IMPLEMETATION OF DISTRICT MENTAL HEALTH PROGRAM AND GLOBAL MENTAL HEALTH ASSESSMENT TOOL IN ALWAR DISRTICT OF RAJASTHAN – A REPORT

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LIST OF ABBREVATIONS

ANMs - Auxiliary Nurse Midwife

ASHA - Accredited Social Health Activist.

CMHO - Chief Medical and Health Officer

CHC - Community Health Center

DMHP – District Mental Health Program

DNO - District Nodal Officer

GMHAT - Global Mental Health Assessment Tool

NMHP - National Mental Health Program

NMHS - National Mental Health Survey

PHC - Primary Health Care

WHO – World Health Organization

ABSTRACT

Historically mental, neurological and substance (MNS) use disorders have been given low preference compared to the communicable and non-communicable diseases (2). As per Global burden of disease report, in the year 2012 mental health disorders accounted for 12 percent of disease burden and is projected to increase to 15 percent by 2020 (3). It is estimated that lower middle-income countries account for more than 80 percent to non-fatal disease burden. Globally depressive disorders with YLD of 7.5 percent is the single largest contributor to non-fatal health loss (8). In India as per National Mental Health survey report about 11 percent of Indians above 18 years of age are suffering from some mental disorder (13). "The median number of psychiatrists in India is only 0.3 per 100,000 population compared to a global median of 1.2 per 100,000 population" (12). The challenges in India are diverse and complex, NHMS reported an overall treatment gap of 83 percent for any mental health disorder (13). In the view of these mental health challenges, the state of mental health services at primary level are examined from the program, management and legal perspective. Hence the following report reviews the District mental health program, National mental health policy, Mental health Act and National Mental health survey. The report has two parts, part A examines the implementation of DMHP in Alwar district of Rajasthan in the form of delivery of services, finance arrangements, governance, shortcomings and other associated factors whereas part B examines whether primary health care workers (ANMs) trained in using GMHAT can detect mental disorder cases with accuracy. Specificity and sensitivity test were led to check with ANMs identifying cases with and without mental illness.

Key Words: Mental Health, District Mental Health Program-Alwar district, Rajasthan, National Mental Health Policy, Global Mental Health Assessment tool

INRODUCTION

Mental, physical and social well-being are essential strands of life that are closely interlinked with each other. WHO's definition of health refers to both physical as well as mental wellbeing which gives us an important intimation that mental health is more than just absence of mental disabilities or mental disorders. WHO defines "*Mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community"* (1).

Historically mental, neurological and substance (MNS) use disorders have been given low preference compared to the communicable and non-communicable diseases (2). In most parts of the world mental disorders are overlooked or underestimated and not given as much emphasis as given to physical health (3). Consequently, to a certain extent this has led to increase in burden of mental disorders and broadened the treatment gap (3). As per WHO estimation in year 2001, "one in four families have at least one-member suffering from mental or behavioral disorder" (3).

As a result, in the year 2001, WHO declared the year as Mental Health year and defined the magnitude of mental disorders and had Mental health as a theme for World health report (2001). To implement the recommendations of the report WHO created Mental Health Global Action Programme (mhGAP) based on four strategies which are enhancing mental health information for better decision making, increasing mental health awareness to reduce stigma, policy and service development and establishing mental health research in poor countries (4).

As per Global burden of disease report, in the year 2012 mental health disorders accounted for 12 percent of disease burden and is projected to increase to 15 percent by 2020 (3). The Global burden of Mental illness is said to be augmented by the increasing treatment gap in mental health, globally around 70 percent of people who need mental health care lack adequate services to care (5). Treatment gap is considered as a practical indicator for the accessibility, quality of health care and utilization of services (6).

Advancement in mental health service delivery has been slow in most low - and middle-income countries. Few of the challenges faced by most of the lower and middle-income countries are delivery of mental health services in primary-care settings, lack of skilled manpower in mental health care, nonexistent mental health outlook in public health headship, delay in seeking care by patients, lack of awareness, low recognized need, stigma associated with mental health and inadequately trained primary health care workers for mental health (7).

Of all the disorders in the category of mental and behavioral disorder, major depressive disorder accounts for the heaviest burden and has increased from 2.54 percent in 2010 to 4.4 percent in 2015 which is estimated at over 300 million people globally (8). Nearly half of this population is from South East Asia reflecting the larger populations which include India and China (8).

It is estimated that lower middle-income countries account for more than 80 percent to non-fatal disease burden. Globally depressive disorders with YLD of 7.5 percent is the single largest contributor to non-fatal health loss (8).

In case of suicide, presence of mental disorder is considered as one of the important risk factors (9). As per WHO, around 800,000 people die every year of suicide where 79 percent of cases occurred in lower middle-income countries in 2016 (10).

MENTAL HEALTH SCENARIO OF INDIA

India is a country of about 1.3 billion people, the second largest country in terms of population spread across extensive area ranking seventh in the world in terms of expanse. Being this vast in terms of population and area there are clearly many challenges in delivering quality healthcare. (11). "As per Global Burden of Disease (GBD), Healthcare Access and Quality Collaborators 2017, India is ranked 154th among 195 countries for access to and quality of healthcare and the health system and is said to be underperforming compared to other under developed countries" (11). In addition, there are significant differences between different states of India (11).

As per Global Burden of Disease report, it is estimated that mental, neurological and substance use disorders will increase from 31 million DALYs in 2013 to 38 million DALYs by 2025. In India at present 7.1 percent of YLDs are attributed to depressive disorder (8). In 2013, India had 100 million people with mental illness but just 43 psychiatric hospitals and approximately 4000 psychiatrists (11). "The median number of psychiatrists in India is only 0.3 per 100,000 population compared to a global median of 1.2 per 100,000 population. Similarly, the figures for psychologists, social workers and nurses working for mental health is 0.03, 0.03 and 0.05 per 100,000 population compared to a global median of 0.60, 0.40 and 2.00 per 100,000 population, respectively". (12)

Though "there have been noteworthy advances in mental healthcare over past decades, human and financial resources remain scarce. As per NMHS report (2015-2016) about 11 percent of Indians above 18 years of age are suffering from some mental disorder" (13). "The challenges in India are varied and complex, NHMS reported an overall treatment

gap of 83 percent for any mental health disorder. The treatment gap of 88% was reported for depression and a treatment gap of as high as 97.2 percent was reported for alcohol use disorders" (13). There are several barriers that contribute to the wide treatment gap, there exist two sides to the barriers, demand and supply side. The demand side barriers contributing to treatment gap are stigma, socio-cultural beliefs and values and the overall low perceived need due to low awareness whereas the supply side barrier comprise of insufficient, inequitably distributed, and inefficiently resources (13). High out of pocket expenditure and substandard quality of mental health services greatly influence the treatment gap (13).

The overall mental morbidity reported in NMHS was 13.7 percent for lifetime with highest of 15.69 percent in the household of lowest income quintile (13). Mental disorders cause a huge load on affected individuals, their families and society and along with poverty and discrimination it forms a vicious circle which ultimately becomes a barrier to economic and social development (14).

"Rising awareness regarding the extent of mental health problems in the country, a bout of health activities in the late 70s which comprised Alma Ata Declaration, the commitment to provide health to all by 2000, and the understanding that mental health care was possible through the existing primary health care system led to the launch of National Mental Health Programme (NMHP) by the Government of India in 1982" (15). Followed by the District Mental Health Program (DMHP) was launched in 1996 for providing community-oriented services that had envisioned the presence of a district mental health unit at each district. (16) Besides having a National Mental Health Programme (NMHP), India has launched its very first National Mental Health policy in 2014 and Mental Health Act 2017.

Afterall this the large treatment gap of 83 percent reported in NMHS is a cause of concern. The fact that India has completed 35 years of NMHP but still there persists concern for the relative failure to educate the population, decrease stigma, and empower the primary health-care personnel to initiate care at their level to reach the population in need of services (17). It is not enough to call for more of the same measures implemented during the past few decades. To that extent, the survey provides a wake-up call to redesign mental health care in the country (17).

HEALTH CARE SYSTEM OF INDIA

The health care system of India includes both private and public healthcare providers. It is a mixed health care system, where the private healthcare providers are majorly concentrated in urban regions whereas the public healthcare infrastructure is set up in rural region (18).

The public healthcare system is a three-tier system consisting of subcenters, primary health care centers (PHC) and community health center (CHC) and district hospitals supported by tertiary centers. (19)

MENTAL HEALTH SERVICES AT DIFFERENT LEVELS OF HEALTHCARE

At the subcenter level, the ASHAs, ANMs and health supervisors only play role in promoting, educating and making the community understand mental health and mental disorders. They work for early detection and referral of psychiatric problems (19).

The PHCs and CHCs have Medical officer to provide primary level of treatment. The medical officers and health workers at this level are given periodic training to offer basic mental healthcare. At this level the medical officers are trained to diagnose the mentally ill cases, treat cases of depressive disorders and alcohol dependence. They maintain mental health case records and send it to district authorities. The medical team organizes

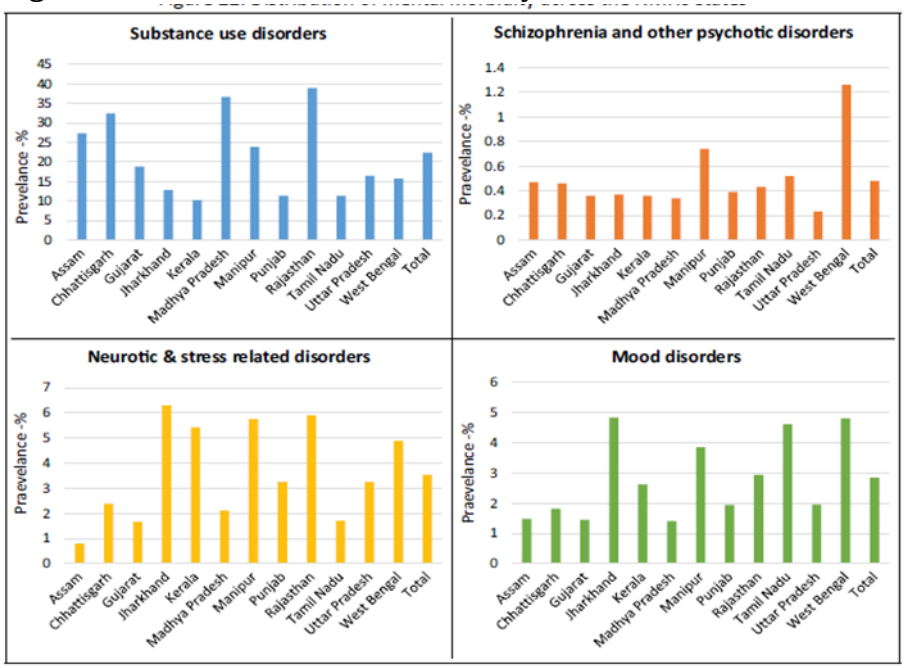
various activities to bring about understanding and awareness of mental health issues in the community (19)

The district level has an exclusive District Mental Health Program with DMHP team consisting of psychiatrist, clinical psychologist and a social worker. It the first referral support center for primary health care workers. The district hospitals are supported by tertiary centers in the form of medical college departments of psychiatry or the mental health institutes (19).

MENTAL HEALTHCARE OF RAJASTHAN

As per the NITI Aayog's "Healthy States, Progressive India" 2017 report, Rajasthan is ranked at the second lowest position to UP which is ranked at the last position and Kerala at the top most in terms of health index which measures the overall performance of the state in health (20). Considering the mental health scenario of Rajasthan, the NMHS reported Rajasthan with highest prevalence of substance use disorder with 38.9% followed by second highest to Jharkhand with 5.90% in case of neurotic and stress disorders (13). The report discusses about the stigma and awareness related to mental illness and highlights one of the respondents from Rajasthan commenting "Once mentally ill, always mentally ill" which reflects the state of limited knowledge and awareness of mental illness as well as the strong belief that there is no cure to mental health problems (13).

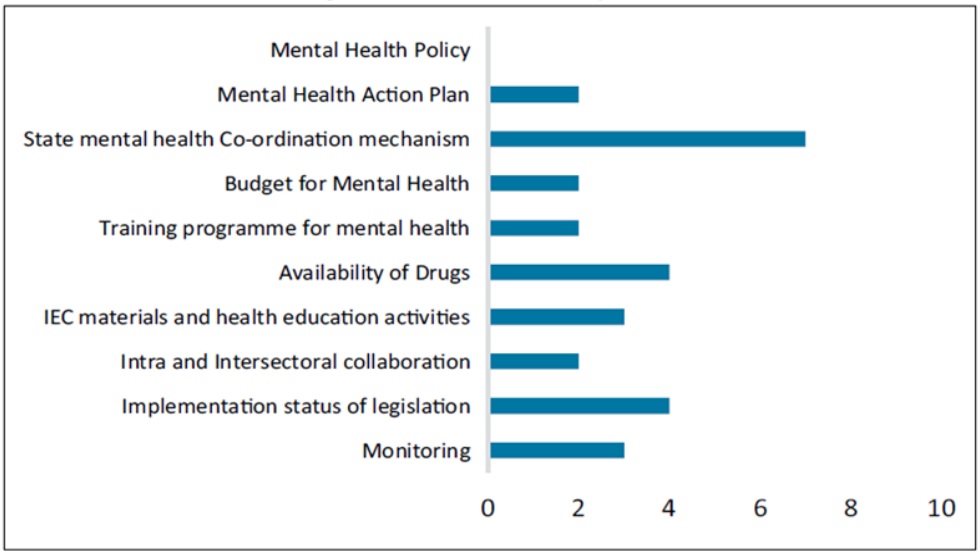
Fig 1: Distribution of mental morbidity across NMHS states



Source: National mental health survey 2015-16

The NMHS survey conducted in 12 states gives the mental disease prevalence data well as the mental health system report of each state in terms of human resource in mental health, mental health policy, coverage of DMHP, IEC activities, intra and inter sectoral collaboration.

Fig 2: Mental health system of Rajasthan



Source: National Mental health survey 2015-16

As per the mental health human resource statistics Rajasthan has 0.10 psychiatrists per 1,00,000 population which is second lowest to Madhya Pradesh which as 0.05. Also, in terms of medical doctors and nurses trained in mental health care Rajasthan ranked the lowest compared to all the other states (0.01 per 1,00,000 population). In case of availability of drugs Rajasthan had availability of more than 75% of the listed drugs. The percentage of districts covered by DMHP in Rajasthan is 21.21 which is better than compared to Assam which lowest 14.29% (13). The State doesn't have its own mental health policy and have adopted National mental health policy.

RATIONALE

Mental illness forms almost one sixth of all health-related disorders, it consists around 26 percent of all noncommunicable diseases in India. Integration of mental health services at primary level being an important agenda of mental health program, policy as well as the act there still lies a treatment gap of 83 percent. In the view of above cited challenges a study was undertaken to examine the state of mental health services at the primary level considering promotive and preventive aspects of mental health.

OBJECTIVE

- To review the NMHP and DMHP, National Mental health policy and Mental health Act
- To provide current Mental health scenario of India using secondary data- NMHS Report 2015-16
- To study the implementation and functioning of the DMHP in the Alwar district of Rajasthan
- To study the implementation of GMHAT in the district Alwar, Rajasthan

METHODOLOGY

Review of literature was done for the context of this report, studies related to prevalence of mental health disorders were searched from PubMed and Google Scholar. National Mental Health Program and District Mental Health Program, National Mental Health Survey, Mental Health Act, National mental Health Policy, WHO Mental Health action plan 2013-2020 were reviewed.

To study the implementation and learn about the functioning of District mental health program data was collected from the Rajiv Gandhi district hospital -Psychiatric ward of Alwar, Rajasthan.

REVIEW OF LITERATURE

NATIONAL MENTAL HEALTH POLICY

The National Mental Health Policy of India is the first ever policy of the country for mental health launched in the year 2014. The "policy was drafted in agreement with the intent of Resolution WHA 65.4 adopted at the 65th World Health Assembly held in Geneva in 2013 to which India also was a member. The Resolution WHA 65.4 highlights the global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the community level" (21).

The policy is developed on the vision to promote de-stigmatization and desegregation of mental health and enabling prevention as well as recovery of mental illness by ensuring universal access to everyone. The policy aims to provide holistic approach as it is inclusive and incorporates integrated care for people suffering from mental disorders and their care givers. (21)

The policy mentions roles to be played by central and state government as well as by the local bodies and civil society organizations which will help in strengthening of leadership in mental health sector at all levels leading to increase possibility of achieving universal access to mental healthcare (22). The policy also identifies population who may need attention like extremely poor population, children with mental illness, disabled and homeless. (21)

To meet the vision and mission of policy there is adequate needs of funds which has been highlighted in the policy, it encourages flow of funds through interdependence between departments such as social welfare, women development and child development (22).

As the foremost step to implement the policy, the district mental health program in the current (12thfive year plan) has been expanded to more 118 districts adjoining to already 123 districts, financial support has been raised "from 46.37 lakhs to Rs. 83.70 lakhs per district per year for additional components like suicide prevention services, work place stress management, life skills training and counselling in schools and colleges" (23). Acknowledging the shortfall of human resource in mental health, the policy recommends upgradation of skill in mental health by offering training programs for primary health care workers, ANMs, ASHAs and Nurses (23).

Development of DMHP is essential to establish mental health services at low cost at community level by trained health workers, availability of inpatient services and to reach out the most vulnerable population (22).

The policy is inclusive in nature and tries to protect human rights of mentally ill patients and their care givers and acknowledges severe issues of stigma attached to mental illness and violation of human rights of the patients.

MENTAL HEALTH ACT /BILL

"The WHO mental health Action plan 2020 encourages the countries to upgrade their mental health legislation with international guidelines and expecting that by 2020 50% of the countries achieve it" (24). India has recently reassessed its mental health legislation and passed The Mental Health Act,2017(24). The introduced bill has adopted progressive way by replacing the old terminology of mental retardation to mental illness (25). The bill has adopted a patient centric approach. The Act guarantees every person the right to access affordable and easy to access mental health care services till the district level. Along with that the patient is empowered with a right to be treated the way he/she wants and can also specify person responsible for taking decisions for them about treatment (26).

The act recognizes the basic right of living with dignity for people with mental illness. The newly revised Act decriminalizes suicide attempt as well as prohibits electroconvulsive therapy without the use of muscle anesthesia (27).

The social, economic and cultural factors like stigma, lack of awareness, superstition and lack of access to mental health care worsens the situation and condition of people with mental health in India. The act does not provide any provision to address these factors as well as does not offer much on prevention and early involvement (27).

NATIONAL MENTAL HEALTH PROGRAM AND DISTRICT MENTAL HEALTH PROGRAM

Various Milestones leading to National Mental Health Program

India was the first post-colonial country to have reform for mental health. The NMHP was a milestone in establishing mental health care in the country. The national mental

health programme (NMHP) was created three decades ago in1982.The program was initiated keeping in view, the objective of delivering mental health services at all the levels of health care (primary, secondary and tertiary) and integrating it with general health services. The NMHP in 1982 set a consolidated approach of utilizing specialist as well as non-specialist work force in delivery of mental health services. There were five important factors responsible for drafting of National Mental health program which are as follows

1)The idea of NMHP started with ***World Health Organization (WHO), Mental health division.*** (28) A meeting of expert committee was held in 1972 with a priority of organizing mental health services in developing countries. The expert committee inscribed the strategy of incorporating mental health services into primary care. (29)

2)Establishment of specially designated ***"Community Mental Health Unit" by NIMHANS in 1975***. It carried out mental health assessment and situational analysis in around 200 villages in rural mental health center of Sakalwara, Bangalore covering approximately population of 1,00,000. Health care personnel at PHC level were trained in basic mental health care. Mental health education materials were developed which could be used by multipurpose health workers in rural area (29). This project led to the development of strategy of incorporating menta health care facilities in rural areas through existing primary health care (29).

3)"World Health Organization (WHO) Multi-country project: ***"Strategies for extending mental health services into the community" (1976-1981)***" The proposed model was integrating mental health care with general health and providing mental health care by trained doctors and health workers. The project was a multicounty project executed in 7 lower income nations, India being one of them. The department of Psychiatry at PGIMER

Chandigarh was the center in India and the model was developed in RaipurRani Block of Haryana. (30)

4)The ***"Declaration of Alma Ata" to achieve "Health for all by 2000" (1978).*** The increasing awareness regarding the mental health problems and the Alma-Ata Declaration in 1970, which emphasizes on the health for all by 2000 led to launching of NMHP by Govt. of India in 1982(29).

5)Collaborative project by ***ICMR- DST on 'Severe Mental Morbidity'***

In late 70's and early 80's this project was done to estimate the likelihood of training of PHC staff to provide mental health care as part of their routine work (29). The evaluation of this mental health intervention strategy was carried out for one year in 4 parts of the country. At the end of one-year period about 20% of the actual cases were identified and managed by the PHC personnel under the overall supervision of the center staff. (30)

The above five factors played a major role in drafting of the NMHP. The implementation of NMHP was adopted and suggested in august 1982 by Central Council of Health and Family Welfare (CCHFW) which is considered as the main policy making body in the field of health (29). The NMHP was launched with comprehensive objectives, strategies and approaches which hold true today as well. (29)

OBJECTIVES AND APPROCHES OF NMHP

"The key objectives of National Mental Health Program:

(a) To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population

(b) To encourage the application of mental health knowledge in general healthcare and in social development

(c) To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community" (30).

"The specific approaches for implementation of NMHP

a) Diffusion of mental health skills to the periphery of the health care system

- Center to periphery strategy - Establishment and strengthening of psychiatric units in all district hospitals, with outpatient clinics and mobile team reaching the population for mental health services
- Periphery to center strategy – Training of primary health care personnel in basic mental health skills to provide minimum mental health care services provided availability of referral services.

b) Appropriate appointment of tasks within mental health care

- To provide appropriate task-oriented training to the existing staff

c) Equitable and balanced territorial distribution of resources

d) Integration of basic mental health care with general health services

e) Linkages to community development, there was a framework for the planners and professionals to develop community mental health program" (28).

The Central Council of Health and welfare recommended that Mental health should be incorporated in all the national policies and programs related to the field of health, education and social welfare. It must be fundamental part of all the healthcare programs.

CHANGING GEARS TO DISTRICT MENTAL HEALTH PROGRAM (DMHP)

On understanding that the NMHP was not possible to be implemented on a larger scale without demonstration of its feasibility in larger populations, decentralization of NMHP occurred through District Mental Health Program (31). In year 1985 NIMHANS initiated a DMHP model known as "Bellary Model "as it was implemented in Bellary district Bangalore and was later adopted by other states for implementation.

"KEY OBJECTIVES OF DISTRICT MENTAL HEALTH PROGRAM

a) To provide sustainable basic mental health services including prevention, promotion and long-term continuing care at different levels of district healthcare delivery system.

b) Early detection of mental illness at the community level itself and to obviate the need for patient to travel long distance to tertiary care facilities.

c) To augment institutional capacity in terms of infrastructure, equipment and human resource for metal health care.

d) To reduce stigma of mental illness by promoting community awareness and participation in delivery of mental health services.

e) To broad base mental health into other related programs" (32).

HISTORY AND CURRENT SCENARIO OF NMHP AND DMHP

Initially in the year 1996 the "DMHP was launched in 4 districts, one district of each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu and later in the 9th 5 year plan it was extended to 27 districts" (29).

In the 10th 5 year plan the NMHP was re-strategized wherein the government medical hospitals with psychiatry wings as well as the state-run mental hospitals and Psychiatry were upgraded. Implementation of training programs, research and IEC activities was

considered to improve service delivery and DMHP was expanded to 100 more districts (29).

The DMHP included components of school and college mental health counselling services where in teachers should be trained to counsel students. The DMHP also incorporated suicide prevention services and counselling at district level along with IEC and sensitization activities (29).

By the of 10th 5-year plan, psychiatric wings of 71 colleges and 23 mental hospitals were funded for upgradation and DMHP was expanded to 110 districts (29).

In the 11th 5-year plan DMHP was spread to 123 districts in 30 states /UTs.16. Under the DMHP, formation of DMHP team was essential consisting of "Psychiatrist, Psychiatric Social worker, Psychiatry Nurse, Clinical psychologist and a record keeper'' (29).

In efforts to address the issue of human resource in mental health a manpower scheme was developed in the 11th 5-year plan which comprised of 2 schemes. Scheme A was based on upgrading the existing mental health facilities and establishment of 11 excellence centers for providing academic sessions on mental health. Under scheme B, setting up of PG training courses in mental health by Government medical colleges and improve mental health specialties to increase the uptake of the course. By far 27 PG departments in 11 colleges have started the PG courses (29).

The NMHP in 12th 5-year plan focuses on certain special and vulnerable groups like senior citizens, children and adolescents, victims of sexual abuse, domestic violence, rape, destitution, poverty. The DMHP in 12th 5-year plan DMHP will be extended to the remaining 161-districts with focus on increasing the IEC activities along with comprehensive assessment by state level (29).

DISTRICT MENTAL HEALTH PROGRAM – THE ALWAR EXPERIENCE

Alwar is a district situated in the north east of Rajasthan, it is bounded by Jaipur on its South-West, Gurgaon in the North, Dausa on its South and Bharatpur and Mahendragarh to its North-East. (33). It is said to be the third most populated district of Rajasthan with population of about 3,674,179 as per 2011 census report (34). About 17.8% of population lives in urban areas whereas the large population of 82.2% resides in rural areas (34). The occupational structure of Alwar is relatively varied. There are people working in government, private services or small-scale business as well as people involved in informal sector like drivers, mechanics etc. In case of healthcare facilities there are many private hospitals and clinics whereas in case of government run there is Rajiv Gandhi District hospital. In terms of Mental healthcare services in Alwar again there are many private clinics, but the government services are available only at the district hospital. The district hospital in Alwar have psychiatric OPD running since last 18 years whereas the District Mental Health Program has been implemented in the year 2018.

The study in Alwar was undertaken with an aim to understand the progress of mental health services at the primary level. Considering the objectives of DMHP and the recommendations of the policy of early detection of mental illness and ensuring mental healthcare services at primary level has led to increasing recognition of considering active involvement and upgradation of skills of primary health care workers for identifying mental illness. Hence, the study in Alwar has two aspects that is to analyze the implementation of District Mental Health Program as a decentralized model of mental health care in India and to study the implementation of GMHAT which has been developed not only to assist health professionals to make quick and comprehensive mental health assessment but also to help detect the mental health problems at the primary level by training the primary health work force on its use.

The study has two parts, part A is a modest attempt made from the perspective of existing Mental health program and policy to examine the implementation in form of delivery of services, finance arrangements, governance, shortcomings and other associated factors of DMHP in Alwar and part B is examining to what level of accuracy can ANMs detect mental illness cases at primary level using the GMHAT.

The report gives implementation and functional insights of DMHP in Alwar, Rajasthan.

PART A

STATUS OF DMPH IN ALWAR DISTRICT OF RAJASTHAN

The DMHP in Alwar was scheduled to be initiated in 2017 under 12th 5year plan, but it was officially implemented in the month of April year 2018. The implementation of DMHP was delayed because there was only one psychiatrist and no support staff. Thereafter a DMHP team was formed and the program was effective from April 2018. The program is implemented at the Rajiv Gandhi district hospital. Psychiatric center, Jaipur is the Nodal center implementing the program. The budget allocated for implementation of DMHP in 2017 was INR 90,000 for a year which is being used now in the year 2018. The budget allocated is being used for salary of the DMHP team whereas funds are provided as and when the activities such as camps, trainings, IEC are conducted.

Composition of DMHP Team

The DMHP team in Alwar is composed of a psychiatrist (DNO- District nodal officer), clinical psychologist, psychiatric nurse, case record assistant and ward assistant except for psychiatric social worker. The psychiatrist at Alwar is permanently salaried government employee whereas the other health care workers in the DMPH team are salaried under DMHP. Before the implementation of program for 18 years the Psychiatrist OPD was single handedly managed by the Psychiatrist.

DMHP – Service provision at Alwar

• Outpatient and Inpatient services

The Psychiatric OPD is situated at the Rajiv Gandhi District Hospital in a room allocated to the psychiatrist. The OPD is open on all days except for Fridays from morning 8 am to 2 pm in the noon. The outpatient services include registration of the patient followed by assessment by the psychiatrist. As per clinical needs patients are counselled by the clinical psychologist in a separate room. In case of patients who need inpatient management/ treatment services there is an exclusive 16 bedded psychiatry ward in the hospital. The average inflow of patients monthly in Alwar is about 1000 - 1500 patients.

The patients who are diagnosed but cannot be treated at District hospital or need further treatment are referred to SMS Psychiatric center Jaipur.

Before the implementation of the program only new and old cases were recorded in a separate register, but after the implementation of the program a monthly progress report is prepared in the format given in which the recordings of old and new cases, no of cases of different mental illness, number of camps conducted, number of trainings, IEC activities conducted as well as a separate report of depression cases is made and the final report is sent to the psychiatrist center in Jaipur before 5th of every month.

Sr.NO	MONTH	NO OF NEW CASES	NO OF OLD CASES	TOTAL
1	January 2018	686	513	1199
2	February 2018	713	623	1336
3	March 2018	705	521	1226
4	April 2018	725	559	1284
5	May 2018	835	613	1448
6	June 2018	973	643	1616
7	July 2018	558	533	1091
				9200

Table 1: Number of New and Old cases after the implementation of DMHP

• **Provision and availability of drugs**

Minimal mental health care means making available antipsychotic or anti-depressant drugs. The DMHP has provided a list of drugs for District hospital/CHC/PHC levels. As per the guidelines the district hospital dispenses drugs only if there is Psychiatrist in the district hospital. The district hospital in Alwar provides drugs to the patients as well as to the beneficiaries at outreach/diagnostic camps conducted by DMHP team. The district hospital in Alwar often faces unavailability and irregular supply of drugs. The reasons identified for the same was no separate inventory and lack of dedicated drug procuring mechanism for DMHP as the medicine supply to the hospital is from Jaipur Directorate of health and services and the drug requirement for psychiatric department is not given as much importance as given for other departments. The drugs are supplied as and when needed and are not available on regular cycle.

- **Outreach services**

The DMHP team once in every week on Wednesdays provide outreach services. They conduct three types of camps which are outpatient clinics, target group camps and counselling centers. The outpatient clinics are the ones where the DMHP team conducts diagnostic clinics in the nearby towns which have no access to mental health care services or have fewer number of CHCs /Taluka hospitals. From the time of DMHP has started the DMHP team has conducted 9 outreach camps and 3 mental disability camps at Rajgarh, Tijara and Malakhera. The target group camps concentrate on specific locations such as temples and mosques to educate and aware people about the mental health disorder and mental health services available whereas the counselling centers are yet to be implemented which will focus on children in schools, colleges and other educational institutes as well as train the teachers about mental illness and work as counselors in their own institutions.

DMHP- Capacity Building

One of the important aspects of DMHP is training of the DMHP, CHC and PHC personnel which includes Medical officers, Psychologists, Social workers, nurses and community health workers. The entire team of DMHP team at Alwar is trained to offer basic mental health care services.

Till now 30 Medical officers from PHC and CHC level have been trained to provide basic mental healthcare services. They are given one-week training at the Psychiatric center in Jaipur. The session includes field visits where the trainees are shown cases of mental illness and provided with study material

The DMHP team has not yet conducted any training sessions for community health workers like ASHAs or ANMs. But about 12 ANMs from Rajgarh block are trained for assessing the mental health using GMHAT as a part of the study which is an aspect of DMHP.

The guidelines of DMHP suggest on conducting sensitization / training sessions for members of Gram Panchayat, Zila parishad or NGOs working in that area whereas DMHP team of Alwar has by far not conducted any such sessions.

DMHP – Community Awareness

One of the integral parts of DMHP is the Mental health promotion and awareness through Information education communication (IEC) activities. As per the guidelines of DMHP the community should be sensitized by the community health workers about the mental health disorders and its management and the present health services through means of posters, flip charts, group meetings and wall writings. But as per the information given by the Psychiatrist at Alwar they have just been provided with few posters and haven't conducted any exclusive IEC activities and rather their 18 years of Psychiatric OPD which

has been ongoing even before implementation of DMHP has helped create awareness about mental illness.

DMHP – Monitoring and Supervision

Monitoring and reporting play a crucial role in accessing the proper functioning of any program. The DMHP guidelines suggest reporting of all the financial and physical progress to the State Nodal Officer (NMHP) before 5th of every month. The DMHP team has recently started reporting of all the details in the provided format from the month of May 2018 whereas till now a manually made report was sent. Monitoring and evaluation of the program is occasionally done by the visit of State Nodal officer.

IMPLEMENTATION PROBLEMS AT ALWAR

Although the DMHP is active in Alwar there are few problems observed in implementation and functioning of the program

1. Lack of technical support and clarity on guidelines

Inadequacy of technical support in implementation of DMHP was one of the barriers. Technical support includes inputs such as capacity building, human resource planning, forming mental health information system and executing management protocols (35). With non-availability of the guidelines the objectives were differently interpreted. As per psychiatrist the main agenda of DMHP is just spreading Awareness of Mental health disorders whereas the main agenda of DMHP is capacity building of health personnel for mental illness and spreading awareness as the second agenda (35).

2. Inconsistent fund flows

Fund flow was recognized as an impediment in appropriate implementation and functioning of DMHP. This is generally due to administrative delay and incoordination

between the state and district health departments. The Alwar DMHP is currently using the budget allocated to them last year which has led to delay in salaries of the health personnel in DMHP team. Also, the team gets funds as and when any other activities are conducted.

3. Unavailability of drugs

Adequate availability of drugs is one of the noted issues. The reasons recognized for the same was the absence of dedicated drug procuring mechanism for DMHP.

4. Fragmentation of responsibilities for Mental Health care

Poor coordination is observed between CMHO and DNO. The CMHO at the district hospital looks after the administrative aspect whereas the District Nodal officer (DNO – Psychiatrist) is responsible for the curative aspect. Lack of administrative authority and leadership to the DNO creates ground for conflict between DNO and CMHO.

5. Inadequate manpower/human resource

As per the suggested DMHP team, the Alwar DMPH team doesn't have psychiatric social worker. There is still lack of understanding of mental health professional. With just one psychiatrist he is absorbed in attending patient flow and conducting camps which leads to work burden. The role of social workers, psychologists and ANMs is usually negated because most frequently service delivery is circled around the district Psychiatrist or the medical officer at PHC (35).

6. Lack of governance system

One of the major problems in managing and scaling up the DMHP is weak governance system. There administrative, technical and operational responsibility is disintegrated leading to weak implementation of the program.

PART B

ASSESSING IMPLEMENTATION OF GLOBAL MENTAL HEALTH ASSESSMENT TOOL (GMHAT), ALWAR RAJASTHAN.

INTRODUCTION

According to the National Mental Health Policy, Government of India, mental health services need to be integrated with primary health care system.

Health workers such as primary care nurses, ASHAs and ANMs trained in mental health assessment at primary level could be a value addition in detecting the cases at earliest stage. “Early intervention not only helps patient in getting the required treatment timely but also helps the person to recover completely and better re-integrate into society” (36).

A through and well-constructed assessment of mental health is an essential to providing quality care. Dr Vimal Kumar Sharma and Copeland developed the Global Mental Health Assessment Tool (GMHAT) which is a computerized, semi structured, clinical assessment tool to determine and diagnose mental illness at primary health care level, with frontline health workers. The tool now has been programmed and installed on touchscreen PDA which makes it easy to use anywhere (37).

To increase access to mental health services especially in rural areas and to enhance availability of skilled human resources, a pilot study “Assessing and Managing Mental Health Problems through Frontline Workers” is being implemented by IIHMR in the partnership of state and district health system financially supported by ICMR.

METHODOLOGY

The study is a quasi-experimental “Study and Comparison Group Pre-test/Post-test Design”. The study was implemented in Alwar district with the permission of Director Public Health (Directorate of Medical and Health, Government of Rajasthan) and Chief

Medical and Health Officer, Alwar. The intervention block was Rajgarh where two model primary health centers (Rajpura Bada and Gola ka Bas) while non-intervention block was Malakheda (Chandoli and Baleta PHC). The study was started in the month of January 2017 for period of two years. Before the implementation the first 6 months were invested in preparation of all the activities. The preparatory phase included activities like preliminary meeting with State and district officials, making available GMHAT in android based version, purchasing TABLETS, uploading the GMHAT and conducting pre-test survey.

IMPLEMENTATION OF GMHAT

Before the implementation of the program the AMNs were given 5-day training. After the training they applied GMHAT.ANMs (five in Gola ka Bas, nine in Rajpur Bada) were able to explain about mental health, identify the person suffering from mental health problem, administer GMHAT and diagnose the type of problem. GMHAT was administered on 892 persons and 461 (52%) were found having one or another mental health problems. A total of 84 patients were given treatment. The ANMs in case of any query were able to interact with Psychiatrist, district hospital, Alwar and/or Dr Vimal Sharma, using WhatsApp call or video conference. Mental health camps were organized to create awareness and IEC material was developed. During the intervention period, supervisory and follow up visits were made on monthly basis on an average with Dy CMHO, Alwar, state, national and international Psychiatrist to provide supportive supervision if any health worker face problem in using GMHAT, check the functioning of Tablet, and solve their problems in meeting people suffering with psychiatric problems and to verify the diagnosis made by ANMs with the Psychiatrists. Currently the post-test survey is going on.

Data of 58 patients who were assessed by the ANMs using the GMHAT and the same patients were clinically assessed by the physiatrist from the PHC of Rajgarh was taken to check whether ANMs can identify patients with and without mental illness. Sensitivity and specificity were used as measures of validity.

RESULTS

Sensitivity and specificity analysis were then used to determine how the GMHAT assisted ANMs interviews could identify cases with and without mental illness as determined by the clinical diagnosis of psychiatrist. The sensitivity and specificity test were carried out using SPSS software.

		Clinical diagnosis by psychiatrist		
		Yes	no	Total
GMHAT Screening results by ANMs	yes	37 82.2%	3 23.1%	40 69.0%
	no	8 17.8%	10 76.9%	18 31.0%
Total		45 100.0%	13 100.0%	58 100.0%

TABLE 2: Sensitivity and specificity test table

The above table shows sensitivity (0.82) and specificity (0.76) with ANMs correctly identifying 37 out of 45 patients diagnosed with mental illness and 10 out of 13 patients without mental illness.

The validity (sensitivity and specificity) test findings to an extent are encouraging. The results suggest that training to ANMs on using GMHAT can help in detecting mental disorders. It could be an advantageous intervention for detecting the mental illness cases at the lowest level as well as enhancing knowledge and attitude of primary health care

workers about mental disorders (38). Agreed that the detection of mental health issues is crucial to improve outcome in many chronic mental illnesses it is essential to improve their recognition rates (37). Training is essential for ANMs on use of GMHAT and to improve their knowledge and attitude about mental disorders as it will play vital role in success of integrating mental health services at primary level (38). With the objective of DMHP of identifying mental health illness cases at primary level and considering the issue of lack of adequate mental health resources to deal with a tool such GMHAT can assist primary care health workers in detecting patients with mental health conditions.

DISCUSSION

The above literature has given the insights on programs, policy, developments, shortcomings and struggles involved in improving mental health coverage.

Significant developments are made from the perspective of program, management and legal aspect that signal integration of mental health care into primary health. Training of the primary healthcare workers in mental health to detect cases at earliest aimed to meet the objective of DMHP and National mental health policy.

Integration of mental health care at primary level is observed with DMHP in Alwar as well as with involvement of ANMs on training them on use of GMHAT for detection of cases at the primary level.

While in function, though the feasibility of conducting DMHP at Alwar was well established and covered certain objectives with respect to NMHP and policy there lie lacuna in various aspects. The program needs significant strengthening from different outlooks like managerial front, constructing straightforward written action plan and increasing mechanism for integration.

There is need for program management team incorporating of both district administration /management (CMHO/Dy CMHO) and operational aspect (district psychiatrist) to the program. A task force/team involving of representative from managerial, operational and grassroot level will a create balance, ensure coherent structure for funding, coordinate the activities and enhance the implementation of the program as well as help in resolving administrative and logistics issues. There is also strong need of technical support which will assist the district with implementation issues. Involving primary level functionaries in mental health require training. In Alwar it was observed that till now only 30 Medical officers have been trained at PHC/CHC level while no training has been introduced for grassroot level functionaries like ASHAs and ANMs.

The DMHP did not create any mechanism for collaboration with private sector for delivering mental health services despite significant presence of private sector in mental health. Also, like other programs be it TB, reproductive and child health and HIV/AIDS programs, the DMHP did not see active involvement or partnership with NGOs (35).

In case of assessing the implementation of GMHAT it is demonstrated that training ANMs on use of GMHAT can help in detecting cases at the primary level. The training can also enhance their knowledge and attitude towards mental health problems. The specificity and the sensitivity test indicated the number of cases ANMs could identify with and without mental illness after being trained on using GMHAT, which is to an extent is encouraging and gave a picture that ANMs can be trained to detect mental illness with accuracy using the GMHAT.

CONCLUSION

Decentralization of mental health services and integration with general health care is the need right now. The mental health programs, policy and Act focuses on the aspect of

capacity building and incorporating primary healthcare workers in detecting mental health diseases. The GMHAT could demonstrate that the frontline health workers (ANMs) can be trained and incorporated into the adequate case detection system. Applying the GMHAT by training ANMs at the primary level can help in detecting cases at the earliest as well as may contribute to increasing their knowledge and awareness about mental disorders and reducing stigma at the community level.

In case of DMHP, though being implemented in Alwar it is important to realize that better managerial and technical support, access to funds, rethinking of program leadership at district level and continuous capacity building is essential for successful implementation and functioning of the program.

In view of Rajasthan being the largest state with varied physiography, customs and culture it should entail its own mental health policy as it will help in strengthening the mental health services and scenario of the state. Considering NMHS 2015-16 which is a milestone in understanding the epidemiology of mental disorders, the state should conduct a survey too to understand the prevalence, pattern and outcome of mental disorders not just by covering all the districts but by outstretching to the block level too which can help in identifying mental health issues and services required at the remotest settings. Recently the Mental health Act declared that every insurance company shall offer medical insurance for mentally ill patients as well. Even the newly launched Ayushman Bharat which is the government funded healthcare scheme has incorporated mental health services which is a positive and encouraging move on integrating mental health with general health.

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