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IMHO INDIA MENTAL HEALTH OBSERVATORY

Deconstructing the DMHP: Part I

Introduction to India's District Mental Health Programme

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Introduction

The District Mental Health Programme (DMHP), launched in 1996[1], is the flagship community mental health Programme of the Central Government of India. It is an integral component of the National Mental Health Programme (NMHP) launched in 1982 by the Ministry of Health & Family Welfare, with the objectives of integrating basic mental healthcare in general healthcare and promoting community healthcare. The NMHP was a first of its kind state-led mental health initiative among low- and middle- incomes countries (LMICs)[2,3].

This Issue Brief is the first in the four -part series on the District Mental Health Programme. The purpose of the series is to provide perspective on the nature of information and data that exists on the DMHP, and to build a descriptive understanding of it's evolution, structure, framework, and implementation, since the information currently available on it is sparse and fragmented. The focus of this brief will be on the history and evolution of the DMHP.

Historical Background

At the time of India's Independence, there were nearly no mental healthcare services for persons with mental illness. The development and strengthening of mental healthcare services in India began after 1947. In the first two decades after independence the focus remained on increasing the number of beds available for persons in need of mental healthcare and improving the living conditions in these existing hospitals[4]. It was during this period that there was a shift in the psychiatric approach to recognise the role of families in providing care to persons with mental illness[5].

In 1975, initiatives were introduced to integrate mental healthcare services with general health services, drawing on what came to be recognised as 'community psychiatry'. While this began as an extension of psychiatric clinics in primary health care centres, these reforms were institutionalised with the introduction of the National Mental Health Programme (NMHP) in 1982. Such developments and reforms in India's mental health policy and service delivery Programme over the years have been influenced by local situations as well as international developments[6].

In 1943, the Government of India appointed a Health Survey and Development Committee, popularly known as the Bhore Committee. This Committee was tasked with (a) conducting a broad survey of the health conditions and infrastructure in British India, and (b) providing recommendations for future health Programmes in the country[2,7].

The Bhore Committee submitted its report in 1946, in which it took note of the high infant mortality and maternal mortality rates, low life expectancy and overall poor health conditions of the population. The report included recommendations and a plan for improvement based on a set of objectives to be achieved through the plan. These objectives included increasing the number of healthcare facilities and human resources in the country, ensuring access to healthcare services, special provisions for women, children, and persons with disabilities and mental illness, and improving healthcare in rural India.[8] Post Independence, two other important Committees were appointed: the Health Survey and Development Committee, commonly known as the Mudaliar Committee (1959) and the Group on Medical Education and Support Manpower, widely known as the Srivastava Committee (1975).

The Mudaliar Committee was set-up to (i) review the implementation status of the Bhore Committee's recommendations, and (ii) make recommendations for the third and subsequent Five-Year Plans (FYP). It submitted its report in 1962, in which it observed the absence of reliable data on the prevalence of mental illness, and the gap in treatment.

The Srivastava Committee (1974) was set-up to provide inputs for (i) reorienting medical education as per national needs & priorities; and (ii) developing a curriculum for health assistants. The Committee recommended the Community health volunteer (CHV) scheme[9]; further suggesting that CHVs be trained to provide support to persons with mental illness, including for identification and management[2].

The three committees identified gaps and in their respective reports, made recommendations for the provision of mental healthcare services. These recommendations are summarised in Table 1.

While the first two decades post-Independence were focused on addressing infrastructure and human resource deficits for mental health services, the concept of community psychiatry became popular with the international shift in focus to provide support to persons with mental illness outside of institutions and mental health hospitals, thus leading to the adoption of more community-based approaches. In India however, community psychiatry assumed a different role, and has been seen as a means to provide basic mental health care to a large population with insufficient resources[10].

Internationally, between the years 1975 and 1981, there was a push to include mental healthcare in primary health services and adoption of community healthcare models. The Declaration of Alma Ata (1978) which identified primary health-care services as the key to attainment of health for all[11], and a multi-country project by the World Health Organisation (WHO) on "Strategies for extending Mental Health Services into the Community", (1976-1981) were some of the international milestones that led to the formulation of the National Mental Health Programme[2].

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Table 1: Recommendations on Mental Healthcare

Bhore Committee (1946)
(i) Psychiatric beds be increased; (ii) Mental health organisations be created at the Centre and in States; (iii) Training in mental health for all medical and ancillary personnel; and (iv) creation of a department of mental health in the proposed All India Institute of Mental Health (present day National Institute of Mental Health and Neurosciences [NIMHANS]).
Mudaliar Committee (1962)
(i) Providing preventive mental health services; (ii) Improvement of curative services; (iii) Training of psychiatric and mental health personnel to address the acute shortage of human resources; and (iv) Promotion of research to better understand the mental health challenges being faced by the population.
Srivastava Committee (1974)
Recommended the Community Health Volunteers (CHV) scheme and suggested that the training for CHVs include mental health components, to equip them with the skills of identifying persons with mental illness and provide support during crises.

National Mental Health Programme

In the 1980's following international developments around the community healthcare model, the Government of India recognised the need for an action plan to incorporate mental health in the national health Programme. Thus, the Government constituted an expert committee for drafting the National Mental Health Programme. A first draft of the Programme was presented to 60 experts from across the country in 1981. Following feedback and comments from the experts, a revised draft was prepared and submitted to the Central Council of Health (the highest health policy-making body of India at the time)[8].

The draft submitted was approved and in 1982, the National Mental Health Programme was launched, with the objective of facilitating the integration of mental health care with primary healthcare services. The aims of the Programme were to: (i) ensure availability and accessibility of minimum mental healthcare for all, particularly the most vulnerable sections of the population; (ii) encourage mental health knowledge and skills in general healthcare and social development; and (iii) promote community participation in mental health service development and promote self-help in the community[10]. The focus of the NMHP at the time of its launch was on treatment, prevention, and rehabilitation through decentralised and phased training courses to equip district-level health personnel for providing basic mental healthcare services in rural India.

In 2003, under the X FYP, the NMHP underwent a review and was re-strategized as a comprehensive mental healthcare delivery system.[8,9] The renewed objectives of the NHMP were to expand the scope of the medical education curriculum for undergraduate training in psychiatry, modernisation of mental healthcare institutions, strengthening of central and state mental health systems, and promoting research and training in the field of community mental health, substance abuse and child/adolescent psychiatric clinics[12].

Between 2007-2012, under the XI FYP, the objectives of the NMHP were further revised. Since then, the focus of the NMHP has been on (i) establishing centers of excellence in mental health; (ii) setting up and strengthening Post Graduate studies departments in mental health specialties; (iii) implementation of the District Mental Health Programme (DMHP) for detection, management and treatment; (iv) building partnerships with NGOs and the public sector; and (v) conducting awareness campaigns and research[1]. Some key milestones are summarised in Table 2.

Table 2: Key milestones

Year	Milestones
1943	Bhore Committee
1959	Mudaliar Committee
1975	Srivastava Committee
1982	Launch of National Mental Health Programme
1992	Eighth Five Year Plan
1996	Launch of District Mental Health Programme
1997	Ninth Five Year Plan
2002	Tenth Five Year Plan
2007	Eleventh Five Year Plan
2012	Twelfth Five Year Plan

District Mental Health Programme

Between 1985 and 1990, NIMHANS conducted a pilot project in Bellary district of Karnataka, to assess the feasibility of what is today known as the District Mental Health Programme. The 'Bellary Model' conceptualised by NIMHANS entailed identifying and training suitable personnel to join the DMHP team for providing mental healthcare support to persons with mental illness and their families in the district. The services provided by the DMHP during this pilot included out-patient service, a 10-bed inpatient facility, referral services, awareness Programmes and community assessment. The pilot demonstrated the viability of delivering basic mental healthcare services in the district, taluk and Primary Healthcare Centres (PHCs), by trained PHC staff, under the supervision of the DMHP team. The "Bellary Model" paved the way for the launch of the DMHP, as a service delivery component of the NMHP in other districts of India.

To expand and decentralise mental health services under the NMHP, the DMHP was launched in 1996, with the aim to (i) ensure the availability and accessibility of minimum mental healthcare for all, particularly to vulnerable and marginalised communities; (ii) encourage integration of mental healthcare into primary healthcare, and (iii) promote community participation in developing mental health services. The adoption of the DMHP in India has been an important public health initiative in mental health service delivery. It was one of the first concerted attempts to provide a decentralised framework for mental health services at the primary level of the public health system. The specific objectives of the DMHP, at the time that it was adopted were to[13]:

- Provide sustainable basic mental health services to the community and to integrate these services with other health services.
- Early detection and treatment of patients within the community.
- Ensure patients and their relatives do not have to travel long distances to access hospitals or nursing home in cities.
- Reduce the stigma attached towards mental illness through change of attitude and public education.
- Treat and rehabilitate persons with mental illness within the community, after their discharge from hospitals/ institutions.

At the time of the DMHP's launch in 1996, a budgetary provision of INR 27 crore under the VIII FYP was made - making it a centrally funded Programme - for providing community based mental health services in the country at PHCs through trained medical personnel and psychiatrists.

The DMHP was first launched in four districts and gradually increased to 27 districts during the IX FYP (1997-2002)[12]. During the X FYP it was expanded to 94 districts, with a budgetary allocation of INR 190 crores; followed by an expansion to cover 123 districts with a budget of 1000 crores in the XI FYP. During the XII FYP, the Programme was revitalised, with a budgetary outlay of INR 1,265 crore for expanding the Programme in a phased manner to cover the whole country[14,15].

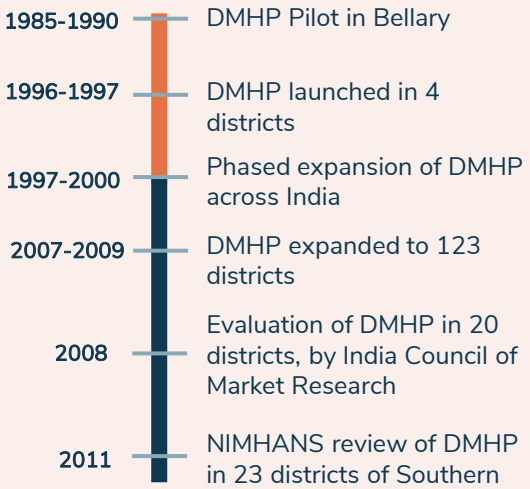
In this duration, infrastructure expansion initiatives too were undertaken for the upgradation of psychiatric wings in 71 medical colleges/general hospitals and modernisation of 23 mental healthcare hospitals, under the NMHP[2]. Improve and build the capacity of hospitals for persons with mental illness

Current Scenario

Since its inception, provisions under the DMHP have been revised under every FYP to address gaps and challenges, and several evaluations of the Programme too have taken place.

In 2008, the Indian Council of Market Research (ICMR) undertook an evaluation study to examine the DMHP[15] and its performance during the IX and X FYP. It examined 20 districts where the Programme was in operation, in addition to 5 non-DHMP districts.

Figure 1: Evolution of DMHP
(Image credit: IMHO)



Based on the evaluation and additional inputs received from consultations, the Programme was expanded to include interventions to such as (i) School Mental Health Services; (ii) College Counselling Services; (iii) Workplace Stress Management; and (iv) Suicide Prevention Services[2].

In 2012, the MoHFW appointed a Mental Health Policy Group (MHPG) to draft recommendations for the DMHP under the XII FYP (2012–2017). The MHPG emphasized several findings of previous evaluations. The DMHP was revised under the XII FYP based on the recommendations by the MHPG and the Programme is currently implemented based on the guidelines issued by the MoHFW in 2015. Its components include i) service provisions, ii) capacity building and iii) awareness generation[15].

The XII FYP concluded in the year 2017, following which the Government of India discontinued the Five-Year Plan Programme. However, at present the DMHP continues to be implemented based on the guidelines issued in 2015 under the XII FYP. There exist no government notifications or reports to suggest otherwise.

In response to a question raised in the Lok Sabha, in September 2020, the government reported that it was supporting the implementation of the DMHP in 692 districts of the country[16].

Conclusion

The DMHP is an important government Programme, which by ensuring the integration of mental healthcare services with general healthcare services, ensures access to mental healthcare services in rural India through the public health system.

Following its inception, the Programme and its objectives were revised and broadened under the Five-Year Plans. However, it appears no comprehensive evaluation of the DMHP has been undertaken since the Programme was revised under the XII FYP based on recommendation made by the Mental Health Policy Group. Further, several recommendations from previous evaluations of the Programme remain unaddressed.

To thoroughly assess the DMHP, it is crucial to understand some of its core building blocks, like the governance structure, fiscal processes, budgetary utilisation, and the service delivery component. The next briefs in this series will provide a descriptive understanding of the above-mentioned aspects of the Programme and will attempt to map these structures and processes at the Central and State level.

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