National Institute of Mental Health and Neuro Sciences
(Deemed University), Bangalore, 560 029. INDIA

Operational Manual for District Mental Health Program

Ministry of Health and Family Welfare

Government of India

Modified after the National Consultative Meeting of DMHP for the 11th Year Plan

The document was prepared at the

National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore

Department of psychiatry
NIMHANS

Work Book

Operational Guidelines Manual
For
District Mental Health Program

Operational Manual For District Mental Health Program

Ministry of Health and Family Welfare
Government of India

Modified after the National Consultative meeting DMHP for the 11th 5 Year plan

The document was prepared at the National Institute of Mental Health and Neuro-sciences, Bangalore

OPERATIONAL MANUAL FOR IMPLEMENTATION OF DMHP

Contents of the operational manual-

Introduction.

Mental health care is too important to be neglected or undermined for whatever reason.. Efforts of the professionals in the country, commitment of the Government and developments in brain sciences, has made mental health care possible out side the four walls of the institution. Community care of person with mental health problems means care in the community by using the available resources. Primary health care system has spread its reach to such an extent in the country that there is no part of the nation left uncovered. However, there are issues with respect to effectiveness and responsiveness of the primary care system to the needs of the people. It is therefore appropriate to integrate mental health care into the existing system to ensure delivery of services, monitoring of the progress of such a service and to evaluate its impact. The public health care system has the required infrastructure to implement mental health program like any other national program in the country. Mental health professionals will extend their expertise into this process periodically depending on the local resources. Professionals who contribute to this process will be from institutes of mental health and neuro-sciences, medical college departments (both private and government), psychiatrists in the Government sector and private psychiatrists in the area.

District mental health program is considered as an important and pragmatic approach to improve the mental health services in India as part of NMHP in phased manner. This scheme was launched by the Ministry of Health, Government of India. The Government of India had launched DMHP in 27 districts during the 9^{th} five-year plan. This was increased to 94 districts in the 10^{th} plan. It is planned to increase the number of DMHPs to cover all of the districts in the country as part of the 11^{th} five-year plan in a phased manner. The Government of India scheme envisages developing mental health services through organization of DMHP. This involves assistance the State Governments to implement the DMHP in each district. A specified sum of money about rupees one crore per district is given to each state for a period of 5 years for implementation of DMHP.

The objectives are follows.

1. To provide sustainable basic mental health care services in the community by integrating mental health into the existing general health care services in primary care settings.
2. Early identification and treatment of persons with mental disorders in the community by active case identification by health workers, conducting periodic mental health camps in each taluk /tehsil of the district.
3. All persons with mental health problems should be referred to their respective primary health unit or primary health center or the taluk hospital after initial evaluation and initiation of treatment in the camps.
4. To launch intensive education for the community about availability of treatment for mental disorders, universal nature of mental illness, and regarding the need for regular follow up in the primary health center. These efforts should bring in large number of persons with mental disorders into care and consequent reduction in stigma and discrimination.

5. To facilitate adequate psychosocial care of the recovered mentally ill in the community by making appropriate linkages with NGOs in the local area.
6. To initiate mental health promotion activities through schools, colleges from the second year of DMHP.
7. The 11th plan envisages active public –private partnership taking into consideration that Government alone may not be able to respond to all the needs of the community. A good example of such a partnership can be thought of is in the area of psychosocial care, public education, and linkages with social welfare department and health promotion.
8. It is recognized that, the needs of the population can vary from one geographical location to the other. Certain modifications are required for the DMHP after mid term evaluation. To facilitate this, specific research grant amounting to 55 lakhs will be available with the central monitoring agency and application for such a grant should be addressed to the appropriate agency.
9. By DMHP, it is meant not only a rural district but also a unit of urban metropolis. Some modifications in the DMHP structure to suit each metropolis must be permitted.

Preparation for implementation of DMHP in a district.

The revitalized DMHP envisages the assessment of the preparedness of the district / Unit for undertaking the set of prescribed activities under the programme. The preparedness is assessed by reviewing the resources already available for implementing the programme and also by the commitment given by the concerned state government towards implementing the project as per guidelines. The Principal Secretary health and family welfare of the state government would identify the district where DMHP is proposed to be started in consultation with the Director of Health and Family Welfare services (or equivalent). He / She is also the official signatory representing the state government. The principal secretary health and family welfare will be assisted by the State nodal officer for mental health. The formal application (Form 3 to be obtained from the ministry and completed) along with the document for readiness to implement DMHP is to be prepared in consultation with the respective Member Secretary of State Mental health Authority. This is submitted to the central government. The DMHP grant will be allowed if the following are complied with

Check list of the documents needed:

a) Resource map for mental health activities within the district (Annexure 1)

b) Letters of commitment / MOU by the state government

c). Letter of appointment of the State Nodal Officer. The State Nodal Officer for NMHP is a person not less than the rank of Deputy Director with atleast 5 years experience of actively managing national health programme at the district level and has a minimum of 8-10 years of service prior to superannuation.

d). Letter of commitment for proper utilization of funds

e). Letter of commitment for appointment of the District Programme Officer with office facilities. And also an assurance that the officer shall not be transferred from the district in the five years of DMHP. If at all he /she is transferred, it should be to another DMHP district rather than anywhere else. This will cause least disruption to the programmme.

f). Letter of consent by the programme officer.

g). Letter of commitment for continuation of the activities of the project after the project period.

Components of DMHP as part of 11th 5 year plan.

The 11th five-year plan for national mental health program has taken into consideratiuon mental health needs of the urban, rural and tribal population in the country and has set its vision on addressing the needs of all sections of the society. It has also taken into consideration the logistic, administrative and other barriers in the implementation of DMHP in the country. Based on the review of DMHPs and its findings, opinion of the mental health experts, professional bodies in mental health and non-governmental agencies as part of the national consultative meeting, the 11th plan was revised to ensure that needs of all sections of the society was reflected in the plan. Further, the logistic and administrative difficulties encountered during implementation were taken into consideration to develop a guideline book.

A. Integration of mental health care into the existing general health services

The most important aspect of the DMHP is the training of the PHC personnel (doctors, health workers, nurses and pharmacists) to offer basic mental health care by integration into the existing general health services. The program will be launched after training the members of the DMHP team and the Program Officer in the philosophy of de-centralized mental health care within the district like any other national program. Following this, the district mental health team consisting of the program officer and the psychiatrist (where available) or the mental health professionals from near by medical college will conduct/organize training programs for the primary health care personnel to provide essential mental health care in the district.

The training program for doctors will be for three days and refresher-training program will be conducted every six to twelve months in an ongoing manner. The training program for health workers and other paramedical staff will be for one day with refresher training program every six months. This approach is used to ensure that all the staff of the district health services is trained in a short period of time so that identification, referral, diagnosis and management of mental disorders are possible. Paramedical workers will educate the ill persons and their family members as well as conduct follow up of the treated persons. The district team will address practical difficulties that might come up in the process of implementation in a structured and predictable manner. This support is ensured by regular visits to the PHC and by conducting regular review meetings with the staff. **Training curriculum and materials are provided in the medical officers manual, ref appendix 7, 8, 9 and 10 for training modules.**

Training program for DMHP staff

Name of the personnel	Duration of training	Location of the training	Number of Training programs	TA/DA
Program officer	6 months in two phases of 3 months each.	Regional centers	One for the first two years	Funds allocated
Psychologist	12 weeks	Regional centers	First year only	Funds allocated
Social worker	12 weeks	Regional centers	First year only	Funds allocated
Nurse	6 weeks	Regional centers	First year only	Funds allocated
Medical Officer 30 per batch	3 days each	District Headquarters	Two /Year	As applicable
Paramedical workers 75-100 per batch	1 day each	Taluk/Tehsil Headquarters	Two /Year	As applicable
Half a day sensitization training program for elected representatives	Half a day	District/taluk headquarters using the trained medical officer	Two per year	Funds from the Zilla panchayat/ District Health Society

Training for medical officers

- The program officer should generate a list of all doctors in the district after discussion with DHO/CMO.
- At least thirty doctors should be posted for every training program.
- Intimation about the training should be posted well in advance.
- Training program should be between 9 am in the morning till 5 pm in the evening.
- Doctors who miss the training program should be posted for the next batch.
- Doctors for the training should include medical officer working in the PHC/PHU, CHC / Taluk hospital doctors and the doctors working in the general hospital.
- District Health and Family Welfare training center /institute hall should be used for the purpose. The first round of the training program should be completed within three months of receipt of funds.
- Arrangements should be made for the stay of the doctors in the District Health and Family Welfare training center/institute to avoid delays in commuting.

- The resource person for the training program may be a psychiatrist in the district/ psychiatrist from the medical college or psychiatrists in private practice in the local area.
- The resource person should strictly adhere to the syllabus in the appendix.
- Honorarium will be paid to the resource person based on the State Government Guidelines.
- LCD projector, Desktop computer, speakers and mike should be made available on the days of training program from the existing district resources
- Writing pads, pens and KG card Board sheets, adhesives tapes should be available for the purpose of group work and presentation by the trainees.

Training paramedical workers

- The training program for the paramedical workers will be for one day.
- The training should be conducted in TalukTehsil headquarters
- For the first round of training program, all the paramedical workers such as Junior Health assistants, Senior Health Assistants, Health education officer ANMs, Pharmacist, and Nurses working in the PHC/PHU/Taluk hospital and the district hospital should be posted.
- The training venue should be taluk hospital premises
- LCD projector, Desktop computer, speakers and mike should be made available on the days of training program from the available district resources.
- Writing pads, pens and KG card Board sheets, adhesives tapes should be available for the purpose of group work and presentation by the trainees.
- Those who have failed to attend the training program should be handled by the DHO/CMO appropriately using the administrative procedures.

Training program for the elected representatives and NGOs in the Area

- Half a day sensitization of members of the gram panchayat, taluk panchayat should also be done by involving the CEO Zilla parishad and elected representatives of the district.
- NGO representatives should be involved in the training program

The DMHP team will provide support to the primary health care personnel by visiting the PHC, PHU and Taluk hospitals in the District every month. . This support includes on-site training, clarification and suggestions. Such visits will boost the morale of the primary care team. The programme officer monitors the progress every month.

B. Appointment of other staff to the DMHP and capacity building for implementation of DMHP

The program officers, psychologist, social worker, nurse, clerk will be appointed in the DMHP.

1. Appointment of the program officer in every district:

A Medical Officer with atleast 5 years experience will be **(appointed/deputed from the department of health and family welfare)** as program officer- mental health. He /she will be appointed exclusively for the DMHP. He/she will receive training for six months to work as program officer in mental health care, IEC activities, supervisory, administrative, managerial and training skills. The training will be in two phases each of three months separated by one year. The training for the program officers will be done in regional institutes of mental health and neuro-sciences as well as all the Psychiatry PG training centers in different parts of the country. **This approach is considered pragmatic to quickly generate in view of limited number of psychiatrists in the country and to preserve the spirit of public health care approach to mental health care similar to other national programs in the country.**

Selection Process and criteria. :

- Applications for the post of program officer will be called for from the pool of officers working in the department of health and family welfare.
- Those who have completed 5 years of service and those whose probationary period is declared will be eligible for the post.
- He /she should not have postgraduate qualification.
- A completed proforma containing the all the relevant details of the officer should be forwarded by the DHO/CMO to the concerned commissioner of health through the nodal officer mental health.
- The Department of Health and Family welfare may select double the number of officers to ensure that there is no gap in filling the vacancy just in case the officer fails to take up the post.
- He or she will give an undertaking that he/she will not take up any assignment of postgraduate studies or any other assignment (deputation to any other department), which will displace him from the job as program officer. .

Terms:

- The program officer will be reverted back to the Department of Health and Family Welfare soon after completion of the tenure as program officer.
- He/she will continue as program officer if he wishes to, just in case there is an opportunity to do so.
- He/she will be preferred over others in selection for postgraduate seat.
- The program officer will get an increment of Rs.1000 every year during his tenure as program officer and his salary will be met from the funds of DMHP.
- The salary of the program officer may be used for appointing another medical officer in his place on contract basis till the program officer returns to his original post.

- The program officer will not get transferred like other officers and if at all he/she is transferred it should always be to one of the DMHP sites in the State.
- The District health authorities/ State nodal officer can use his/her discretion to repatriate the deputed medical officer in case he/she is found not suitable for the job of program officer DMHP. In such a case, another program officer should be appointed before relieving the earlier officer.

2. Recruitment of psychologist and Social worker for the DMHP.

Process: Psychologists and social workers have specific role in the implementation of DMHP. Advertisements should be sent out to encourage candidates with MA (Psychology/ MSc psychology) to apply for the post of psychologist and MSW in social work for the post of social worker. The selection committee should consist three to five members such as the District Health Officer, District Surgeon, Program Officer-mental health, Social welfare officer and the District Disability welfare officer.

Terms: The appointment of psychologists and social workers will be purely on **CONTRACT BASIS,** which should be renewed after every 11 months of appointment. The selection is purely based on merit and **ROSTER** system of appointment does not apply in this case since it is purely contract appointment for 11 months to be renewed after 11 months.

Training: The appointed psychologist and social workers should be posted for three months training in DMHP and its implementation relevant to their area of work in a training institute in the region. For example NIMHANS, Bangalore for the southern states, IBHAS, Delhi for the northern states, Regional Institute of mental health and Neuro-Sciences, Tejpur for north eastern states and Institute of Mental health and neuro-sciences, Pune for western states and CIP, Ranchi and RINPAS for eastern states. The cost incurred for the training is budgeted in the DMHP funds.

The trained psychologists and social workers will start their work in the DMHP from the beginning of second year. Refer the appendix (page no-) for role and responsibilities.

3. Community Nurse educators.

One in-service nurse to be retained on deputation for the five years of DMHP. This nurse with B.Sc Nursing qualification will be supported from DMHP as regards salary. He/she will receive 6 week training (annexure…) in a PG training center (as mentioned above) .His/her role is to help the conducting of mental health camps in the first year of DMHP and IEC activities in addition to other mental health care activities assigned by the program officer.

4. Clerk/office assistant

A clerk/office assistant will be appointed for the DMHP to assist the program officer in the compiling data, organizing training programs and communicating with other

functionaries. A person who has completed graduation and familiar in handling computers should be preferred for this post.

Budget for the salary of the Staff

Salary	1st Year	2nd Year	3rd Year	4th Year	5th Year
Program Officer	Rs.2, 40,000	Rs.2, 52,000	Rs. 2,64,000	Rs.2, 76,000	Rs.2, 88,000
Psychologist	Rs.1, 20,000	Rs.1, 26,000	Rs. 1,32,000	Rs.1, 38,000	Rs.1, 44,000
Social worker	Rs.1, 20,000	Rs.1, 26,000	Rs. 1,32,000	Rs.1, 38,000	Rs.1, 44,000
Clerk	Rs. 72,000	Rs. 75,000	Rs. 78,000	Rs. 81,000	Rs. 84,000
Nurse	Rs. 1,44,000	Rs. 1,50,000	Rs.1, 56,000	Rs.1, 62,000	Rs.1, 68,000
Total	Rs. 6,96,000	Rs.7, 29,000	Rs.7, 62,000	Rs.7, 95,000	Rs.8, 28,000

Salaries of Program Officer Rs 20,000/- per month with increase of Rs 1000 per year. While that of the Psychologist and Social workers will be Rs 10,000 each per month with Rs 500 increase every year and for Clerk Rs 6,000/- with increase of Rs 250 every year.

5. Vehicles for the DMHP

There is no provision to purchase a vehicle in the DMHP. However, availability of outsourced vehicle for mobility of the DMHP team has been ensured. As an alternative, the program officer can use the vehicle at the disposal of the Chief medical officer or District health officer. Mobility of the program officer and the DMHP team has been ensured in the revised 11th plan by allocating a sum of Rs. 1.5 lakhs for this purpose. Funds for the travel incurred by the DMHP staff can also be reimbursed from the same amount as per the CSR rules of the state.

6. The District Hospital

The revised 11th plan will get support for strengthening the district hospital only if the psychiatrist is posted in the district hospital.

Please note: If the psychiatrist is not available in the district hospital, the program officer should make linkages with private psychiatrist in the local area/neighbouring districts or psychiatrists in the Medical colleges to seek higher level of care for patients in the DMHP district.

7. IEC activities in the entire district

Every person in the primary health center catchment area population should be aware of the DMHP in the district. The population should be educated by the trained paramedical workers about the features of mental disorders, availability of treatment in the primary health center, benefits of treatment to the ill persons and the family through posters, flip charts, slide shows, group meetings and wall writings.

A specified amount of 10 lakhs will be available for the same for five years. Mental Health Record, and reporting formats should be printed and distributed to all PHCs/PHUs/CHCs and Taluk hospitals at the time of launching the DMHP. Manual for doctors and paramedical workers should be provided to all the staff at the time of training

from the above funds. Manuals for the trainees will be given to those who have come for the training afresh. Each district will have a minimum of 1000 kits of IEC material that has one poster of 10 features of mental disorder and one flip chart that features the same for use in health education by the health workers

Information education and communication is an integral part of any healthcare programmes. Utilization of the service available in the district is directly related to the degree of awareness about the services and the nature of mental health problems in the community. District mental health programme envisages care for priority brain disorders such as psychosis, depression, neurosis, mental retardation, epilepsy, substance abuse disorders and mental health problems in children. The following activities should be undertaken as a part district mental health programme. Like the school mental health programme IEC component of DMHP may be implemented using the NGO resource in the area. A specified fund is available as part of DMHP for the same. The IEC components are as follows:

Methodology

Conduct of mental health camps or organization of mental health camps at every taluk / Tehsil of all DMHP districts. This activity should be conducted for the first 12 months in the district on receipt of DMHP funds after appropriate preparations. The camp activity will involve advertisement about the mental health camp in the local area using clip charts posters, wall writings, radio and TV announcements. A mental health team consisting of psychiatrist, program officers, psychologists, social workers, will conduct clinical evaluations for the camp attendees. Depending upon the nature of the mental health problem on hand appropriate mental health records are generated and treatment is initiated for the patients. The treated patient is immediately referred to the respective primary health center to the respective PHC / PHU / taluk hospitals so that he/she continues treatment in that center. Camp approached to mental health care generates a number of patients who need mental health care in a very short period of time and it helps to root patients appropriately to the resources available. Patients and families also get an opportunity to understand about mental disorders and treatment available for the same by the exhibition organized by the camp. Funds to the tune of Rs.8000 will be available for each camp. It is important to encourage social service organizations like lions, rotary's Leo's and other philanthropic organizations in this activity.

- As part of IEC kit posters, clip charts, wall writing messages, and slides will be available and this should be used to educate people all over the district.
- Public education about mental disorders should also be undertaken by the ANM's, JHA's, SHA's and the block health education officers of every primary health centers. A kit with poster, clip chart, slides and wall writings should be made available at every sub-centre.
- As part of IEC activities training materials like an interactive CD will be made available to all DMHP's. These materials and modules provided in the appendix will be used as the training resource for doctors and health workers.
- IEC activities should also be conducted regularly in all Mela's, Car festivals, shandy's, fairs and exhibitions regularly in he DMHP district. The NGO's and

department of health education and training wing should actively carry out these activities.

- Sensitization of the community should also be done through school and college sector. Debates should be conducted at taluk level by inviting atleast 2 students from each school in the taluk. The topics for the debate will cover mental health issues. (see appendix for IEC kit).

In addition to the above, the program officer and the DHO/CMO should use the All India Radio and the FM stations to sensitize the local community of the DMHP in the district and its various components.

8. Health promotion using Life skills approach in the schools

In a country like ours, where resources and trained professionals are sparse and few, it is pragmatic to involve and work with the teachers. **The teachers are the personnel who are interacting with the adolescent closely.** They could be trained to transfer required skills to the adolescents. This methodology ensures reproducibility of the program within the existing infrastructure of the school year after year at no extra cost. Experience of working with secondary school teachers has shown that teachers can be trained to impart LSE effectively**. It is observed that there is a significant change in the attitudinal approach of the teachers who are trained in LSE.** They are more receptive to the problems of the adolescents and there is an improvement in the relationship between teachers and the taught with the implementation of LSE. Hence, **Training the Teachers (Training the Trainers) is the methodology, which might have a wider coverage, continuity and cost-effectiveness.** Experience also has shown that teachers need support in the form of syllabus, resource materials and training to be able to promote Life Skills among the adolescents. Generalization to other activities would occur if promoted actively and encouraged to do so. Children can be encouraged to use these skills for specific issues of Family Relationships, Developmental Crises, Substance Abuse, Violence, Bullying, Sexuality, and Career Choice etc.

School Mental Health – Promotional and Preventive

On the background of what is mentioned in the above paragraph, there is an urgent need to have a comprehensive School Mental Health Program in India – predominantly Promotional with an Interventional Component added to it.

In health care there are three frameworks based on behavior or health status of the target population

- Primary – To decrease the incidence of a disorder
- Secondary – To decrease prevalence of a disorder
- Tertiary – To decrease Disability after the onset of disorder.

According to the goals of the mental health program enumerated above, a comprehensive program should be both promotional (**increasing the resilience of all students to cope with various opportunities and challenges that they come across**) and at the same time also provide specific treatment services for students who are at risk to develop mental health disorders

Strategies for School Mental Health Program

- To develop a comprehensive promotional and preventive School Mental Program
- Recognition of the SMH Program to be an integral part of NMHP.
- Collaborative Liaison between Departments of Health and Education and other departments like Women and Child Welfare, Human Resource Development and Department of youth and sports.
- Allocation of Funding over 5 years (11^{th} five year plan)
- A two pronged Model of (High Schools)
- Promotion – Life Skills Education Approach for High Schools
- Intervention: Identification of Psychological Problems in students, Referral & Treatment.
- To have an integrated continuous model with Capacity Building – Training of Teachers in a Cascade Manner (TOT).
- Implementation, Monitoring and Evaluation
- Active NGOs & INGOs dialogue and participation

AIMS of the SCHOOL MENTAL HEALTH PROGRAM

- Provide Class Teachers with Facilitative Skills to Promote Life Skills among their Students.
- To provide the Class teachers with Knowledge and Skills to Identify Emotional, Conduct, scholastic and substance use problems in their students
- Provide Class Teachers with a system of referral for students with psychological problems to the District Mental Health Team for inputs and treatment.
- Involve other stakeholders like parents, community leaders to enhance development of adolescents etc.

Methodology

The district mental health will be primarily responsible for facilitation of the training program. NGOs working in the area of adolescent mental health having the know how of imparting skills through LSE can be encouraged to undertake this task where ever possible. Two master trainers from each education block will be trained to impart training in their block. About 100 teachers will be trained from each block having about 25- 30 schools. Master trainers will be trained for 6 days and schoolteachers will be trained for three days respectively. The trained teachers will implement LSE classes as part of school curriculum. They are expected to identify emotional problems in school children and refer such children to the DMHP team- psychologist, social workers and psychiatrist if available. Chart of events is given below.

Non-school adolescent mental health program:

Counseling services will be organized for out of school children with mental health problems in both urban and rural districts as part of the adolescent mental health program. A sizable number of children are out of school in any district in the country. These children have high mental health needs because of problems such as – Disturbance in conduct, substance use and sexual abuse. The 11^{th} plan envisages care for such children by establishing linkages with organizations and departments working

for the welfare of such children in the district. They are department of social welfare, department of youth and sports, NGOs and other voluntary agencies. Field staff of the above agencies, NGO staff and other volunteers is trained by the DMHP staff or the NGOs themselves to provide counseling services for such children. The manual developed for interventions of emotional problems is also used for this work.

Budget for one block in the Rural District

	1st year	2nd year	3rd year	4th year	5th year
Per block*	3,91,500	1,08,000	2,08,000	1,08,000	1,08,000

* Expenditure to be estimated for total of 600 blocks (one in each of 500 in rural and 100 on urban districts; 2/UMHP). Expenditure in this table excludes rupees fifty lakhs that is required for in the first year for the development of IEC material. (see summary of budget at the end)

Total budget for Adolescent/school mental health programme
(2 block- Urban district)

School MH	1st year	2nd year	3rd year	4th year	5th year
Per District	7,83,000	2,16,000	4,16,000	2,16,000	2,16,000

Total budget for 500 education blocks in Rural districts and 100 block in urban district is 56 crores.

9.College mental health program

College students are the cream of adolescent and young adult population. They are under tremendous pressure as they are expected not only to succeed but also become toppers in their classes and courses. At the pre-university level, there is intense need to join professional courses like MBBS or BE. Courses like B.A., B.Sc., B.Com, attract a few students only. Students who fail to get into the courses of their or parents' choice, get frustrated. Though they join Arts or Science or Commerce courses, their morale is very low. They start complaining about the parents, teachers and the society. They are less motivated to learn and complete the course. They may drop out of the course. The deteriorating value system in the society, failure of the political and administrative systems to provide them job opportunities complicates issues. The print and electronic media on one hand put an unrealistic glamorous life style as the norm and on the other hand glorify sex, crime and violence. This influences the college students in a negative manner. Families are becoming smaller and smaller and are unable to provide the needed support and guidance. Ambivalence, confusion, helplessness prevail in the student community. There are a few epidemiological studies in the area of mental health of college students. The studies report that 15 to 20% of the students having recognizable mental disorders in the form of depression, anxiety, somatoform disorders, adjustment disorders, personality disorders and alcohol and drug abuse. Many more students may be

suffering from sub-clinical symptoms, and emotional disturbances. These contribute to the observable behavioral abnormalities in them in the form of

- Irritability, anger outbursts, aggression including ragging, being hostile to others
- Boredom, sadness, lack of interest, hopelessness and helplessness, being dull, withdrawn, express negative thinking
- Apprehensions, fears, feelings of inferiority, severe examination fear
- Conduct - problems like lying, stealing, running away from home, criminal activity, sexual promiscuity and immoral sexual activities
- Alcohol and substance abuse and addictions
- Absenteeism, irregular to attend the class, dropping out from the course, poor performance or failure in the examination.
- Having medically unexplained somatic symptoms, often getting sick, accident proneness
- Suicidal attempts

Thus, students who have these problems have to be identified and helped.

Except a few private colleges, counseling services are not available in most of the colleges in the country. Similarly trained counselors and counseling services are very few in the community. Students with psycho-social problems and mental morbidity do not seek psychiatric treatment because (1) psychiatric services are not available in an affordable and approachable manner (2) Severe stigma is attached to mental disorders and psychiatric consultations, (3) Lack of awareness. Thus majority of the students who need help, remain unattended and uncared.

NIMHANS has developed many community based preventive and promotive programmes to reduce mental morbidity and to improve mental well-being of people. NIMHANS has designed and developed many innovative programmes to involve non-mental health experts, professionals and lay volunteers in organizing primary secondary and tertiary preventional activities in the society. College students being a high-risk group to develop mental disorders; NIMHANS has developed a programme to involve college teachers as counselors and act as referral and support giving agents for those students who are having psychosocial problems and mental morbidity.

Objectives

1. To sensitize the college teachers - about:
   a) Modern - scientific understanding of human behavior
   b) Biological, psycho-socio-cultural development of adolescence and the needs of adolescent boys and girls.
   c) Common psychosocial problems, minor and major mental disorders seen in the late adolescent period (16 to 21 years).
   d) Specific needs and problems of college students in their family and college life.
   e) Changing family and social life and its impact on students
   f) Role of parents, family, teachers, educational institutions and society in the care of students

g) Impact of stress on health and intellectual functioning of an individual stress management and positive health.

2. To impact knowledge and skills to teachers in the following areas:
   a) Interviewing skills
   b) Psychosocial management of student's emotional problems
   c) Techniques and practice of counselling: Individual and group counselling
   d) Identify moderate to severe mental health problems in students and make timely referral to the experts
   e) Follow up the student for the required period
   f) Conduct educational activities to improve the health & functioning of the students

College teachers will be trained to work as counselors in their own colleges. This training will be conducted in the district headquarters. The program officer mental health will organize the program in the district and the Deputy director collegiate education will identify teachers for the training. Two teachers from each college will attend the training program. About 25- 30 teachers will comprise one training batch. All the trained teachers from the district will attend half a day support group meeting every month to discuss problems they encountered in their work in the past one-month. Psychologist and the social worker and the program officer will be available to provide clarifications, suggestions and guidance to the teachers. Psychiatrist if available will provide guidance and support to the teachers periodically. District level officer from collegiate education will be present to sort out administrative issues of the teachers.

The trained teachers will organize sensitization sessions in their college after the training for their colleagues. The principal of the college should be actively involved in the process. The principal and the trained teachers should officially launch the counseling center in their college premises. Teachers are requested to identify boys and girls with the following problems and refer them for help from the counselors.

College counseling program - (Budget for one rural district)

Domain	**Budget**
Training 100 teachers* 6 days trg* Rs.200 per day (At least one teacher from one college)	Rs.1, 20,000
Annual refresher training program 100 teachers* 1days trg* Rs.200 per day	Rs.20, 000
Honorarium and Travel allowance for resource persons Rs. 3500* 2 persons per batch * 3 batches	Rs.21, 000
Support group meetings 100 teachers* Rs. 150* 12 months	Rs.1, 80,000
Stationary Rs.2000 per college* 100 colleges	Rs.20, 000
Total	Rs.361,000

Total number of training programs for one district = 3 batches
Total number of support group meetings =12 meetings

Translation of counseling manuals and printing = Rs. 25, 00,000

College counseling program (Budget for one Urban district)

Domain	Budget
Training 300 teachers* 6 days trg* Rs.200 per day (Atleast one teacher from one college)	Rs.3,60,000
Annual refresher training program 300 teachers* 1days trg* Rs.200 per day	Rs.60, 000
Honorarium and Travel allowance for resource persons Rs.3500* 2 persons per batch * 9 batches	Rs.63, 000
Support group meetings 100 teachers* Rs. 150* 12 months	Rs.1, 80,000
Stationary Rs.2000 per college* 100 colleges	Rs.20, 000
Total	Rs.6, 83,000

10. Suicide prevention program

Prevention of suicide has gained tremendous important in view of the impact of suicides on the families, communities and society at large in recent times. Evidence suggests that about one fifth of suicides are related to under treated or untreated mental morbidity, while the remaining is related to a host of factors. The 11th plan envisages interventions to prevent suicide and this is a very positive development. The following are the key strategies to focus on suicide prevention in the community.

1. Mental Health Care

The NMHP strategy for the 11th five-year plan is to set up revitalized DMHP in the country. This is approach is targettted to cover 500 rural districts and 50 urban district in the country over the plan period. It is envisaged that all person needing urgent mental health care (severe mental disorders) will be provided appropriate and adequate care to recover from the illness and this will subsequent impact on prevention of suicides/ reduction of suicides in the community. Primary care Doctors, Health Workers, ANMs, NGOs working in the mental health will actively collaborate to deliver mental health services to the needy in every primary health center catchment area in the country.

2. Health promotion using life skills and intervention for emotional problems in schools.

High school teachers are trained to implement life skills education program as apart of school curriculum. The trained teachers will impart skills to promote psychosocial competence in adolescents within the context of school over the academic year for 8th, 9th and 10th standard students using structured lesson plans. This program will cover at least

one education block in every rural district in the country and at least two education blocks in 50 urban district over the plan period. Like the students in the school sector, adolescents and youth who are out of school (street children) will be provided intervention or substance abuse, emotional and conduct disturbances.

3. College mental health program.
College lectures will be trained to provide counseling inputs for distressed college students as part of the college activity. 500 rural districts and 50 urban colleges will be taken for such an intervention as part of 11th five-year plan. The above activity is consequent to the need for such interventions within the context of higher secondary schools/ pre-universities and degree college students.

4. Counseling centers in the district
Suicide prevention activity will be initiated by establishing counseling centers at the district headquarters. These centers will be manned by two qualified professionals (psychologist or social workers) with masters' degree in the respective fields. They will trained in a central institute for three months in counseling skills, resource mobilization, networking, training and managerial skills to organize interventions for the risk population in the district.

5. Lay counselors.
Each counseling center in the district will have provision of appointing 10 lay counselors on part basis. These person will trained by the counselors using the local mental health resources available such as program officer mental health, psychiatrist in the Government sector, medical college faculty or psychiatrists from the mental hospital if available. The lay volunteers will be deployed to different areas of the district depending on the need. This activity should occur through coordination with the nodal officer, district administration, social welfare and other relevant departments in the district.

6. Training of police personnel
Three police constables (2 males and 1 female), per police station in the district, will identified by the district head of the police to undergone training for three days. This has been considered important because field level police officials are the key persons who handle reported cases of completed suicide or attempted suicide. The three-day training will focus on documentation skills, emotional support skills and networking with other agencies to make linkages for emotional first aid in the local area. The training coordinators will develop a list of all such agencies so that such information is available to all the trainees.

7. Sensitization of district officials.
A large proportion of suicides are related to multiple factors. Support for distressed individuals in the community can be linked to several departments such as agriculture, banking services, rural development, social welfare, law enforcement agencies, other developmental agencies in the district. It has been recognized that all the above agencies can play a vital role in handling beneficiaries in a human manner and make linkages with appropriate departments for redressal of grievances. A sensitization program would

go a long way in making the officials and system responsive to the needs of the distressed individuals.

8. Nodal Officer mental health

The District mental health program is implemented through the nodal officer of the respective state. He will also initiate the suicide prevention program for the district. An officer from the Department of social welfare since will assist the nodal officer to facilitate networking for interventions. Further, the program officer and other members of the district health society will make appropriate inputs as and when required. The nodal officer will be provided technical support by the state technical team as and when required to respond to the needs of the population if there are adversities like droughts, floods or other man made disasters.

BUDGET

The following budget per district is allocated for suicide prevention. This will be initiated in 100 districts, at least one district per state. More districts per state to be included depending on the endemicity of suicides.

Budget for state surveillance activity: This will be maintained by the state Nodal officer mental health. He will keep a record of all suicide events (completed/attempted). The numbers to be brought to notice to the central monitoring cell as well as the directorate. He may employ a clerical assistant at a consolidated salary of Rs 5000/month. Rs one lakh for travel expenses for a year and miscellaneous expenditure of Rs 40,000/year. Total Rs 10,00,000

Budget for suicide prevention per district

Domain	Activity	Cost	Total
Training	**A. Primary Health care** **Doctors** **Health workers** **Ashas** **School & college**	**Cost met as in DMHP**	**00.00**
	B. Police personnel **100 female constable** **200 Male constables**	**300*150*3 days in 10 batches 0f 30 each + resource persons' fee & misc**	**2,50,000.00**
	3 months for counselors and one week for volunteers	**Rs 16,000/- one time may require repetition if the staff leave**	**50,000.00**
IEC activities	**10,000 posters on suicide prevention education** **IEC Kit (Radio & TV)**	**Rs 100 per piece**	**10,00,000.00** **5,00,000.00**
Counseling centers &	**One per district with two counselors and 10 part-time**	**Rs 10,000 per counselor & Rs 2000**	**30,00,000.00**

Crisis intervention	**taluk-level volunteers Office, telephone & misc**	**per volunteer and rent + telephone etc. Total Rs 50,000 per month**	
Sensitization program of half day	**Agriculture officers BEOs Social welfare officers Police and Judicial officers Bank and Revenue officials Media staff Agriculture staff Elected representatives Once a year**	**Rs 25,000/- per session for a number of 50**	**2,50,000.00**

Domain wise costs for activities in suicide prevention one district.

Domain	**1st Year**	**2nd year**	**3rd Year**	**4th Year**	**5th Year**
IEC activities **Poster, Radio and TV Messages**	**11,00,000**	**1,00,000**	**1,00,000**	**1,00,000**	**1,00,000**
Training					
Police personnel	**1,25,000**	**1,25,000**	**Nil**	**Nil**	**Nil**
Resource person for TRG	**25,000**	**25,000**	**Nil**	**Nil**	**Nil**
Counselors TRG* 3 Months* 2 persons	**60,000**	**Nil**	**Nil**	**Nil**	**Nil**
Volunteers training *10 persons * 2days	**25,000**	**25,000**	**Nil**	**Nil**	**Nil**

Domain	**1st Year**	**2nd year**	**3rd Year**	**4th Year**	**5th Year**
Salaries					
Counselors*2* 10,000 per month	**2,40,000**	**2,40,000**	**2,40,000**	**2,40,000**	**2,40,000**
Lay volunteers * 10 *2500 Per month	**3,00,000** **60,000**	**3,00,000** **60,000**	**3,00,000** **60,000**	**3,00,000** **60,000**	**3,00,000** **60,000**
Office assistant * 1*5000 Per month					
Sensitization personnel from all sectors	**1,00,000**	**1,00,000**	**50,000**	**Nil**	**Nil**
Counseling center					
Rent * 5000 pm	**60,000**	**60,000**	**60,000**	**60,000**	**60,000**
Telephone expenses	**60,000**	**60,000**	**60,000**	**60,000**	**60,000**

Total in lakhs	**21.55**	**10.95**	**8.7**	**8.2**	**8.2**

Total budget per district for 5 years = 57.6 lakhs

Budget stratified for suicide prevention over 5 years.

Districts	2007-8	2008-9	2009-10	2010-11	2011-12
First Year 30 districts	6,46,50,000	3,28,50,000	2,61,00,000	2,46,00,000	2,46,00,000
Second year 30+ 20	Nil	4,31,00,000	2,19,00,000	1,74,00,000	1,64,00,000
Third Year 50+ 20	Nil	Nil	4,31,00,000	2,19,00,000	1,74,00,000
Fourth Year 70+20	Nil	Nil	Nil	4,31,00,000	2,19,00,000
Fifth Year 90+10	Nil	Nil	Nil	Nil	2,15,50,000
Total	6,46,50,000	7,59,50,000	9,11,00,000	10,70,00,000	10,18,50,000

Total for 5 years 100 districts = 44,05,50,000

Budget for central nodal agency and state surveillance

Domain	**2007- 8**	**2008-9**	**2009-10**	**2010-11**	**2011-2012**	**Total**
Central Nodal Agency	**1,00,00,000**	**1,00,00,000**	**1,00,00,000**	**1,00,00,000**	**1,00,00,000**	**5,00,00,000**
Development of IEC material	**2,50,000**	**2,50,000**	**Nil**	**Nil**	**Nil**	**5,00,000**
Consultation	**20,00,000**	**20,00,000**	**20,00,000**	**20,00,000**	**20,00,000**	**1,00,00,000**
State Surveillance	**68,00,000**	**68,00,000**	**68,00,000**	**68,00,000**	**68,00,000**	**3,40,00,000**
Total.	**1,90,50,000**	**1,90,50,000**	**1,88,00,000**	**1,88,00,000**	**1,88,00,000**	**9,45,00,000**

Total budget for suicide prevention year wise.

Domain	**2007- 8**	**2008-9**	**2009-10**	**2010-11**	**2011-2012**	**Total**
Program	6,46,50,000	7,59,50,000	9,11,00,000	10,70,00,000	10,18,50,000	**44,05,50,000**
Nodal agency	**1,90,50,000**	**1,90,50,000**	**1,88,00,000**	**1,88,00,000**	**1,88,00,000**	**9,45,00,000**
Total	**8,37,00,000**	**9,50,00,000**	**10,99,00,000**	**12,58,00,000**	**12,06,50,000**	**53,50,50,000**

Budget (Rs in Crores) for the suicide prevention activity

Activity	**Budget**
District-level program* 100 Districts	**50.5**

State surveillance*33	**3.4**
Central surveillance cell	**5.0**
Total	**58.9**

Total for 100 districts is 58.9 crores

Budget: Monitoring, support and supervision

Head of account	Details	Total per year
At the District level		
One time infrastructure grant	25,000	25, 000
Recurring expenses for office	2,500 per month	30, 000
Miscellaneous	1,000	12, 000
At the state level		
One NMHP assistant (with social sciences background and experience of working in field conditions 5 years being computer literate)	10,000	1,20,000
One time infrastructure grant	50,000	50, 000
Recurring expenses for office maintenance	5, 000 per month	60, 000
Quarterly meeting expenses (including TA / DA and other expenses)	25, 000 per meeting	1, 00, 000
Towards State TST		2, 00, 000
Towards annual report		25, 000
Towards annual state review participation		25, 000
At the central level		
Systems Analyst	20, 000 per month	2, 40, 000
Data entry operator and Statistical assistant	10, 000 per month	1, 20, 000
Infrastructure	50, 000	50, 000
Recurring office expenses	10, 000 per month	1, 20, 000
Visit to the DMHP States		2, 00, 000
Towards Central TST		4, 00, 000
Towards biennial evaluation and report		2, 50, 000
Towards biennial review (meeting expenses)		5, 00, 000
Web hosting expenses		1, 00, 000
Review of mental Hospitals and Urban mental health projects	Rs 10, 000 per institution	

Summary Monitoring budget (Rupees in lakhs)

Year→ Domains	I-year	II-year	III-year	IV-year	V-year	Total
District	**18.7**	**34.9**	**51.1**	**67.3**	**83.5**	**255.5**
States (25)	**61.6**	**50.0**	**50.0**	**50.0**	**50.0**	**261.6**
Central	**20.3**	**19.3**	**19.3**	**19.3**	**19.3**	**97.5**
Total	**100.6**	**104.2**	**120.4**	**136.6**	**152.8**	**614.6**

Total Budget for monitoring Rs 6.15 crores

11. Stress Management

Stress Management implies understanding the effects of stress on the individual, his family, and work and on the larger social life. As mentioned earlier, there are no quick fix solutions to reduce stress except working on damage limitation strategies. Most individuals who attend stress management courses are pessimistic about the practical utility of the programme because of their fatalistic attitude. Very often they tend to reflect on various lacunae in the system (which is understandable) but fail to internalize the fact that impact of stress can be nullified/ minimized by personal efforts like physical activity, relaxation; networking, seeking social supports, diet, weight reduction; time management and so on. It is important to note that stress management is a health promotion strategy. It involves commitment and motivation to remain healthy despite adversities around us; learning practical tips is possible and potential benefits from such learning can impact every aspect of ones life and make professional careers of individual meaningful and creative.

Methodology for stress management course in the 11th 5-year plan.

The administrative training institutes of the respective states are key agencies identified to conduct stress management courses in the states for their officers from all the departments. Five faculty members from each of the administrative training institute of the states will be trained for a period of 6 days. These master trainers will impart training to the trainers working in the district administrative training centers for three days. The local faculty will in turn incorporate stress management module into their training in all the program they conduct for the Group A and B officers from various departments. .

Evaluation.

Stress management courses are conducted periodically at the Administrative Training Institute of the respective states for Executive Officers serving in the Government. The training is conducted over 3 days and methodology used includes didactic lectures, group discussions, role-plays, and brain storming sessions and problem solving methods using specific examples. This methodology has been found to be useful because of the dynamic and participatory learning methods used in the program. Evaluation of such programmes in terms of impact on skills development at individual level to minimize the effects of

stress at work place, family and social situations has been very limited. This is attributed to lack of follow up of persons who have under gone the training and other logistic and administrative obstacles.

It is absolutely essential to carry out such evaluations annually so as to enable professionals and make appropriate inputs and also to facilitate development of methods to continuously interact with personnel to address ongoing needs. Efforts are made current to change the methodology to increase the effectiveness of the programmes. This will make the programme user-friendly; facilitate skill development to minimize the impact of stress and to plan for specific life style changes. It is well known that experiential learning methods are very effective to bring about changes for damage limitation. Stress in work places, family and social situations are inevitable today. Stress management course does not produce an instant solution nor is it a quick fix. Effectiveness of the programme therefore depends on the individual's commitment and motivation to work towards "harmonizing personal needs with that of professional demands".

Objectives of stress management course:

Stress management course should have in following objectives

1. To encourage the executives understand the impact of stress on personal life.
2. To learn skills for stress management despite adversely.
3. To incorporate specific life style changes to minimize damage due to stress.

Implementation at the state and district administrative training centers .

Stress management strategies through experiential learning methods like

- Games
- Group Activities
- Role plays
- Brain storming sessions
- Group Discussions
- Facilitation for conceptual clarity
- Practical skills - Relaxation
  Yoga
  Breathing exercise
  Communication
  Assertiveness

Year wise budget for stress management for all states and union territories

Domain	2007-8	2008-9	2009-10	2010-11	2011-12	Total
IEC	30,00,000	Nil	Nil	Nil	Nil	30,00,000
Training 170 MTs	50,00,000	Nil	Nil	Nil	Nil	50,00,000
Training support	3,00,000	Nil	Nil	Nil	Nil	3,00,000
Monitoring	6,00,000	6,00,000	6,00,000	6,00,000	6,00,000	30,00,000
Refresher MTs	10,00,000	10,00,000	10,00,000	10,00,000	10,00,000	50,00,000

					0	
Follow up of trained officers / MTs (both state and district level	**5,00,000**	**5,00,000**	**5,00,000**	**5,00,000**	**5,00,000**	**25,00,000**
Total.	**1,04,00,000**	**21,00,000**	**21,00,000**	**21,00,000**	**21,00,000**	**1,88,00,000**

Budget for various domains in stress management

Domain	Activity	Cost	Total for 5 years
Development of Resource material	**Manuals** **Interactive training CDs**	**20,00,000** **10,00,000**	**20,00,000** **10,00,000**
Training	**Master Trainers** **5 from each state * 34 units* 6days at four centers in the country** **(TA/DA)**	**50,00,000**	**50,00,000**
Training support	**Resource persons** **4* 20,000* 3 batches per year (TA/DA)**	**3,00,000 * 1**	**3,00,000**
Monitoring and Supervision of the MTs	**Resource person** **4* 20,000* 3 batches per year**	**3,00,000* 2 times year**	**30,00,000**
Refresher training program for MTs	**Master Trainers 5 from each state * 34 units* 1 day at four centers in the country annually (TA/DA)**	**10,00,000 per year**	**50,00,000**
Follow up of trained officers / MTs (both state and district level	**Telephone, office furniture, Fax, Email** **Postages & Miscellaneous**	**5,00,000 per year**	**25,00,000**
Total budget for stress management training & monitoring			**1,88,00,000**

Release and Use of Budget

The Government of India has allocated a specified sum of funds to the start Government to start the mental health services in the form of DMHPs.

The budget is released from the Ministry of Health, Government of India to the Nodal Officer rooted through the respective State secretary of health services. The nodal officer should be the Deputy Director Mental Health or the Joint Director health who in turn disburses the funds to the District health officer of the DMHP district. The district health officer is the official who hold the funds and releases periodically funds to the program officer.

- He/she should open and Savings Bank account in a nationalized bank and operate the same.
- He/she should consult the District Health Society periodically to take some decision about purchase of drugs in case the same is not available in the drug logistic society using the rules framed by the respective state Government. Similarly, Purchase of drugs, stationary and other essentials for the DMHP should be done through the District Health Society.
- The 11th plan proposes that the nodal officer is always the state level officer of the rank of Deputy Director or the joint Director. This arrangement will integrate the mental health program as one of the programs of the state health services.
- The nodal officer will be responsible to monitor the program and submit Utilization certificate to the Government of India. It is important to note that interest accrued from the funds should be added to the funds while auditing the accounts before submitting the utilization certificate
- Release of the subsequent grants for the state is dependent upon the receipt of utilization certificate in the first week of April and on the report of the state and central monitoring committee.

Budget for the salary (Rs) of the Staff (One Rural DMHP)

Year→ Staff	1st Year	2nd Year	3rd Year	4th Year	5th Year
Program Officer	2,40,000	2,52,000	2,64,000	2,76,000	2,88,000
Psychologist	1,20,000	1,26,000	1,32,000	1,38,000	1,44,000
Social worker	1,20,000	1,26,000	1,32,000	1,38,000	1,44,000
Clerk	72,000	75,000	78,000	81,000	84,000
Community Nurse	1,44,000	1,50,000	1,56,000	1,62,000	1,68,000
Total	6,96,000	7,29,000	7,62,000	7,95,000	8,28,000

Salaries of Program Officer Rs 20,000/- per month with increase of Rs 1000 per year Psychologist and Social workers Rs 10,000 each per month with Rs 500 increase every year and for Clerk Rs 6,000/- with increase of Rs 250 every year. Nurse is deputed from service. Rs 12,000 per month and increment of Rs 500 per year **Total for Salaries of field staff Rs 38, 10, 000.**

Budget (Rs) for Training component of DMHP

Year→ Staff	1st Year	2nd Year	3rd Year	4th Year	5th Year
1. Medical Officers @ Rs.300*170* 3 days * 2 programs per year 2. Expenditure* 2 training (Miscellaneous)*	3,06000 10,000	3,06000 10,000	3,06000 10,000	3,06000 10,000	3,06000 10,000
Paramedical workers @ Rs 125 *550* 1 day * 2 program per year Miscellaneous Expenditure* 2 training	1,37,500 10,000	1,37,500 10,000	1,37,500 10,000	1,37,500 10,000	1,37,500 10,000
Program Officer @ 2*3 months	40, 000	40, 000	Nil	Nil	Nil
Nurse * 12 weeks	12, 000	Nil	Nil	Nil	Nil
Psychologist@1*3 months	36,000	Nil	Nil	Nil	nil
Social worker@ 1* 3 months	36,000	Nil	Nil	Nil	Nil
Total	5, 87,500	5,03,500	4,63,500	4,63,500	4,63,500

1. A sum of Rs 300 per day per medical officer is allocated which includes travel and dearness allowance during the training program.
2. *Miscellaneous expenditure includes TA/DA for the resource persons (2) , LCD hire charges/ stationary for the training program.
3. The budget for the resource person should be increased after discussion with MOH

Total Costs for training- Rs 24, 81, 500

Budget (Rs)- Office Equipment, IEC and drugs: Recurring expenditure

Year→ Item	1st Year	2nd Year	3rd Year	4th Year	5th Year
Drug	500,000	500,000	500,000	500,000	500,000
Equipment	75, 000	Nil	Nil	Nil	Nil
Travel	150,000	150,000	150000	150,000	150,000
Contingency & Stationary	10,000	10,000	10,000	10,000	10,000
IEC Activity	200,000	200,000	200,000	200,000	200,000
Total	9,35000	8,60000	8,60000	8,60000	8,60000

Total recurring expenditure Rs. 43, 75, 000

Summary Budget (Rs) for DMHP

Year→ Domain	1st year*	2nd year	3rd year	4th year	5th year
Staff	6,96,000	7,29,000	7,62,000	7,95,000	8,28,000
Training	5,87,500	5,03,500	4,63,500	4,63,500	4,63,500
IEC, Drugs..	9,35,000	8,60000	8,60000	8,60000	8,60,000
Adolescent MH	7,83,000	2,16,000	4,16,000	2,16,000	2,16,000
College Teachers Training in MH	10,83,000	6.60,000	6.60,000	6.60,000	6.60,000
Special Services	2,00,000	2,00,000	2,00,000	2,00,000	2,00,000
Total / District	**42,84,500**	**31,68,500**	**33,61,500**	**31,94,500**	**32,27,500**

Procurement of Drugs

Availability of all the essential drugs in every primary health center and primary health unit/CHC and taluk hospital is must in the DMHP. The drugs should be procured from the drug logistic society/ rate contract / after discussion with district health society if rate contract or drug logistic society is not functional in the state.

District mental health program is a public health approach to mental health care. Person with mental illness is encouraged to use the mental health service in the district. In keeping with the philosophy of mental health care in primary care, minimal mental health services are delivered at the primary care settings. Minimal mental health care means, anti-psychotics drugs for person with psychosis, anti-depressants drugs for person with clinical depression, education, support and linkages with NGOs for person with mental retardation, Counseling for person with neurosis and Out patient detoxification and education for alcohol dependent individuals, counseling for children with emotional problems and anti-epileptic for person with epilepsy.

The following table shows drugs that should be available in PHC/PHU /CHC/Taluk Hospital and District Hospital

SL NO	Name of the drug that should be available in PHC/PHU/Taluk Hospital
1	Tab. Chlorpromazine 100mgs
2.	Tab Risperidone 2mgs
3	Inj Promethazine 50 mg
4	Tab Imipramine 75mgs
5.	Inj.Fluphenazine 25 mgs
6	Tab.Trihexyphenidyl 2mgs
7	Tab. Lorazepam 1mgs
8	Tab Phenobarbitone 30 mgs and 60mgs
9	Tab. Diphenylhydantoin 100mgs

SL NO	Name of the drug that should be available in District Hospital
1	Tab. Chlorpromazine 100mgs
2.	Tab Risperidone 2mgs
3	Inj Promethazine 50 mg
4.	Tab Imipramine 75mgs
5.	Inj.Fluphenazine 25 mgs
6.	Tab.Trihexyphenidyl 2mgs
7.	Tab.Lorazepam 1 mgs
8.	Tab Phenobarbitone 30 mgs and 60mgs
9.	Tab. Diphenylhydantoin 100mgs
10.	Tab Lithium Carbonate 300mgs
11	Tab Carbamazepine 200mgs
12	Inj Haolperidol
13.	Cap.Fluoxetine 2omgs

- A budget of Rs. 5 Lakhs is allocated for essential drugs per year.
- These drugs should be procured every 6 months in required quantities
- The program officer should ensure that drugs are available at all times in every primary health center /CHC/Taluk hospital of the district.
- Drugs should be procured through the established channels of the Government-Drug logistic society/ rate contract.
- If there are delays in procuring the drugs through the drug logistic society, the DISTRICT HEALTH SOCIETY should be approached for special permission to procure the same directly from the rate contract supplier.
- The program officer should review the drug position in the PHC/PHU/Taluk hospital very month. He should review monthly report and carry out random checks periodically during his field visits.
- Purchase of drugs should be the only ones mentioned in the above list.
- The drugs for the district hospital will be available ONLY if the psychiatrist is posted. If the psychiatrist is not available, patients needing specialist care should be referred to the medical college hospital/ mental hospital or private psychiatrist.
- If private psychiatrists services are availed by the program officer for specialist consultation, a nominal fee Rs. 30/= will be paid to the psychiatrist per patient only for new consultation only. The patient will be subsequently referred back to the respective PHC/PHU/CHC/Taluk hospital.

Public private partnerships in NMHP:

Public private partnership is recognized as a vital strand in all programs whether it is health or development. The DMHP program envisages very active public private partnership with respect to IEC activities, linking welfare measures to the person with mental illness and rehabilitation, mobilizing volunteers to support families caring for person with enduring mental health problems in the community, school mental health program, setting up self groups in the community and lastly to build up consumer activism. A certain amount of funds will be available as part of DMHP to encourage NGOs to take up above activities in the DMHP district. The important aspect of public private partnership is to work in unison to reach the needy rather than antagonize and paralyze the ongoing programs in the government (see page 10 for details).

Budget for NGOs in a district

SL NO	Activity	Budget
1.	One day sensitization program for NGO managers Rs.200 per day* number of NGO managers (Approx 20 in a district)	Rs 4,000
2.	IEC activities through street plays Rs.500 per play 20	Rs. 10, 000
3.	* Disability welfare camps Rs.8000 per camp * 10 per year	Rs. 80, 000
4.	Mental health camps once a month in selected five areas of the district Rs. 10,000 per camp	Rs. 6,00,000

Approximately, **Rs. 20 lakhs** (4 lakhs X 5 years) is proposed for one district for a period of five years.

*A sum of Rs.8, 000 should be spent on organizing the camps; fee to the professionals (Rs.1000), Transport (Rs.1, 000), publicity about the camps (Rs.1, 000), refreshments (Rs. 1, 000) and rest of the budget is for drugs not available in the DMHP and other miscellaneous expenditure.

In addition an NGO may apply for grants to conduct a school mental health programme including counseling for out of school adolescents for one or more blocks according to the module available.

Monitoring DMHP

Monitoring of the DMHP should start from the first month of the implementation of DMHP programme. The monitoring activities start from the medical officer, the program officer, district health officer, joint director (Nodal officer) and the Secretary of health in their monthly review meetings. The medical officer sends reports to the program officer every month and the program officer consolidates the report of all the primary health care institutions in the district and reviews the same in the monthly meeting of the DHO / CMO. The joint director (Nodal officer) reviews the monthly report of DMHP in the states every month. Problems in implementation and other difficulties that might have been encountered in the month prior to the review will be addressed appropriately. Reports of the progress of DMHP will be sent to the state-monitoring cell which inurn is sent to the central monitoring cell every month. The state-monitoring cell headed by the joint director (the nodal officer) will review the progress of DMHP's in that state every 3 months. Similarly the central monitoring cell under the Ministry of health and family welfare cell, Government of India will monitor the progress every 6 months by actually visiting the DMHP sites. See appendix for monitoring proformas.

Review meetings

The program officer and the DHO/CMO should conduct the review meeting of DMHP in the district headquarters every month as part of the monthly review.. Progress of DMHP in terms of new cases registered, follow of cases, number of patients on treatment, number of patients referred for specialist care, number of camps conducted, number of certificates issued for person with mental retardation and the drug stock should be reviewed. Practical problems reported should be sorted out immediately with the help of District Health Officer or the CMO as the case may be. Poor progress with regards to DMHP should be taken up seriously and all attempts should made to set aberrations as early as possible. The nodal officer should review the progress of the DMHP in his monthly meetings. Appropriate measures should be initiated if there are difficulties in implementation of the DMHP in a particular district.

Incentive

The review process must also include a monthly award for the best medical
Officer. The number of cases seen as new and follow up can be one of the indicators of performance. The DMHP team must develop guidelines in collaboration with the District Health Society for conducting this scheme of rewarding best performance from the funds of the state Government available with the Deputy commissioner / District health officer/Chief medical officer. .

Field visits

Field visit by the program officer is an integral part of the DMHP. This approach ensures hand holding of the primary care staff. The program officer should visit thePHC/PHU/Taluk hospital atleast once a month. The program officer should check for the following.

- Number of new cases registered in the last one month
- Total number of cases registered till date.
- Completeness of the case record.
- Discuss problems encountered in the process of providing care
- Drug stock balance and expiry of drugs
- Verification of random cases in the field.
- On job training for the staff
- Verbal compliments for good work
- Encouragement and support for those who are not doing well.
- Administrative action if the performance is consistently poor.
- Random cross checking of some registered patients by visiting them at home.
- IEC activities for the elected representatives during the field visits.
- Check about the number of untrained staff in the institution visited
- Facilitate action through the DHO/CMO if there are vacancies in the centers after field visits.
- Check list should be used for each visit.

Check list Items

Date of visit
Institution visited
Number of Doctors working # trained_____ # untrained _____
Number of paramedical workers # trained _____ # untrained _____
Regularity of monthly report Regular/Irregular
Number of cases on hand As per report____ After verification _____
Stock position of drugs Adequate /Inadequate / Poor
Drugs expired
# of difficult cases referred
Nature of the difficulty
Performance in other national programs Good /Average/Poor
Involvements of NGOs/ Elected representatives

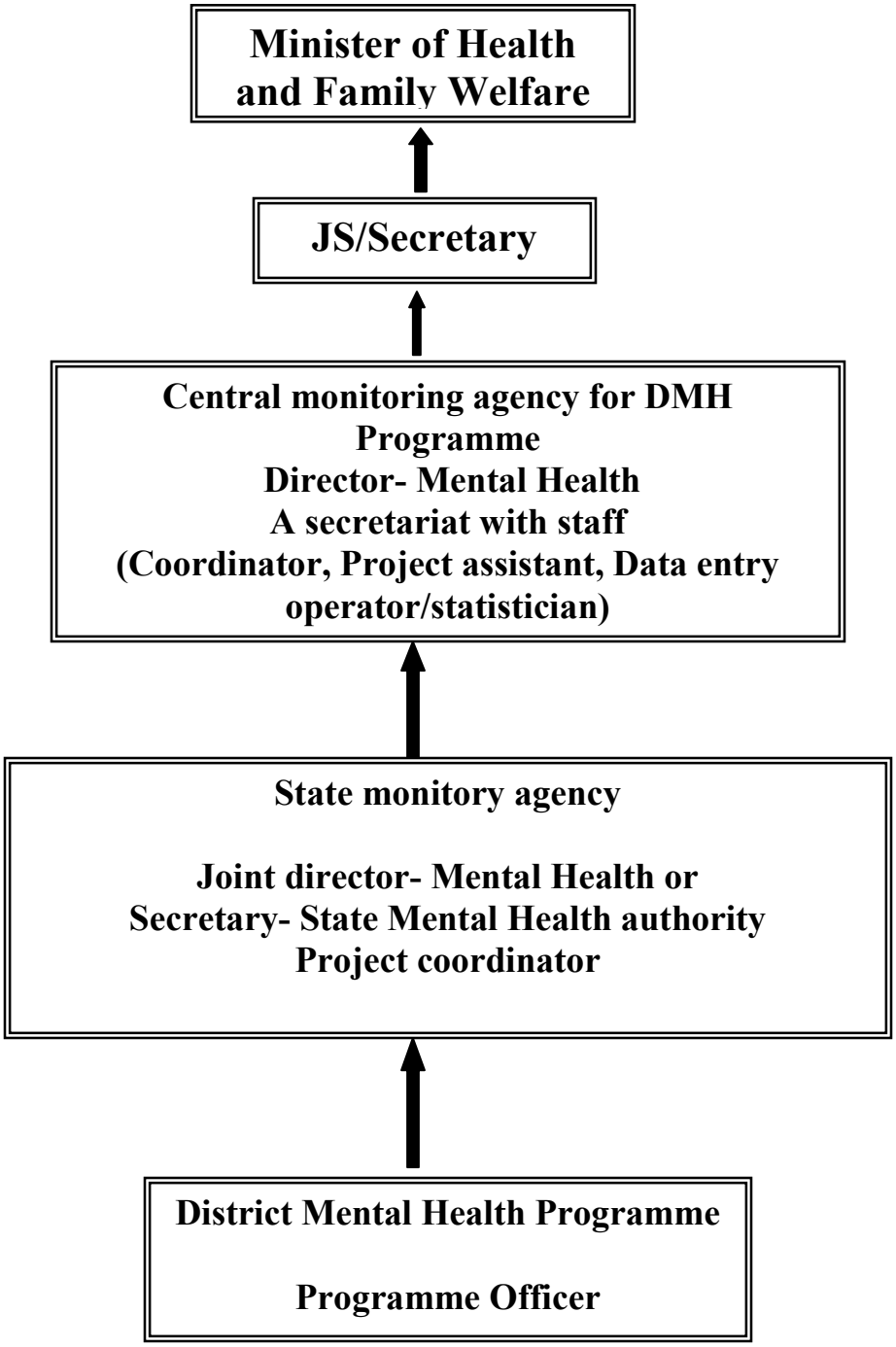
Targets to be achieved in DMHP with respect to mental health care

Domains	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR	5th YEAR
Psychosis	All cases to be identified in one year	**Follow up care**	**Follow up care**	**Follow up care**	**Follow up care**
Depression		**Care starts from 2nd year**	**Continue**	**Continue**	**Continue**
Neurosis		**Care starts from 2nd year**	**Continue**	**Continue**	**Continue**
MR		**Care starts from 2nd year**	**Continue**	**Continue**	**Continue**
Epilepsy		**Care starts from 2nd year**	**Continue**	**Continue**	**Continue**
SUD		**Care starts from 2nd year**	**Continue**	**Continue**	**Continue**

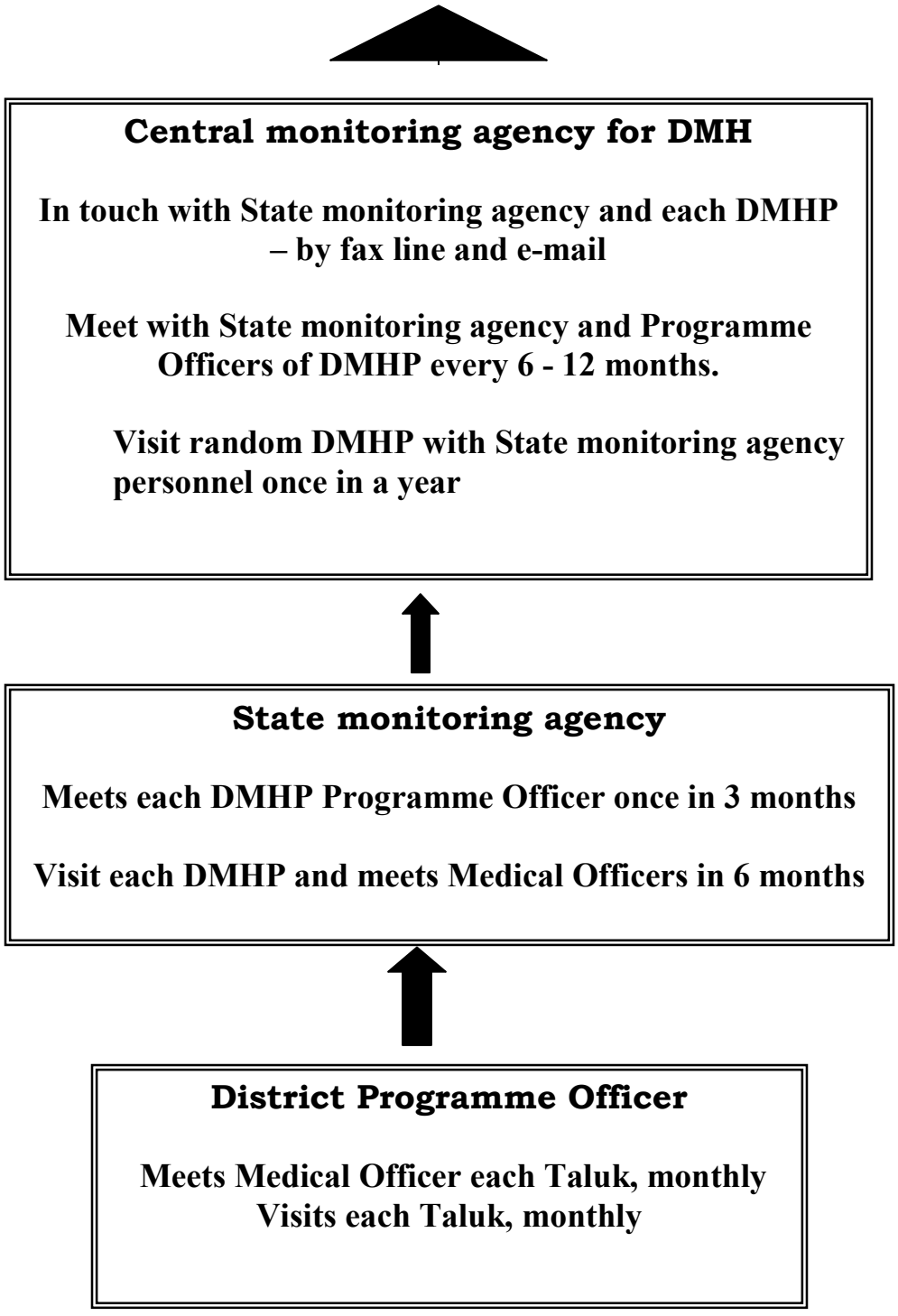
Targets to achieved in DMHP with respect to activities

Domains	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR	5th YEAR
Mental health care	All cases to be identified in one year	Follow up care	Follow up care	Follow up care	Follow up care
Mental health camps	10 camps in one year at taluk level	Care in the PHC	Care in the PHC	Care in the PHC	Care in the PHC
IEC activities	Starts from 1st year	Continue	Continue	Continue	Continue
School mental health program		Care starts from 2nd year	Continue	Continue	Continue
College mental health program		Care starts from 2nd year	Continue	Continue	Continue
Stress management		Care starts from 2nd year	Continue	Continue	Continue
Suicide prevention program		Starts from 2nd Year	Continue	Continue	Continue
Monitoring supervision	Starts from 1st year	Continue	Continue	Continue	Continue

MONITORING DMHP – STRUCTURE



MONITORING OF DMHP- FUNCTION



Time line for events in the DMHP

DMHP Month → Activities of the DMHP ↓	0-3	4-6	7-9	10-12	13-15	16-18	19-21	22-24	25-27	28-30	31-33	34-36	37-39	40-42	43-45	46-48	49-51
Recruitment Program Officer & staff	Yes																
Training DMHP staff	Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes
Distribution of IEC Activities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Monthly Reporting Medical Officer to Program officer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Paramedical Workers to Medical officers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DMHP Officer to SMA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SMA to CMA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Drugs PHC/PHU/Taluk Hospital	Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes
Stationary Case records, Reporting format,	Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes
Field Visits by the DMHP Officer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adol Mental Health Program (school)					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adol Mental health problems (out of school)					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
College mental health program					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Suicide prevention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Stress management	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Case Registration **All Psychosis (5/1000)** **Depression** **MR (10/1000)** **Neurosis** **Substance use**	20% 20%	40 % 40 %	80% 80%	100 % 100 %													

Urban Mental Health Care

The universal nature and uniform prevalence of mental health problems have been well demonstrated by series of epidemiological investigations in the country. In terms of nature and magnitude of mental disorders, there is no difference between urban, rural and tribal locations in the country. However, geographical realities, manpower availability, population density (for example- population density in tribal and hilly areas is less compared to a convention rural area, while the population density in urban locations can be much higher). Urban life brings with it , a certain kind of mental health problems (for example marital disharmony, work stress) and the problems of homeless mentally ill person. The DMHP in urban locations will address the mental health needs through the existing public health care infrastructure such as Municipality hospitals/ Corporation hospital/ other Specialty hospitals, Mental hospitals and Medical college hospitals. Since the number of paramedical workers is significantly less in urban locations, involvement of the volunteers, net working with NGOs and other agencies working in such locations are very vital. The linkages required in the urban DMHP is likely to far more than what one would expect in rural areas.

The urban locations should also have community based detoxification centes; self help groups, halfway homes, day care centers, long stay facilities, respite care centers, crisis intervention centers and counseling services.

A significant proportion of the homeless mentally ill in any city or town are mentally ill. They have diagnosable serious mental disorders and substance use disorders, which need attention. The needs of the homeless mentally ill can be addressed through coordination between department social welfare, health and family welfare and the urban development authority of the corporation.

Urban locations also have Sate home for women, state home for person with mental handicap and the prisons. All these facilities need, mental health inputs in a systematic manner.

Health promotion in schools and colleges is an important input that is required. Net working with education, collegiate education and NGOs working in such locations are essential to meet the needs of the urban population.

Budget for the salary (Rs) of the Staff (for one urban DMHP)

Year→ Staff	1st Year	2nd Year	3rd Year	4th Year	5th Year
Program Officer	2,40,000	2,52,000	2,64,000	2,76,000	2,88,000
Psychologist	1,20,000	1,26,000	1,32,000	1,38,000	1,44,000
Social worker	1,20,000	1,26,000	1,32,000	1,38,000	1,44,000
Clerk	72,000	75,000	78,000	81,000	84,000
Community Nurse	1,44,000	1,50,000	1,56,000	1,62,000	1,68,000
Total	6,96,000	7,29,000	7,62,000	7,95,000	8,28,000

Salaries of Program Officer Rs 20,000/- per month with increase of Rs 1000 per year
Psychologist and Social workers Rs 10,000 each per month with Rs 500 increase every year and for Clerk Rs 6,000/- with increase of Rs 250 every year. Nurse is deputed from service.Rs 12,000 per month and increment of Rs 500 per year

Total for Salaries of field staff Rs 38, 10, 000.

Budget (Rs) for Training component of DMHP

Year→ Staff	1st Year	2nd Year	3rd Year	4th Year	5th Year
Medical Officers @ Rs.300*170* 3 days * 2 programs per year	3,06000	3,06000	3,06000	3,06000	3,06000
Expenditure* 2 training (Miscellaneous)*	10,000	10,000	10,000	10,000	10,000
Paramedical Workers@550* 1 day * 2 program per year	1,37,500	1,37,500	1,37,500	1,37,500	1,37,500
Miscellaneous Expenditure* 2 training	10,000	10,000	10,000	10,000	10,000
Program Officer @ 2*3 months	40, 000	40, 000	Nil	Nil	Nil
Nurse * 12 weeks	12, 000	Nil	Nil	Nil	Nil
Psychologist@1*3 months	36,000	Nil	Nil	Nil	Nil
Social worker@ 1* 3 months	36,000	Nil	Nil	Nil	Nil
Total	5, 87,500	5,03,500	4,63,500	4,63,500	4,63,500

*Miscellaneous expenditure includes TA/DA for the resource persons (2), LCD hire charges/ stationary for the training program.

Total Costs for training- Rs 24, 81, 500

Budget (Rs)- Office Equipment, IEC and drugs: Recurring expenditure

Year→ Item	1st Year	2nd Year	3rd Year	4th Year	5th Year
Drug	500,000	500,000	500,000	500,000	500,000
Equipment	75, 000	Nil	Nil	Nil	Nil
Travel	150,000	150,000	150000	150,000	150,000
Contingency & Stationary	10,000	10,000	10,000	10,000	10,000
IEC Activity	200,000	200,000	200,000	200,000	200,000
Total	9,35000	8,60000	8,60000	8,60000	8,60000

Total recurring expenditure Rs. 43, 75, 000

Summary Budget (Rs) for DMHP

Year→ Domain	1st year*	2nd year	3rd year	4th year	5th year
Staff	6,96,000	7,29,000	7,62,000	7,95,000	8,28,000
Training	5,87,500	5,03,500	4,63,500	4,63,500	4,63,500
IEC, Drugs..	9,35,000	8,60000	8,60000	8,60000	8,60,000
Adolescent MH	7,83,000	2,16,000	4,16,000	2,16,000	2,16,000
College Teachers Training in MH	10,83,000	6.60,000	6.60,000	6.60,000	6.60,000
Special Services	2,00,000	2,00,000	2,00,000	2,00,000	2,00,000
Total / District	42,84,500	31,68,500	33,61,500	31,94,500	32,27,500

Referral services in the DMHP

Community care for the mentally ill as a part of the DMHP programme is a public health approach care. It is well demonstrated that approximately 70-80% of all mental health problems in the community can be effectively managed using the resources in the PHU/PHC Taluk or Tehsil hospitals or the district hospital. The needs of 20-30% of patients should be addressed using the specialist's resources either in the local area or from the neighboring district. The specialist services can be availed from either a private psychiatrist in the local area (if district psychiatrist is not available) or nearby mental hospital or medical college, psychiatry department should be considered.

Each state is expected to form a advisory committee consisting of mental health professionals in the state so that they can advice the Principal secretary, Mental health authority secretary and the nodal officer mental health so that there is smooth implementation of the DMHP.

SL NO	DMHP Domain	Referral support
1	**Integration of mental health into primary health care services and provision of basic mental health care** in PHC/PHU/GAD/ CHC/Taluk Hospital and District hospital. The **program officer** may chose to refer patients for higher level of care after he/she feels the need for referral support	Patients needing higher level of care may be referred to the following agencies in the local area. • Medical college psychiatry department • Mental hospital • Private psychiatry if first two options are not available
2.	**Health promotion using life skills approach in the schools** The **psychologist and social worker** may refer children for higher-level care even after **program officers intervention** falls short of child's need.	Children needing higher level of care may be referred to the following agencies in the local area • Medical college psychiatry department • Mental hospital • Private psychiatry if first two options are not available • Or any other specialist child psychiatry services in the local area
3.	**College counseling program** The **psychologist and social worker** may refer college students for higher-level care even after **program officers intervention** falls short of child's need.	College students needing higher level of care may be referred to the following agencies in the local area • Medical college psychiatry department • Mental hospital • Private psychiatry if first two

		options are not available • Or any other specialist counseling services available in the local area
4	**Suicide prevention program** The **program officer/ psychologist/Social worker** may consider referral of individuals for higher level of care in the context of suicidal behavior	Persons using mental health services/ undergoing counseling for psychological distress needing higher level of care may be referred to the following agencies in the local area • Medical college psychiatry department • Mental hospital • Private psychiatry if first two options are not available • Or any other specialist counseling services available in the local area
5	**Stress management program** The faculty of the Administrative training institutes are sensitized about the need for care and networking for the officers needing higher level care	Officers who have gone through the stress management course either at the State Administrative training institute/ District administrative training institute needing higher level of care may be referred to the following agencies in the local area • Medical college psychiatry department • Mental hospital • Private psychiatry if first two options are not available • Or any other specialist counseling services available in the local area • Marital therapist/ Relationship specialist

The 11th plan envisages payment of consultation fees if services of the private psychiatrist is availed.

Research

The National consultative meeting group identified the need for action research in the DMHP district as an important need to make mid course correction in the DMHP. A small amounting to Rs. 50.000/= (Fifty thousand) will be available for this purpose. Non-Governmental agencies working in the district, medical college, department of psychiatry can be encouraged to take up such research work.

Experience with other National Health Programmes has proven beyond doubt that both applied and fundamental research contributes significantly to the successful implementation of the programme. It is widely acknowledged that while translating research into action is a major challenge for health care delivery systems, learning from ongoing programme implementation is crucial and critical. Operational research capability needs to be built into the programme so that it could also serve as internal evaluation of the programme. Towards this end, operational research is being considered as a specific component and a major domain under the revitalized NMHP within each DMHPs. This is in addition to the research funds available under NMHP and also research undertaken by other agencies. The Central technical support team along with its secretariat will administer these funds.

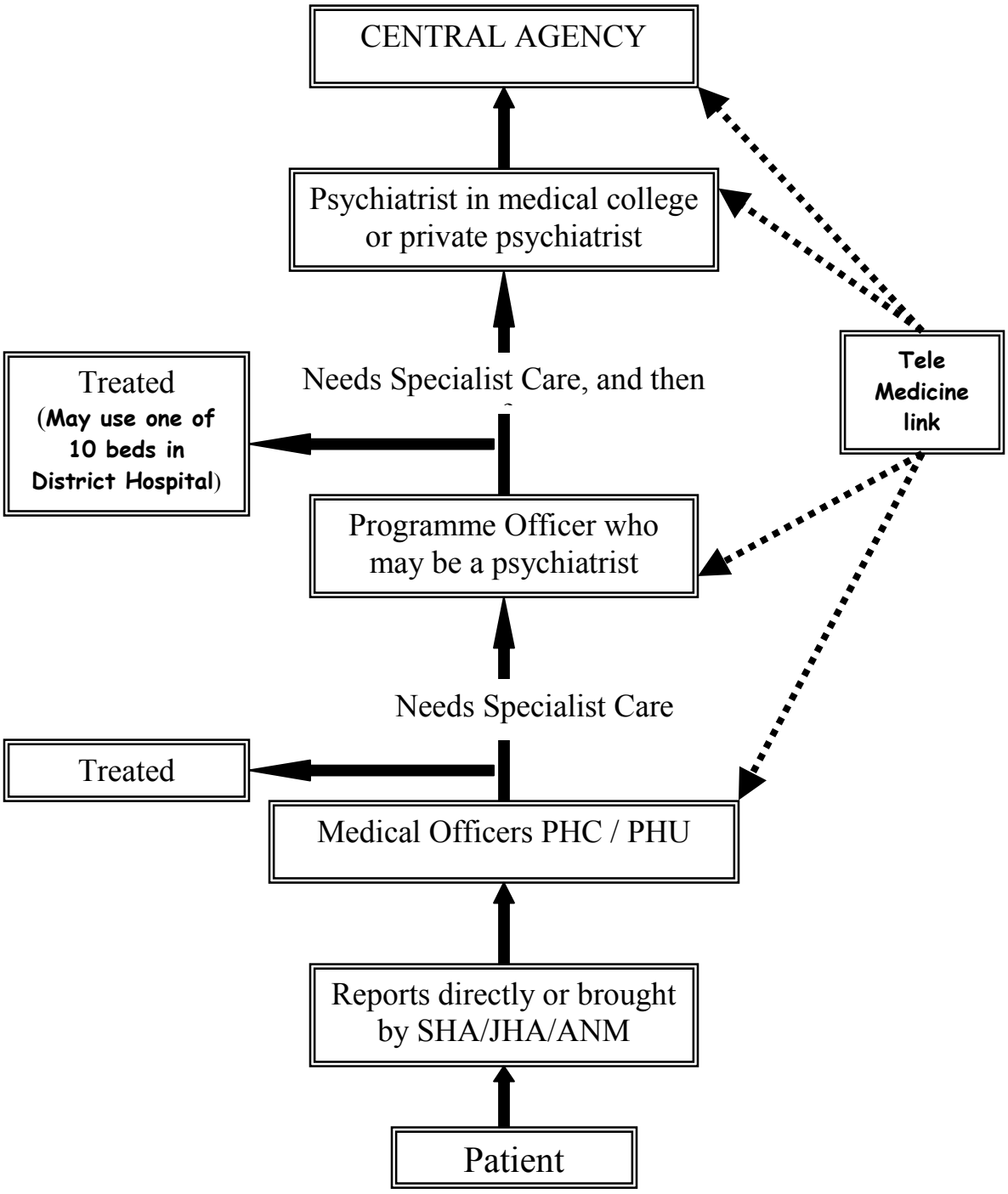
a) A small grant programme to be set up with a provision of Rs 50 lakh from the second year of the NMHP implementation. Each DMHP-PO can avail this research grant once a year, the maximum grant being Rs 50,000 per year. The State and Central TST member(s) will guide and supervise the PO to undertake research endeavor that would contribute to better implementation of the project.
b) A field NGO research grant up to a maximum of Rs 50,000 per NGO during the 5-year project period is set up specific action oriented research to support health promotion activity under the guidance and supervision of the State TST. Towards this end the amount allocated is Rs 50,00,000 per year.
c) The Central Monitoring Team can identify areas of operational research relevant to implementation of the programme in consultation with the Central TST and provide research grants upto the extent of 1.5 lakh per project. Towards this end Rs 1,50,00,000 to be budgeted from the second year of the NMHP.
d) Identifying innovations in service delivery, developing monitoring indicators, supporting perspective planning effort, developing evaluation mechanisms, evolving surveillance systems, evaluating human resources development efforts, validating screening instruments, documenting best practices, enhancing mental health literacy – these are some of the areas of research which are of immediate interest and importance to bring in the vigour and vitality to the implementation of the NMHP. In addition, national consultation on specific areas of concern, for example minimum standards of care, treatment protocols, nosology, curriculum for training and capacity building, ethical issues in management and follow up, needs of special groups and vulnerable section of the society, research themes in mental health, etc, need to be proactively pursued. To support such endeavors an amount of Rs. 1,00,00,000 to be budgeted.

e) The Joint Director -MH as the National NMHP Programme Officer would also liaison with Indian Council of Medical Research, WHO-India Country Office and other national research institutions and international and multilateral agencies (both within government and outside government sector) to bring about a systematic approach to mental Health research in the country.

Apart from these above, independent adhoc research grants to be encouraged for research that would add to knowledge for improving NMHP.

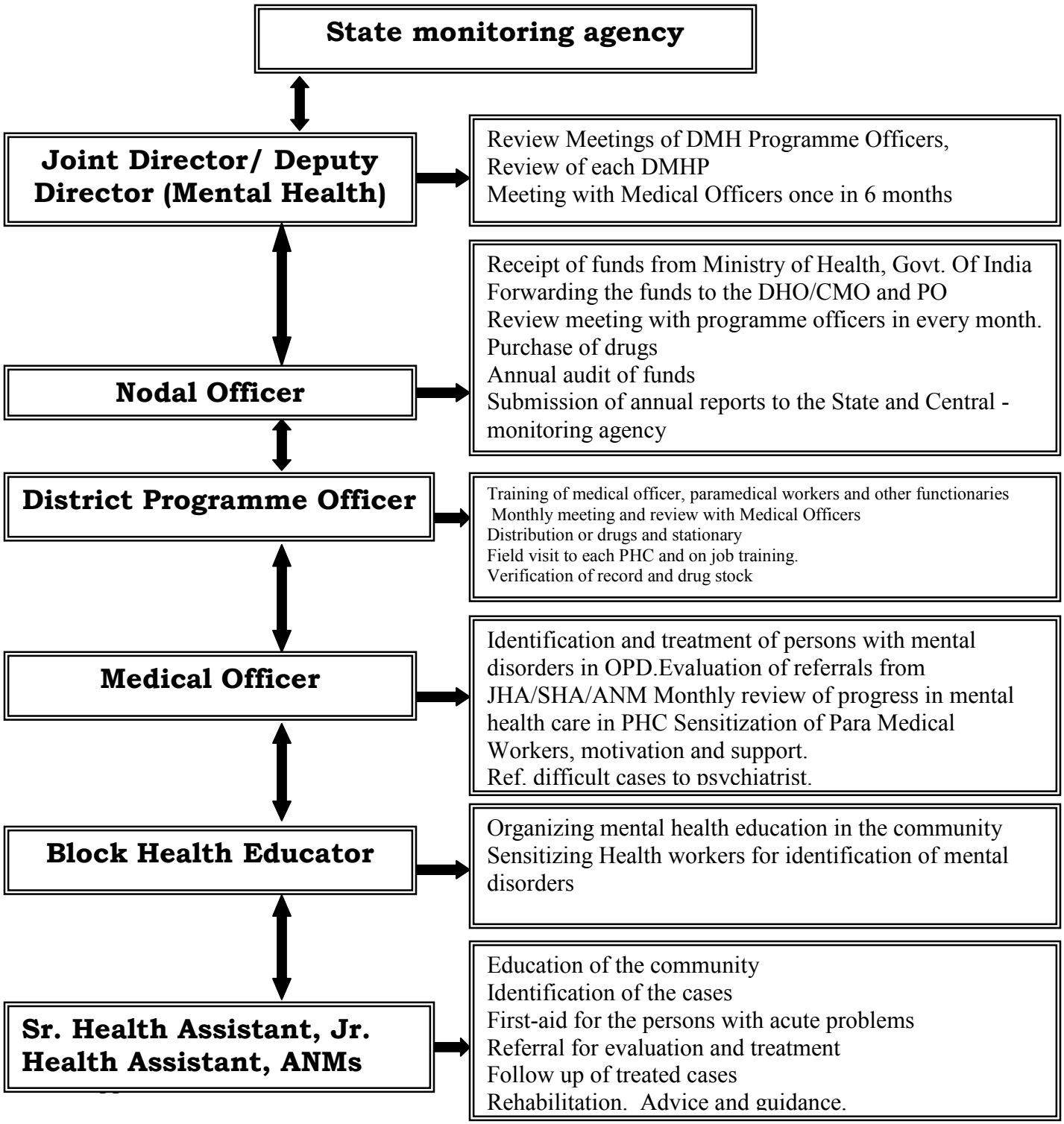
Appendix:1 Referral services in the DMHP

PATHWAY OF CARE FOR A NEW PATIENT OR FOR A PATIENT ON FOLLOW-UP



Appendix:2

ROLES AND RESPONSIBILITIES OF THE OFFICIALS UNDER DMHP



Utilization certificate

1. Certified that out of Rs……. of grants in aid sanctioned during the year

---------- in favor of District Health and Family Welfare Officer, ---------- -------- under the Ministry of Health and Family Welfare Sanction NO of Government of India, New Delhi Dated---------- Rs ---------- on account of unspent balance of previous sanctioned wide sanction number ---------- dated ---------- Rs ---------- on account of interest received during the year a sum of Rs---------- year ----------. This amount has been utilized for the purpose of various activities approved by the Govt of India for implementing the District Mental Health Program for which it was sanctioned. An amount of Rs---------- remained unutilized at the end has been adjusted towards the grant in aid payable during the next year ----------.

2. Demand No---------- Department of Health and Family Welfare, Major Head 2210, medical and public health 06.101 prevention and control of diseases 34 National Mental Health Program 340031 grant in aid during the year ----------

3. Certified that I have satisfied my self that the condition on which the grant in aid was sanctioned have been duly fulfilled and that I have exercised the following checks to see that money was actually utilized for the purpose for which it was sanctioned

Signature
District Health and Family Welfare Officer