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IMHO INDIA MENTAL HEALTH OBSERVATORY

Deconstructing the DMHP: Part II

Understanding the Framework and Implementation

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Introduction

Launched in 1996, the District Mental Health Programme (DMHP) was constituted under the National Mental Health Programme (NMHP) for the decentralisation of mental health services and their provision at the community level through the integration of mental health services within the general healthcare delivery system, and is the main mental healthcare service delivery programme in India[1,2].

This issue brief is the second in the series on the District Mental Health Programme. It provides a detailed description of the specific components and services under the DMHP, its governance structure and implementation, and existing monitoring and evaluation mechanisms.

Objectives of the DMHP

Since its inception, the objectives of the DMHP have been revised under each of the Five-Year Plans (FYP). At present, the DMHP is implemented based on the guidelines issued in 2015 by the Ministry of Health and Family Welfare (MoHFW), under the XII FYP.

Under these guidelines, the objectives of the DMHP are to (i) provide mental health services, including prevention, promotion, long-term and continuing care at different levels of the district healthcare delivery system; (ii) augment institutional capacity in terms of infrastructure, equipment and human resources for mental healthcare; (iii) promote community awareness and participation in the delivery of mental health services; and (iv) integrate mental health services with other related programme.

Setting up the DMHP

The district for implementing the DMHP is identified by the Principal Secretary of the State Department of Health and Family Welfare along with the State Nodal Officer for mental health. Before the DMHP is implemented in a district, a formal assessment of the preparedness of the district to undertake the prescribed activities is carried out, alongside a mapping of the existing resources available in the district.

As the next step, a formal application along with a document to show readiness for implementing DMHP are submitted to the central government, following the approval of which a grant is awarded for implementation. Documents required to be submitted with the application include:

1. A Resource map for mental health activities within the district
2. Letter of commitment / Memorandum of Understanding (MoU) by the state government
3. Letter of appointment of an appropriately experienced and qualified State Nodal Officer
4. Letter of commitment for proper utilization of funds
5. Letter of commitment for appointment of the District Program Officer with an assurance that the officer shall not be transferred from the district in the five years of DMHP
6. Letter of consent from the Program Officer.
7. Letter of commitment for continuation of the activities of the project after the project period.

In order to widen the reach of the DMHP, proposals received from States with lesser representation in the DMHP scheme are given preference for implementation of DMHP[3].

Human Resources for DMHP

Once a district is approved for implementing the DMHP, the State Department of Health and Family Welfare appoints the DMHP staff. The staff appointed includes personnel for the Community Healthcare Centres (CHC)/ Taluk and Primary Healthcare Centres (PHC) in the district as well as for overseeing the district. The main DMHP team is multi-disciplinary in its composition and consists of 8 members including specialists and allied healthcare professionals (depicted in *Figure 1)* [3].

The appointment of staff at the CHCs/ Taluk level and PHCs are subject to the level of functioning of the DMHP in that district. For example, if the Programme has not been fully operationalized in a particular district, only outreach services are provided at the CHC/s Taluk and PHCs of that district. The appointment, salaries and contracts of the DMHP staff are managed as per the rules and policies of the State.

Components of the DMHP

There are three main components of the DMHP: (1) service provision, (2) capacity building and (3) awareness generation. While implementing the DMHP, States may make changes or accommodations in the DMHP keeping in mind the needs, availability of resources and ground realities, while ensuring the implementation is in compliance with the guidelines laid down by the Central Government. The sections ahead describe each component of the DMHP in detail.

Component 1: Service Provision

This component of the DMHP focuses on the identification and management of mental disorders at different levels of the healthcare delivery system with a focus on (a) providing Out-Patient (OPD) and In-Patient (IPD) services at the district hospital; (b) referrals through OPD services at CHCs and PHCs; and (c) outreach services at CHCs and PHCs by the DMHP team at regular intervals to extend support to the Medical Officer.

Outpatient services under this component are provided by the psychiatrist, along with one nurse from the district hospital. In districts with insufficient human resources, DMHP services are provided by doctors trained as General Duty Medical Officers. In further cases of insufficient human resources, the XII FYP guidelines provide for the engagement of psychiatrists in private practice to support with the DMHP.

Within service provision, it is mandated that a register with a unique registration number of all persons accessing services under the DMHP is maintained. The guidelines mandate the availability of adequate infrastructure to ensure the privacy and confidentiality of service-users. The assessment of persons accessing DMHP

Figure 1: Human Resources for DMHP
(Image Credit: IMHO; Data Source: 12th Plan Guidelines for the DMHP)

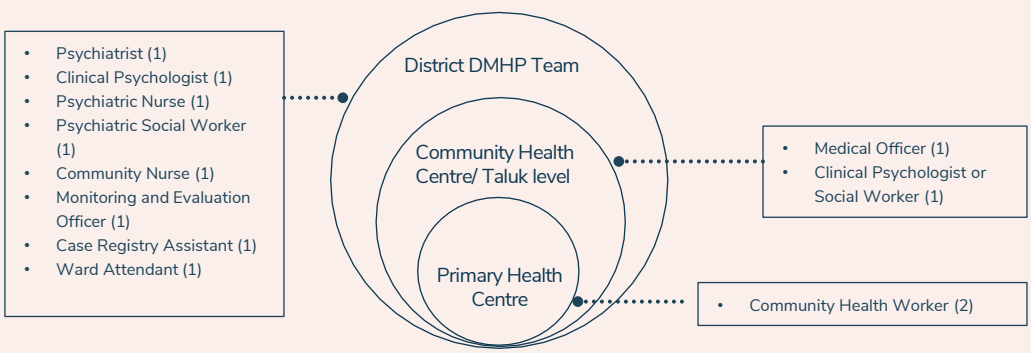
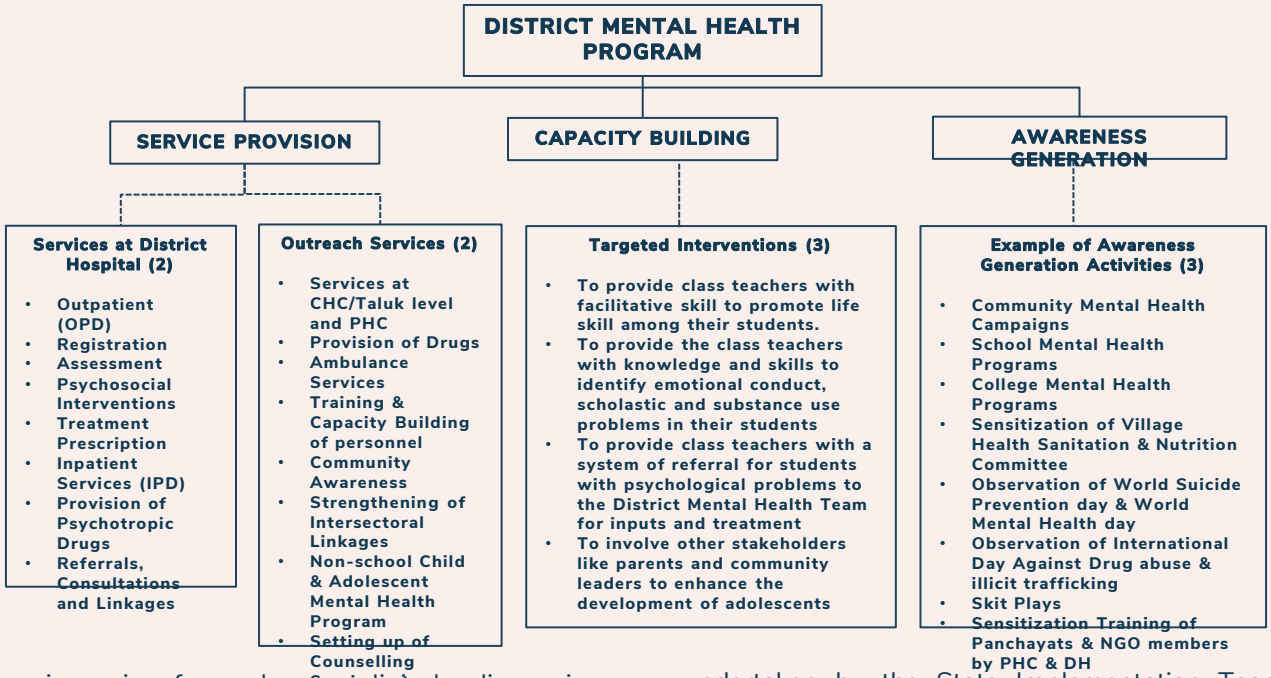


Figure 2: Components of the DMHP
(Image Credit: IMHO; Data Source: 12th Plan Guidelines for the DMHP)



services is focused on clinical diagnosis, treatment, and interventions. Counselling services and other psychosocial interventions are provided by the medical social worker or psychologist appointed as DMHP staff

For in-patient services under the DMHP, each district hospital is required to have an exclusive, 10-bedded psychiatric ward. The services provided in the ward are to include assessment and diagnosis, nursing care, emergency care, psychosocial support, medication, food, and recreational facilities. Standardised healthcare packages for people with mental illnesses accessing primary healthcare facilities, including OPD, IPD and referral services are also to be provided.

Under the DMHP, essential psychotropic drugs, such as antipsychotics and antidepressants are provided at the District Hospital, CHCs and PHCs. It is the responsibility of the Psychiatrist/ Programme Officer to ensure that the drugs for treatment and management of mental illness are available at all times. The procurement of the drugs and ensuring their availability is undertaken by the State Implementation Team and the District Programme Manager. In case of delays in procurement, the District Health Society may provide special permission to purchase the drugs directly from the supplier. At the district hospital, drugs are provided only if a psychiatrist has been appointed. In the absence of a psychiatrist, the individual may be referred to the medical college, hospital or a private psychiatrist engaged under the DMHP.

Annually, each district is provided with funds for ambulatory support for transport for persons with mental illness to public health facilities. Examples of other activities undertaken within this component, are listed in *Figure 2*.

Component 2: Capacity Building

The capacity building component of the DMHP focuses on training of personnel by providing information, knowledge and skills for prevention, early detection, identification and management of mental disorders, through various means including counselling and providing referrals[3,4].

These trainings are conducted by the Medical Officer and the DMHP team posted at the District Hospital for a range of stakeholders, including healthcare workers at the CHC/Taluk and PHC level, elected community representatives, community health workers (ASHA, ANM, AWW, etc.) and school teachers[3].

Apart from routine training, the purpose of training staff at CHCs and PHCs is to facilitate the integration of mental healthcare services in primary healthcare services[3,4]. The implementation guidelines provide details on the number and duration of training sessions for each category of personnel. It is recommended that training sessions be held at the District Hospital, CHC, Taluk headquarters, or nearby Centres of Excellence or Medical Colleges. The resource persons for the training sessions vary depending on the category of personnel being trained. For instance, the resource persons for training Medical Officers and Paramedical staff of the DMHP may be a State Nodal Officer or the Head of the Department of Psychiatry of a Medical College or Centre of Excellence; whereas the prescribed resource person for the training of Medical Officers and para-medical workers at the CHCs or PHCs is a psychiatrist. Further, the resource persons are prescribed a syllabus to be followed during the training[3].

Component 3: Awareness Generation

Another component of the DMHP is to generate awareness related to mental health through Information, Education and Communication (IEC) activities. These activities are specifically aimed at early identification and management of mental disorders, providing information of available mental healthcare services and to reduce the stigma attached to mental illness. These activities are coordinated by the District Programme Officer. Additionally, as a part of the awareness generation component in some states, educational material is disseminated through healthcare workers and other community stakeholders[3].

Each district under the DMHP receives funds from the National Health Mission's Non-Communicable Diseases flexi-pool for IEC and awareness generation activities. aimed to promote community knowledge and participation. Activities under this component take place in the community, schools, colleges, workplaces, and may include street plays, wall paintings and mass messages in local newspapers and radio platforms among others[5],[3,6].

Governance, Monitoring and Evaluation

The DMHP was brought under the umbrella of the National Health Mission from the 2013-14 Union Budget onwards. Similar to other health Programmes, the DMHP is governed by the MoHFW at the Centre and by the State Department of Health and Family Welfare. Under the DMHP's administrative structure, Mental Health Cells are constituted at the state and district level, and their functioning is overseen by the Central Mental Health Cell[3].

Monitoring

Monitoring is an integral part of the DMHP and begins from the very first month when the programme is implemented. States and districts are required to provide updates at regular intervals regarding the progress, in a format prescribed by the Central Mental Health Cell. The State Nodal Officer for the DMHP oversees the programme's implementation and monitoring for

the State. The State Nodal officer acts as the representative official of the DMHP at the State Health Society and is responsible for receiving and disbursing funds to the districts implementing the DMHP in that state. Similarly, District Programme Officers represent the DMHP at the District Health Society and are responsible for overseeing activities at the district level[3]. The State monitoring structure is depicted in *Figure 3*.

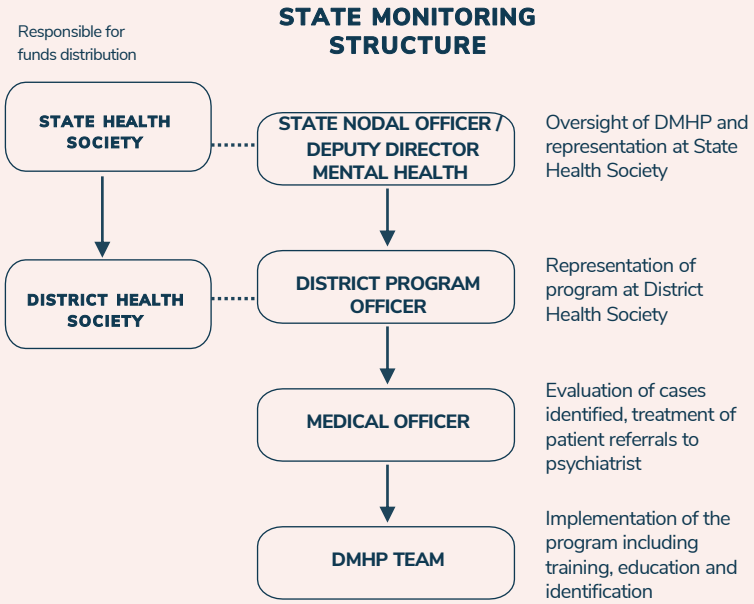
It is mandated that District Programme Officers visit their respective district for monitoring and review on a quarterly basis, as well as to provide training and consultation. Some of the parameters for review and evaluation include the availability and performance of the DMHP implementation team [including Medical Officers, Health Assistants and Auxiliary Nurse and Midwives (ANMs)], the number of training and capacity building sessions held, status of services available, awareness generation activities undertaken, fiscal expenses and utilisation, and levels of community engagement[3].

Another important monitoring tool within the DMHP is research. During the revision of the XI FYP guidelines, the National Consultative group, composed of mental health experts and professionals, acknowledged operational research as crucial for addressing gaps in implementation while also serving as an internal evaluation mechanism of the DMHP. According to the operational guidelines under the XI FYP, funds for research are allocated within the DMHP and can be supplemented with funds for research allocated for the NMHP and from external sources of funding such as research institutes and non-governmental organizations[7].

Governance and funding

Since the DMHP falls under the umbrella of the National Health Mission, a part of the funds for the programme are allocated under the NCD Flexible pool. In order to obtain funds for the DMHP, states are required to submit a consolidated proposal of activities to be undertaken for the DMHP in the State Project Implementation Plan (PIP) on a yearly basis[3].

Figure 3: Governance of the DMHP at the State-level
(Image Credit: IMHO; Data Source: 12th Plan Guidelines for the DMHP)



The State PIP includes information about the implementation of the DMHP in each district. Thus, every district implementing the DMHP is required to submit proposals in the form of a District Health Action Plan. The creation of the District Health Action Plan is facilitated by the District Programme Officer and the Psychiatrist at the District Hospital acts as the resource person. The consolidated PIP includes details of the officers responsible for implementation, existing health infrastructure, current availability of mental healthcare services, present status of the implementation of the DMHP, activities envisaged for the next financial year, and the proposed budget and timeline of these activities[3].

The State PIPs are submitted to the MoHFW for processing. Once reviewed and revised if needed, the approved proposals are sent to the National Health Mission division for inclusion in the final Record of Proceedings (ROPs) and the funds earmarked for DMHP activities are released. The funds from the Centre to the States/ UTs are released to the State Health Society, which then releases the funds to the District Health Society[3,7]. Description of the fiscal and budgetary components of the DMHP are described in detail in the next part of this series.

Present status

As of September 2020, the MoHFW reported that the Government was supporting implementation of the DMHP in 692 districts across the country[8].

In an effort to strengthen the delivery of primary health care in India based on provisions under the National Health Policy, 2017, the Government launched Ayushman Bharat in 2018. The programme aims to create 1,50,000 Health & Wellness Centres (HWCs) by transforming existing Sub-Health Centres and PHCs to deliver comprehensive primary healthcare[9]. The HWCs are envisioned with an expanded range of services, including screening and basic management of mental health conditions. According to the operational guidelines for Ayushman Bharat released by the MoHFW, mental healthcare will be provided at the community level as well as in HWCs and services will include diagnosis, counselling, provision of medicines and referral services. While strengthening service delivery at the primary healthcare level is a welcome initiative, it remains unclear how this will affect the current implementation and governance structure of the DMHP[9].

Conclusion

While the guidelines and framework for implementing the District Mental Health Programme are prescribed by the Central government, the programme's implementation across the country is not uniform. Health being a concurrent subject, states are free to make adaptations in how they implement the DMHP taking into consideration factors such as availability and quality of human resources, infrastructure, and financial resources available. For example, the National Mental Health Survey (2016) found that 13.64% of the districts in Punjab were covered by the DMHP, whereas in Kerala 100% of the districts were covered, indicating the range of variation in implementation and utilization of the programme among states[10].

A crucial aspect in the implementation and governance of the DMHP are the fiscal processes, budgetary allocations and utilisation. The next brief in this series maps the various fiscal processes of the DMHP.

References

1. Singh OP. District Mental Health Program - Need to look into strategies in the era of Mental Health Care Act, 2017 and moving beyond Bellary Model. *Indian J Psychiatry*. Published online 2018:2017-2018. doi:10.4103/psychiatry.IndianJPsychiatry
2. *XIIth Plan District Mental Health Programme Prepared by Policy Group*.; 2012.
3. Ministry of Health and Family Welfare. Guidelines for implementing of District Level Activities under the NMHP. Published online 2015. https://main.mohfw.gov.in/sites/default/files/56464578341436263710_0.pdf
4. Rasaily S, Lall Sharma I, Ongmoo K. Capacity building and community process in DMHP implementation in Gyalshing District, Sikkim: Two year report (13-14). *J Med Res*. 2017;3(3):169-171. Accessed May 4, 2021. http://www.medicinearticle.com/JMR_20173_15.pdf
5. Union Minister Choubey: Govt Spent Rs. 545 Cr On Mental Health Awareness Initiatives. Accessed May 4, 2021. https://indusdictum.com/2019/11/19/union-minister-choubey-govt-spends-rs-545-cr-on-mental-health-awareness-initiatives/
6. Gupta S, Sagar R. National Mental Health Programme – Optimism and Caution: A Narrative Review. *Indian J Psychol Med*. Published online 2018. doi:10.4103/IJPSYM.IJPSYM
7. Ministry of Health and Family Welfare. Operational Manual for District Mental Health Program: 11th 5 Year Plan. *NIMHANS Publ*. Published online 2011.
8. *Increase in Suicides. Unstarred Question 2196*.; 2020. http://164.100.24.220/loksabhaquestions/annex/174/AU2196.pdf
9. NHSRC. *AYUSHMAN BHARAT: Comprehensive Primary Health Care through Health and Wellness Centers - Operational Guidelines*.; 2018. Accessed May 4, 2021. http://nhsrcindia.org/sites/default/files/Operational Guidelines For Comprehensive Primary Health Care through Health and Wellness Centers.pdf
10. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK et al. National Mental Health Survey of India, 2015-16: Summary. *NIMHANS Publ*. Published online 2016:1-62. http://www.indianmhs.nimhans.ac.in/Docs/Summary.pdf