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Deconstructing the DMHP: Part IV

A critique of the District Mental Health Programme

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Introduction

The District Mental Health Programme (DMHP) is the largest and most important public health initiative in India for mental health, aiming to integrate mental healthcare with general healthcare[1]. The origins of the DMHP lie within the National Mental Health Programme (NMHP) launched in 1982, where India was one of the first developing countries to adopt such a programme. The DMHP developed from the success of the 'Bellary Model' piloted in 1984. The implementation of the DMHP began in 4 districts in 1996, and as of 2021, it is being implemented in 692 districts[2]. The DMHP has been both widely applauded for its important contribution toward strengthening public mental health service delivery as well as criticised for its ineffective design and functioning.

The National Mental Health Survey (NMHS) 2016 found that 10.6% of the population live with a mental illness out of which a majority do not, or cannot, access treatment with a care gap of around 80%[3]. Information on the implementation of the DMHP, especially that released by the Government of India, is scarce. Reconstructing a comprehensive picture of the DMHP requires piecing together several documents published over the years. The latest publicly available guidelines outlining the objectives, scope, components and administrative structure of the DMHP are the Ministry of Health and Family and Welfare (MoHFW) guidelines issued under the XII Five-year plan (FYP) in 2015[4].

The DMHP was originally set up as a pilot study in Bellary district of Karnataka, closely monitored by the National Institute of Mental Health and Neurosciences (NIMHANS), a national mental health institute located in the state. The direct involvement of highly trained mental health professionals to monitor the mental health workforce in Bellary contributed greatly to the success of the implementation of the programme in Bellary[5]. While the pilot study was deemed successful, the high variances and unevenness of demography, and the fact that not all States have the infrastructural, technical and human resource capacity as that of Bellary district or the state of Karnataka appears to have been overlooked leading to non-uniform adaptation of the programme across districts and states[5]. These variances have led to non-uniform adaptation of the programme across districts and states. Further, the 'one-size-fits-all' approach means that the DMHP has not been uniformly adapted to highly diverse contexts and settings across the vast sub-continent of India, and thus at times, even where it has been implemented, has not met the specific mental health needs of people in the community[6,7].

Over the 25 years of the existence of the DMHP, there have been only two Central Government sanctioned, systematic evaluations of the DMHP. The first one was conducted by NIMHANS in 2003 in 27 districts across 20 states throughout the country. And the second such evaluation was done by the Indian Council for Market Research, an external consulting agency, between 2008 and 2009 based on an analysis of 20 districts across the country[8,9]. Other important evaluations include an evaluation by NIMHANS in 2011, covering 23 DMHPs in the southern states of Karnataka, Tamil Nadu, Maharashtra and Andhra Pradesh as well as the National Human Rights Commission (NHRC) Technical Committee on Mental Health Report published in 2016[10,11]. The objective of these evaluations was to assess the degree and effectiveness to which the DMHP was being implemented in different states and union territories. An important development in this regard was the constitution of the Mental Health Policy Group by the MoHFW in 2012 to review the implementation of the DMHP and provide recommendations for the better implementation of the DMHP under the XII FYP through holding regional workshops and consultations[12,13,14]. In addition to these evaluation reports, there have been numerous research studies on the DMHP, in the form of reviews, critical ethnographies, focused analyses, as well as pilot intervention studies.

The DMHP, when developed, was envisaged to be decentralised, yet critiques have found it

continues to follow a top-down approach, with heavy administration challenges, and a lack of involvement of users and caregivers in the design, implementation and monitoring of the DMHP[5]. In this issue brief, we highlight the gaps in the design, structure and implementation of the DMHP, as indicated by various reports.

Administration

The literature on the DMHP finds a common point of criticism in the administration of the programme: multiplicity in administrative bodies resulting in a fragmentation of responsibilities[13,14]. Critiques have found there is poor coordination within and across ministries, departments, and statutory bodies at the national, state and district level. For instance, healthcare comes under the MoHFW, while rehabilitation falls under the purview of the Ministry of Social Justice and Empowerment and this overlap creates gaps between resources for healthcare and actual delivery. Discussions during the regional workshops conducted by NIMHANS in 2012 revealed that the multiplicity of the administrative bodies results in lack of accountability in the implementation of the NMHP and the DMHP. Eventually this leads to poor collaboration with external actors and related health programmes such as the National Rural Health Mission and thus, interferes with implementation of the DMHP[14].

Finally, beyond a lack of clearly defined and non-overlapping roles, literature on the DMHP highlights political neglect and inadequate leadership as hurdles in the way of effective governance and implementation of the DMHP[15]. Evidence from the ground has shown that successful implementation of the DMHP has often been determined by political will and commitment of the nodal officer or others in leadership roles[8].

State & district level variances

Health being a concurrent subject, States can exercise autonomy in implementing health programmes which can potentially benefit them to prioritize and adapt the DMHP to suit their local contexts.

In general, researchers argue that the top–down and 'one-size fits all' approach to service delivery cannot accommodate diverse local realities[15]. The NMHS (2016) found a majority of the states surveyed had less than 50% of their population covered by the DMHP[3]. However, as indicated above, the implementation of the DMHP is not uniform across the country, where for example in Punjab, 13.64% of the districts were covered by the DMHP, whereas in Kerala, 100% of the districts were covered[3]. Similarly, reports have found that certain states, such as Tamil Nadu, Kerala, and Gujarat, have indeed fared better than other states in implementing the DMHP in terms of efficiency and effectiveness, attributed to multiple reasons including the presence of an existing and well-functioning health system[8,11,16].

Variances in demographic factors between districts play an important role in the implementation of the DMHP too. There are vast differences across districts in terms of population and area. To highlight this fact, the NIMHANS report found that the population size of the 27 districts that were evaluated ranged from 30,000 to 41 lakh individuals and the area covered ranged from 72 sq km to 9600 sq km. Further, the number of taluks in the districts ranged from 1 to 45 and the number of primary health centres in the district ranged from 0 to 94, again indicating the variances in districts covered by the DMHP[8]. Overall, the report found that an important factor contributing to successful implementation was the choice of district, where districts chosen with sufficient consultation and planning, or districts closer to the nodal office or state capital, were often more efficient and thorough in their implementation of the programme[8].

Human Resources

Beyond demographic variances in the implementation of the DMHP, there is also a shortage of human resources in the programme.

Nationally, the ratio of mental health professionals to population is abysmally low, with 1.93 mental health personnel per 100,000 population. These low ratios are reflected in the implementation of the DMHP as well[11]. A report in 2008 found that for every category of mental health professional in the DMHP - psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses - there are more vacancies than posts occupied. The report also found that 44% of all state psychiatric hospitals had no clinical psychologist [5,17]. The total number of professionals required to implement the DMHP are lacking. While the Manpower Development Scheme under the NMHP aims to address this by training more mental health professionals, the lack of availability of professionals is not the only cause of concern[18].

The report from NIMHANS cites administrative and implementation guidelines as a cause for major bottlenecks in the appointment and retention of staff for the DMHP, where strict recruitment rules and minimum required qualifications leave very few eligible to be appointed[8]. Further, consolidated comments from discussion in the Regional Workshops found that the poor salary structure for mental health professionals added to the widespread vacancies under the DMHP[14]. And once appointed, inadequate effort to retain staff led to frequent turnovers within the DMHP. Similar issues are found across the health sector where retention of health professionals in publicly funded rural health services in India is often a concern due to poor pay-scales, large volume of work and limited available resources, further compounding the problem of attracting and retaining specialists[15].

Further, reports found that training and technical skills were lacking in the implementation of the DMHP, both at the level of public health services and mental health services. This is in part due to overburdening of existing professionals, where the psychiatrist responsible for a district under the DMHP is expected to carry out a large range of activities and roles (including coordination, administration, training, communication and research). And in part due to limited training on the job, where the MH Policy Group found that the DMHP staff and personnel were trained only once during their tenure and there was no follow up support or supervision in many of the districts evaluated [10,13]. This has severe consequences, including violation of patient rights, where reports found limited efforts toward sensitizing staff on issues specific to mental health during delivery of services[14]. Thus, inadequate human resources overburdening existing staff coupled with limited training and technical support further contribute to the treatment gap.

The MH policy group recommended several different strategies to address the human resource challenges, including relaxing the educational requirements for specialists to address problems in recruiting staff, as well as the training of a new cadre of community mental health workers at Primary Health Centres, to assist in identification of persons with mental illness, provide basic counselling and help people access the necessary treatment. To also address the high turnover and the sensitive nature of mental health issues, the MH Policy group recommended frequent training and monitoring and feedback mechanisms to ensure continued support for the staff[13]. However, it is unknown whether these recommendations were adopted.

To ease the shortage in human resources further, researchers have found certain models of diagnosis and management of mental disorders to be successful in empowering non-psychiatrist doctors and paramedics to diagnose psychiatric disorders accurately and reliably in remote sites[19,20]. They argue the use of such models can potentially ease the human resources burden with task shifting strategies. Other researchers have highlighted the growing accessibility of telepsychiatry as a tool with immense potential to address the concerns of the NMHP and the DMHP. Given that India has undergone a digital revolution and assuming it will continue to expand to provide digital access to remote areas, telepsychiatry can potentially be harnessed to

address some of the barriers of distance and access[21].

Financing the DMHP

Alongside variances in implementation at the state and district levels, there are specific concerns on the financing of the DMHP. States often reported inconsistent or delayed fund transfers leading to poor utilisation, along with administrative barriers and challenges at the Central level, have impeded the implementation of the DMHP over the years[14]. The funding for the DMHP comes under the NCD Flexible pool of the NHM, with a shared responsibility from the State, usually split with a 60:40 ratio. The funding from the Central Government for each district of the DMHP is usually limited to five years from the date of initiation, after which States are required to take over the financing of the programme. However, it was largely noted that state governments are reluctant to do this, since not all states have the infrastructure or financial resources to effectively sustain implementation, often adding to the poor functioning of the DMHP[14].

Finally, in terms of monitoring the DMHP, regular and detailed breakdowns of the funds allocated and provided for the DMHP are unclear or unavailable to the public. In 1996, when the DMHP was implemented in 4 districts, ₹27 crores were allocated as initial costs. The budget increased to 190 crores in the X FYP and 1000 crores in the XI FYP allocations. However, these budgets were under-utilized citing administrative bottlenecks[15]. As of 2021, while the implementation of the DMHP is being supported in 692 districts, the breakup of budgetary allocations of central funds is not directly discernible to the public[2].

Data and monitoring

At present, the monitoring systems of the DMHP include administrative monitoring at the level of districts and states and the annual budget demands and utilization in the form of annual Programme Implementation Plans (PIPs) and Record of Proceedings (ROPs) submitted to the central government.

Regular quarterly visits to districts are mandated to take place by District Programme Officers, for monitoring and review as well as larger consultations with the State Nodal Officer[4]. However, it is difficult to ascertain the effectiveness of such administrative monitoring. At the external level, other than the two evaluations by NIMHANS and ICMR and the review by the Mental Health Policy Group, there have been no other systematic evaluations of the DMHP.

Similar to the lack of clarity on budgetary data, the lack of consistent and quality data on the implementation has greatly impeded the improvement and functioning of the DMHP. Independent researchers have found data templates to capture data are not uniform at a national, state or district level. The NHRC technical report, which consolidated data from all states and union territories implementing the DMHP, also found a large part of the problem appeared to be with proper documentation of the service utilization[11]. It appears that in most states, the care gap is large, and only a small percentage of the population seeks treatment. However, they found where documentation is prioritised, there is significant utilization of outpatient services[11].

To evaluate the DMHP utilization, experts relied on observations during field visits, which concluded that inpatient use of services was indeed inadequate[14]. A research study on elderly users of the DMHP found that in fact, elderly users were one of the highest users of the DMHP services, yet the DMHP did not pay enough attention to special population groups and many centres were not designed keeping access to the elderly in mind[22]. Such observations reinforce that systematic capture of relevant and up-to-date data, is crucial for monitoring and an important feedback mechanism to improve and respond to the programme implementation. As per WHO recommendations, systematic recording of mental

illnesses should be introduced into the Health Management Information System. For this, the MH Policy Group recommended improving access to data by training staff in a phased manner starting with states that already have the DMHP functional in a significant proportion of districts[13].

Finally, a further shortcoming in monitoring and evaluation is the absence of community monitoring mechanisms and structures. India already has robust and effective structures to allow active community monitoring in the National Rural Health mission, which could be replicated with fairly minimal workstream development in the DMHP[23,24] .

The focus of the DMHP: biomedical models vs the community

A major concern with the DMHP lies in the fact that over the 25 years of existence, there have been no provision for service users and caregivers to participate in the design of the DMHP or governance, delivery or monitoring and evaluation. Thus, there is an absence channels to question the health system or the staff when the functioning of the DMHP has not been ideal[13]. Further, the DMHP has failed to engage with responses to the social determinants of mental health which are set in the community, and are widely recognised and described in India and internationally[25]. Subsequently, this begs the question, has the DMHP, in design and in implementation, been true to the stated goal of providing mental health services at the community level and integrating them into primary health care services? Depending on the teller and the construction of the tale, there are many possible versions of the impact of the DMHP[26].

Among community outreach activities built into the DMHP, there is a limited emphasis on creating awareness around mental health in the community, including through Information, Education and Communication (IEC) activities. A review cited in the Policy group recommendations found that only 10% of the districts under the DMHP utilized funds for IEC activities, with this underutilization indicating that IEC was a low priority. And finally, despite the DMHP guidelines encouraging the participation of external actors in the DMHP, the MH Policy Group highlights minimal NGO and private sector participation in the operations of the DMHP[13].

Within the design of the DMHP, researchers highlight flaws citing that the policies rely excessively on pharmacological solutions for psychosocial problems[6,24,25,27,28]. The NMHP & subsequently the DMHP was reconceptualized in 2003, during the X FYP to have a greater emphasis on modernisation of existing mental health services and an emphasis on the distribution of psychotropic medication as a form of treatment[28]. Scholars argue that this reconceptualization marked a shift from the original aims of the NMHP, which emphasized access to services and community participation with a focus on serious mental disorders[28].

The very structure of the primary health centres and the psychiatric approach to mental health care results in an 'administrative psychiatry' where the focus is on effective distribution of psychotropic medication as a singular form of 'treatment' with limited emphasis on social, cultural and familial dynamics. For example, in their work in Uttar Pradesh, researchers Jain & Jhadav found patients enter the clinic with a presenting problem of 'uljhan,' a single term comprising of complaints ranging from severe mental illness and biological distress to the day-to-day concerns of life, including socio-economic concerns[28]. Given that the structure of the clinic did not allow for the time needed to probe into the nature and causes of the 'uljhan,' they found that complex meanings and implications were often reduced or missed in translating and interpreting this condition in purely biomedical terms. While psychotropic medications administered helped reduce symptoms, the socio-cultural origins of the 'uljhan' people experienced often went unaddressed, pointing to the limits of

the biomedical lens along with the clinical and administrative model of the DMHP[28]. The researchers also highlight the meanings attached to compliance to pharmaceutical treatment, where non-compliance to treatment, such as being irregular with clinic visits and medication, was viewed as irresponsible by the health professionals. The biomedical focus of the DMHP appears to result in a system where people's voices are mediated in biomedical terms leaving the community with little voice, contributing to barriers in care[28].

The researchers advocate for a more decentralised and democratised form of treatment which looks beyond western and biomedical expertise and is rooted in the community,. Community psychiatry focuses on understanding mental health within cultural contexts and providing mental health services using community resources. The researchers advocate for a vision of mental health care that allows various systems of care to work closely together to address mental health prevention, promotion and treatment. This includes integrating existing models of care which are more socially and culturally acceptable, such as community healers and supportive and informal counselling[27,28].

Finally, researchers suggest the DMHP should be reimagined to address the issue of shortage of human resources. According to an expert, even while scaling up the Bellary Project to create the DMHP, there was very little questioning of whether overburdened and poorly utilised PHCs within weak health systems should continue to be the main delivery mechanism for the DMHP[15]. Expert groups advocate for the training of non-specialized medical workers, potentially members of the community, to diagnose and treat mental disorders to deliver community-based care and serve the present lacunae in the mental health system more effectively[27]. Studies in North India have also shown that even where there is sparse or no access to biomedical mental health services, access to psychosocial care delivered by non-specialised mental health workers can improve mental health status and social inclusion.[29]

And further, they advocate for a constant feedback loop to be created between service users, care givers, and primary health care workers, and for this feedback to be regularly translated into services/programme[5].

Present status & way forward

In its final report, the MH policy group provided a list of recommendations for improving the functioning of the DMHP, including clearer programme management, monitoring, and creating the space for technical support and evolving the programme as and when needed to encourage greater community and external participation[13]. They also highlight how most issues within the functioning of the DMHP, such as administrative delays, are systemic issues that require interventions outside the NMHP and are difficult to address solely by the specialists spearheading the programme. More recently, under Ayushman Bharat Yojana, launched in 2018, existing Sub-Centres and PHCs are to be converted into Health and Wellness Centres which will be required to provide mental health services, however, it is difficult to ascertain if and how this will affect the DMHP and its implementation, since no clear guidelines have been issued. This is in line with our criticism where the lack of suitable and updated data on the DMHP makes any comprehensive analysis incomplete. However, given the restructuring of the healthcare systems with the Ayushman Bharat, the provisions within the Mental Health Care Act, 2017, and objectives of the National Mental Health Policy (2014) it is imperative that mental health care be prioritized.

The DMHP has been a progressive model and an important public mental health initiative. It is crucial that the DMHP continues to evolve and deliver the goals it was conceptualised with, making mental healthcare accessible to the community. And finally, beyond the DMHP, it is important for policy makers to retain an intersectoral and holistic approach to mental illness and mental health care which also pursues policy that addresses upstream determinants of mental health.

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