended to 110 districts with the upgrading of psychiatric wings of 71 medical colleges and the modernization of 23 mental hospitals. The budget was also increased to 139 crore INR, 5 times more than the 9th five-year plan.

DMHP was revitalized in the 11th five-year plan (2007-2012) with the provision of the following:
- Program officer (a psychiatrist) and family welfare officer (to work with a Psychiatrist) in each district.
- Ten beds for acute care.
- Essential drugs at PHCs with more advanced drugs such as lithium, valproate, carbamazepine, benzodiazepines, and injectable haloperidol at District Hospital.
- Training programs for medical officers.
- Strengthening infrastructure with the establishment of 11 centres of excellence by upgradation of mental institute/Hospital (Scheme A) and setting up/strengthening 30 units each of psychiatry, clinical psychology, psychiatric nursing, and PSW (Scheme B).

Mid Term Evaluation by NIMHANS in 2003

In 2003 Mid-term evaluation was carried out in 23 districts where NIMHANS, Bangalore started DMHP. The evaluation reported that the program had positive impacts in terms of:
- Enhancement of early detection of mental disorders.
- Reduction in distance traveled by patients to seek treatment.
- A decrease in case-load at the mental hospital. However, there were hurdles for the effective implementation of the program, such as:
- Problems in fund accessibility.
- Unavailability of trained and motivated mental health professionals.
- Lack of effective central support and monitoring.

In the report of the evaluation, it was recommended by the NIMHANS team that there is a need for:
- Effective central support and monitoring.
- Development of an operational manual for effective implementation of DMHP.
- Revamping the PHC personnel’s training in terms of its content, curriculum, and method with continuous support (on-the-job training after initial training).
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- A review of the priority mental health conditions covered under DMHP.
- Incorporation of preventive and promotive mental health services.

**Indian Council of Marketing Research in 2009**

In an independent evaluation by the Indian Council of Marketing Research in 2009, the agency also highlighted the issues pertaining to:
- **Funds** - underutilization and delay in its accessibility
- **Training** - inadequate, less simplistic, and lacking refreshing training, adversely affecting the implementation of the program.

Other areas of concern were related to the
- **Availability of the drugs**
- **Community clinic still not being the most common setting for treatment seeking**
- **Lack of community involvement**
- **Poor awareness programs**
- **Lack of monitoring and implementation system**.

Agency recommended
- Strengthening the services at CHCs, PHCs, and sub centers.
- To gradually shift the financial burden to state government.
- To improve the manpower of allied mental health professionals.
- To integrate DMHP with other health programmes (like NRHM).
- Active involvement of community-based organizations in organizing awareness programs.

**DMHP in 12th Five-year Plan (2012-2017)**

In 2012, the Ministry of Health and Family Welfare (MoHFW) appointed a Mental health policy group (MHPG) to prepare a draft on DMHP. The MHPG assessed the performance of previous 5-year plans and came up with new principles, aims, and objectives.

**Principles**
- A life course perspective with attention to children, adolescents, and adults’ unique needs.
- A recovery perspective through the provision of services across the continuum of care and empowerment of persons with mental illness and their caregivers.
- An equity perspective through specific attention to vulnerable groups and to ensure geographical access to mental health services.
- An evidence-based perspective by following established guidelines and experiences on treatments and delivery models.
- A health systems perspective with clearly defined roles and responsibilities for each sector, from community to district hospital, including a cascading capacity building and supervision model.
- A rights-based perspective to ensure the rights of persons with mental illness are protected and respected by mental health services.

**Aim**

To improve health and social outcomes related to mental health.

**Objectives**

- The primary objective was 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, particularly the most vulnerable and underprivileged sections of the population.
- Provision of basic mental health care in the community by integrating the mental health system into the general health care delivery system (Primary Health Centers) through NMHP.
- Identification and treatment of persons with mental disorders to be done by health workers and primary care physicians.
- To launch extensive Information and communication activities about the nature, course, and availability of treatment for mental disorders.
- To facilitate adequate psychosocial care of the recovered mentally ill in the community by making linkages with non-governmental organizations locally.
- To initiate mental health promotional activities in schools and colleges.
To develop active public-private partnerships.

- Provision of tertiary care institutions for the treatment of mental disorders and to improve the infrastructure for mental health service delivery.
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental health Authority.
- To promote community participation in mental health service development and to stimulate efforts towards self-help in the community.
- To increase access to preventive services for the population at risk addressing the risk of suicide and attempted suicide.
- To establish governance, administrative and accountability mechanisms to realize the above objectives.

Provision of human resources under NMHP from 2015 (after taking over by the National Health Mission Program)
- Psychiatrist
- Clinical Psychologist
- Psychiatric Social worker
- Psychiatric Nurse
- Community level Psychologist – 4 (In pipeline)
- Monitoring & Evaluation Officer
- Community Nurse
- Case registry Assistant
- Ward Assistant

Activities under DMHP:
- School Program
- Jail visit
- Homes (Department of women and child development) visit
- Urban slum camp
- Workplace stress management camp
- Sensitization of local leaders
- Organizing Mental Health Camps
- Dua se Dawa Tak
- Observation of Mental Health Days

DMHP in Uttar Pradesh

- In 1998, the first project was started in Kanpur Nagar under the Department of Psychiatry, KGMC Lucknow (details discussed above).
- In 2005, three more districts were added under the Department of Psychiatry, KGMC Lucknow in Faizabad, Sitapur, and Raebareli.
- In 2014 Department of Psychiatry, GSVM Medical College, started DMHP in two districts Banda and Etawah.
- In 2015 DMHP was taken over in all the districts by National Health Mission.
- In 2016-2017, 24 districts were covered under DMHP.
- In 2017-2018, 45 districts were covered under DMHP.
- In 2018-2019 all 75 districts of the state are covered under DMHP.
- In 45 districts, a psychiatrist is working in DMHP and 30 districts have MBBS doctors who have received one-month training in KGMU Lucknow, GSVM Kanpur, IMH Agra, Mental Hospital Bareilly, and GMC Saharanpur.

DMHP in Madhya Pradesh

- From 2003 to 2015 DMHP was conducted by the Department of Medical Education. In this period DMHP was started in 4 districts - Shivpuri, Dewas, Sehore, and Jabalpur.
- National Health Mission took over the DMHP in 2015 and started in all the districts of MP except Niwari (51 districts out of 52 in the state).
- 27 districts in the state have a psychiatrist working in DMHP.
- 24 districts have MBBS doctors working in DMHP. They have received two weeks of training at Mental Hospital Gwalior and Indore.

DMHP in Chattisgarh

- Started in 2005
In 2015 all 28 districts covered
Total of 3 districts - Bilaspur, Durg & Raipur, have a Psychiatrist as in charge of DMHP
Total of 25 districts have MBBS doctors trained in NIMHANS Bangalore. One-month basic training at NIMHANS in person, followed by twice weekly online training for one year by NIMHANS faculty.

DMHP in Uttar Pradesh

- Establishment of Man-Kaksh in 64 districts of U.P.
- “Dua se Dawa Tak” in 40 districts, where mental disorders are treated by exorcism.
- ‘Man Chetna Diwas’ in 40 districts of U.P. (Ever Thursday).
- Mental Health Review board have been established in 54 districts.

1076 Medical Officers have received training.

CHALLENGES

Although many efforts have been put forward since the advent of the program to make it possible on the ground, the periodic assessments have emphasized various limitations and requirements to make it feasible and convenient. Still, many issues facing the program are worth noticing owing to be mitigated. Various studies have been published regarding the drawbacks and lacunae in the program, and many suggestions to overcome these challenges have been given from time to time. Some but not all the problems in the program have also been resolved, and many are yet to be overcome.

From an administrative perspective, a lack of leadership at every level (Centre, state, and district) has been seen. Apart from it, it has been seen that there are various obstacles while delivering mental healthcare leading to poor implementation of the program like:

- There is narrowed administrative working methods at the centre level,
- There is lack of zeal in primary healthcare professionals
- There is variable coverage, working method across the nation, and fragmentation (irrational division) of responsibilities.

Many psychiatric illnesses are chronic in nature and require management through rehabilitation. The Ministry of Health and Family Welfare takes accountability for treating patients with mental illness, whereas the Ministry of Social Justice and Empowerment is chiefly for rehabilitation part. This irrational division of responsibilities creates a lacuna in the implementation and performance of DMHP.16

Regular flow of funds from centre to state and from state to district could not be ensured.
- Delay in applying for funds,
- Poor utilization of funds by states and poor accessibility due to administrative delay caused irregularities in fund allocation.17,18
- A ‘ring-fenced’ financing program was proposed to ensure regular and adequate fund flow.19

Poorly trained, low-skilled, and poorly paid healthcare workers are overburdened.
- Lack of vigilance support by psychiatrists resulted in poor performance.
- Under DMHP, the training of mental healthcare workers was found less comprehensive and more of a biomedical perspective while overlooking the psychosocial, preventive, and rehabilitative aspects.
- There is a lot of scope for improvement in this area.1

The program has been questioned for not covering the entire spectrum of mental disorders, e.g., substance use disorders and child and geriatric psychiatric illnesses.15

Further, issues such as mental illness and homelessness:
- participation of PWMI and caregivers in program designing, implementation, and monitoring;
- patchy coverage of disability certification and urban mental health are other areas of concern that require their integration into the program.14

To manage these problems, the policy group suggested to
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■ increase the number of specialists
■ lenient educational requirements for them
■ provision of a greater number of courses to empower the supporting team and
■ also creating a new cadre of community mental healthcare workers (CMHW) at the PHC level. A post of chronic disease worker should be created pertinent to strengthening psychosocial support for all chronic non-communicable disease patients.20

For the last 20 years, the government has been running the treatment centres through NMHP without involving NGOs and private sectors and as a result, mental healthcare service delivery has not been sufficient.21

Involvement of various mental health NGOs will bring massive progress in delivering mental healthcare as it will be
■ helpful in running day-care centers and residential facilities for chronically disabled patients or children or mental health promotion activities,
■ Helplines for distressed suicidal patients,
■ facilitating user and family support groups and assisting with livelihoods and employment generation.22

The government has invited various financially supporting NGOs and private sectors for training and sensitization of mental health care workers, continuous community care, and IEC activities. Many private mental health specialists are also being hired for the same.23

The government has recently allotted 45 crore INR for IEC activities to launch websites and TV/radio programs to increase awareness regarding mental health.15

Through IEC activities and community participation, many hurdles in the way of spreading awareness and reducing stigma for People with Mental illness (PwMI) may be overtaken.24

Telepsychiatry under NMHP is the next aid-on service, an innovative modality that is cost-effective and expected to provide a good quality of mental healthcare to all, regardless of their socio-economic status. Although the strategy for proper implementation and functioning of this under the mental health program is a concern that shall be considered on a serious note.25

Conclusion

leadership at all levels of governance, financial and human resources have been essential determinants for the better result of the program.

Community participation, various NGOs and private sector involvement, and IEC activities for spreading awareness are important components.

Strong monitoring and evaluation mechanisms may bring about the desired results for the program.

All ranges of psychiatric illnesses like substance use disorders and neurodevelopmental and geriatric disorders should be covered effectively. Psychosocial intervention and rehabilitation programs need to be implemented robustly.

Proper training of healthcare workers is an essential component that needs to be strengthened for effective coverage of mental healthcare delivery.

Telepsychiatry is a newer modality that has tremendous scope for the effective delivery of mental health services but needs to be planned strategically for the effective performance of the program.

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