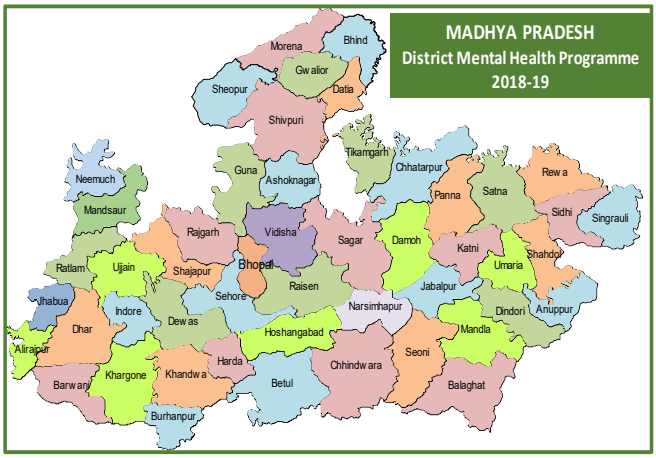
Availability of Mental Health Services in the Districts of Madhya Pradesh: A Situation Analysis



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No Health without Mental Health

Never give up on someone with mental illness

When 'I' is replaced by 'we' 'illness' becomes 'wellness'

Acknowledgement

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CONTENTS

Acronyms

ANM	Auxillary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BMHRC	Bhopal Memorial Hospital and Research Centre
CHC	Community Health Centre
DH	District Hospital
DMHP	District Mental Health Programme
DPH&FW	Directorate of Public Health and Family Welfare
GoI	Government of India
GoMP	Government of Madhya Pradesh
HMIS	Health Management Information System
IEC	Information Education Communication
IPD	In-door patients
NMHP	National Mental Health Programme
MH	Mental Health
MHR	Mental Health Research
MoHFW	Ministry of Health and Family Welfare
MO	Medical Officer
MNS	Mental, Neurological, Substance Use
M.P.	Madhya Pradesh
NHM	National Health Mission
NIMHANS	National Institute of Mental Health and Neurosciences
NMHP	National Mental Health Programme
NMHS	National Mental Health Survey
OPD	Out-door patients
PHC	Primary Health Centre
PIP	Programme Implementation Plan
SN	Staff Nurse
SOHAM	Scaling up of Opportunities for Healthy and Active Minds
TLLLF	The Live Love Laugh Foundation
WHO	World Health Organization

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Executive Summary

Mental health is a condition of psychological maturity-a relatively constant enduring function of personality. More than the absence of mental disease symptoms, it is a condition of personal and social functioning with a maximum of effectiveness and satisfaction. Good mental health is integral to human health and well-being. To summarize, mental health is promotion of mental well-being, prevention of mental disorders, and rehabilitation of people.

A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. The concept of mental health is aligned with the central principle to 'leave no one behind' and contemporary notions of human capabilities and capital. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. Thus mental health is a global public health issue.

M.P. has also implemented the Mental Health Policy. There are only 0.05 psychiatrists per one lakh population in Madhya Pradesh. The implementation of programmes are expected to be augmented at the state level in terms of access to care, availability of services, utilisation by communities and awareness about mental health issues and collecting data for future planning. Therefore it is essential to understand the steps adopted by the state to expedite the process of implementing the DMHP in M.P. which is a flagship programme under National Mental Health Programme (NMHP).

The present study was conducted to assess the preparedness of district level health facilities to provide mental health services through 'mankash' in all districts of the state, to ascertain the adequacy of available infrastructure (medicine, OPD and IPD services) for providing mental health services in these hospitals, to identify availability of trained doctors and other paramedical staff available in the DHs for providing mental health services in the district hospitals. The study also explored among university and college teachers, their awareness about and attitude towards mental health disorders and their knowledge about availability and place for treatment of mental disorders.

The study is based on both primary and secondary data. Secondary data was collected at both the state and district level. At the first stage information was obtained from the state NHM office, and district hospitals. Detailed information included, availability of budget, infrastructure, availability of trained doctors/ psychiatrists/ clinical

psychologists for providing OPD and IPD services and medicines available for treating different mental disorders.

Semi-structured in-depth interviews were conducted to collect the information from the state and district heads to obtain information regarding progress made in providing mental health services, and barriers to implementation of the DMHP.

Each district approximately received Rs. 2.5 lakhs during 2017-18 for mental health activities. Twenty out of 51 districts have been identified for DMHP in 2017-18, although it has been implemented in all 51 districts with psychiatric OPD and drugs.

Only three psychiatrists are available in Guna, Dewas and Ratlam districts and three clinical psychologists in Dewas, Satna and Damoh districts. In the 20 DMHP districts there are total 28 trained medical doctors (Av. 1.4 MOs per district and 51 trained staff nurses (Av. 2.56 SNs per district). In 31 non DMHP districts there are total 42 trained medical doctors (Av. 1.3 MOs per district) and 94 trained staff nurses (Av.3.0 SNs per district). Pharmacists, paramedical workers, ASHAs/ ANMs/ community health workers and other panchayat leaders have not received any trainings in mental health. Apart from MOs and SNs, other staff have not been assigned for MH programme.

There are no separate psychiatric wards in any of the DHs. But each district has four beds ear marked in the DH for inpatient services in MH. Information about functioning of district counselling centre, counselling services in schools and colleges, training of master trainers and school teachers in life skills, number of suicide prevention camps, number of work place stress management sessions was obtained. These interventions are available in some DMHP and non DMHP districts but not all. Crisis helpline is only available at the state level .Community mobilization activities have taken place in some DMHP and non DMHP districts of M.P. Procuring and translation of IEC material and distribution, mass media and outdoor media, folk media, interpersonal communication activities are underway.

The aggregated data reported by the state shows a total of 85577 mental illness cases during April to March 2017-18, (43622: new cases; 41407 follow up cases; 548: cases referred to tertiary hospital). Total 6129 cases of suicidal risk out of total OPD and 820 IPD cases were reported during the year 2017-18. Yearly data of 2017-18 obtained and separately aggregated for individual districts shows low reporting of mental illness cases. Under reporting and data gaps are evident between the two data sources.

The study also highlights the lack of awareness amongst university and college level teachers about the enormity of challenges pertaining to mental health problems and availability of mental health services. However, they showed a positive attitude towards mental illness. If they are to be facilitators in information sharing, education and communication, and providing life skill education to adolescents and youth they need to be actively engaged in delineating all facets of mental health.

Suicide rate is high in M.P in the adolescence age group (14 & above and below 18 years) in comparison to national average (M.P.:15 ; India:9.5) and amongst youth (18 & above and below 30 years) in comparison to national average (M.P.: 25 ; India: 17) and can be managed through active intervention of the teachers as per NMhS 2015-16.

The study suggests that the DMHP is a strong step in the right direction. Mental hospitals, district hospital 'mankaksh' and communiy based clinics are important 'agents' for delivery of mental health sevices. Some significant changes towards improvement have occured, but impetus must be given to increase mental health awareness, manpower and facilities, recruiting trained personnel and enhanced budgetary allocation.

The primary health centers (PHCs) and the community health centres (CHCs), have no psychosocial interventions because of non availability of trained health personnel in mental health. Therefore the onus of providing MH services is upon the DH, where case loads for OPD and IPD services are high. There is lack of psychiatric nurses, psychiatric social workers and occupational therapists. There is no evidence of training of PHC medical officers and non-specialist health workers such as ANMs, Anganwadi workers and ASHAs. The MOs and SNs have to provide multiple services in the different sections of DH and are unable to provide dedicated services to MH patients. MH remains a low priority area in comparison to maternal and child health services.

Although mental illness is included in the existing HMIS but availability of data related to this is limited. There are many illness which come under the overall umbrella of mental health and this data is not being compiled separately for evidence based planning. Currently, no mechanism exists for registering, tracking, and following up mental disorder cases at the facility level, beyond DH.

The present findings suggest that accurate need assessment of mental health disorders and services for all the disticts of M.P. is crucial for optimum implementation of MH programme. Dedicated psychiatric nurses, psychiatric social workers and occupational therapists per district for providing MH services is a prerequisite, because inspite of the present MH training module multitasking by MOs and SNs dilutes MH service delivery. IEC activities through intense media activity is critical to develop programmes for the advancement of mental health and promote community care. Intersectoral coordination between the health and other departments inpatient or out patient service, specialists and non-specialists, social and community workers, providers and outreach care workers will provide impetus to the programme. Data quality needs urgent attention for evidence based planning.

Availability of Mental Health Services in the Districts of Madhya Pradesh: A Situation Analysis

1. Introduction

World Health Organization, refined the notion of mental health in positive terms way back in 1946. Health was described as a 'complete state of physical, mental and social well-being and not merely the absence of disease or infirmity'. 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 make a contribution to her or his community.*"Mental Health Foundation (1999) has opined that mental health should be seen as more than 'a narrow quasi-medical definition of the absence of diagnosable problems'. Traditionally, investigators have conceived mental health predominantly in the sense of emotional well-being. However, in recent times, many thinkers have advised that it is not restricted only to emotional well-being rather it should include contentment, motivation, resilience, flexibility, autonomy, environmental mastery and balance in life. Attempts have been made for measuring the mental health and there are a huge number of tests available in the orbit of psychology field.

What is Mental Health

Mental health is a condition of psychological maturity-a relatively constant enduring function of personality. More than the absence of mental disease symptoms, it is a condition of personal and social functioning with a maximum of effectiveness and satisfaction. A Guide for Teachers and Others Working in Schools (Young Minds, 1996), proposed that: "Mental health is often confused with mental illness, and as such quickly passed over to psychiatrists and other specialists to sort-out. But in fact, mental health is simply what it says it is. It is about the health of the mind-that is, the way we feel, think, perceive and make sense of the world."

Good mental health is integral to human health and well- being. A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Over the

course of one's life, if one experiences mental health problems, thinking, mood, and behavior could all be affected. Many factors contribute to mental health problems, including biological factors, such as genes or brain chemistry, life experiences, such as trauma or abuse and family history of mental health problems. Mental health is a global public health issue. The concept of mental health is aligned with the central principle to 'leave no one behind' and to the contemporary notions of human capabilities and capital. To summarize, mental health is promotion of mental well- being, prevention of mental disorders, and rehabilitation of people suffering from mental disorders.

Mental Health Disorders and its Social Determinants

Mental health problems range from psycho-social distress which may affect a large number of people and, mental illness/ mental disorder and mental disability which affect relatively a small number of people. Mental illness/ mental disorders refer to specific types of disorders such as schizophrenia, obsessive compulsive disorders, bipolar disorders, depression. Persons with mental illness and mental health problems are those who have mental illness and mental health problems respectively. Recovery is a process of change through which individuals improve their health and well- being, live a self-directed life and strive to reach their full potential (MoHFW, 2014).

Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood.

Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. Disadvantage starts before birth and accumulates throughout life. A significant body of work now exists that emphasizes the need for a life course approach to understanding and tackling mental and physical health inequalities. This approach takes into account the differential experience and impact of social determinants throughout life. A life course approach proposes actions to improve the conditions in which people are born, grow, live, work, and age. (WHO, 2014).

A systematic review of the literature found that the prevalence of depressed mood or anxiety was 2.5 times higher among young people aged 10 to 15 years with low socio-economic status than among youths with high socioeconomic status (Lemstra et.al, 2008). Among children as young as three and five years of age, socio-emotional and behavioural difficulties have been shown to be inversely distributed by household wealth as a measure of socioeconomic position (Kelly et.al, 2011).

Actions that prevent mental disorders and promote mental health are an essential part of efforts to improve the health of the world's population and to reduce health inequities. There is firm consensus on known protective and risk factors for mental disorders. In addition, a growing body of evidence exists, not only from high-income countries but growing in low- and middle-income countries, that shows effective actions can be successfully implemented in countries at all stages of development. (WHO,2014.)

Mental Health Policy and Challenges

Mental and behavioural problems are increasing part of the health problems the world over. The burden of illness resulting from psychiatric and behavioural disorders is enormous. Although it remains grossly under-represented by conventional public health statistics, which focus on mortality rather than the morbidity or dysfunction. The psychiatric disorders account for 5 of 10 leading causes of disability as measured by years lived with a disability. The overall Diability Adjusted Life Years burden for neuropsychiatric disorders is projected to increase to 15% by the year 2020. At the international level, mental health is receiving increasing importance as reflected by the WHO focus on mental health as the theme for the World Health Day (4th October 2001), World Health Assembly (15th May 2001) and the World Health Report 2001 with Mental Health as the focus.

The situation in India was on par with amongst the worst country-level mental health indicators in the world before 1982. Earlier there were virtually no community-based mental health services in the country. At the national level, mental health policy has been the focus of Indian public health initiatives during last two decades.

There was hardly any research data available on mental health in India at the time of independence. The first major mental health survey was undertaken under the aegis of ICMR in Agra, U.P. in a study sample of 29,468 in 1961. A series of epidemiological

studies on psychiatric disorders were subsequently undertaken during 1960's and 1970's in south, north, eastern, and western parts of the country but, on relatively smaller study samples. For the first time in the country, ICMR organized a multicentric collaborative study on Severe Mental Morbidity at 4 centres – Bangalore, Baroda, Calcutta and Patiala from 1976-83 (MHR India,2005).

The ICMR ad hoc research projects on mental health have been carried out in areas of biological psychiatry, clinical studies, family studies, therapies, meditation and yoga, child psychiatry, mental retardation, alcohol and drug dependence, psychiatric epidemiology, delivery of mental health services, psychometery, and other social and psychology studies. The monograph covered research in areas in community mental health care, mental health care of rural aged, psycho pathology of depression, collaborative studies on acute psychosis, urban mental health, multicentric study of patterns of child and adolescent psychiatric disorders, training programme of non-psychiatrist primary care doctors a clinical study of HIV infected patients, health modernity, disorders in rural and urban areas (MHR India,2005) .

The results of the recent National Mental Health Survey (2015-16) points to the huge burden of mental health problems while, nearly 150 million Indians need mental health care services, less than 30 million are seeking care; the mental health systems assessment indicate not just a lack of public health strategy but also several under-performing components. With changing health patterns among Indians, mental, behavioural and substance use disorders are coming to the fore in health care delivery systems. In India, suicide is now the leading cause of death of young people, alcohol use is mostly promoted by commercial interests and its abuse has been relegated to a moral issue to be addressed by primitive, punitive policies rather than through a public health approach. These disorders contribute for significant morbidity, disability and even mortality amongst those affected.

The WHO estimates that 20% of Indians may suffer from depression in their lifetime. NHMS (2015- 16) has estimated that only about 10-12% of people suffering from depression in India get treated. This high treatment gap, if not addressed, would result in an increased disease burden. In light of this increasing there is need for support and care for persons with mental illness.

Attitude towards Mental Health in India

People with mental health problems are challenged not only by their symptoms and disabilities but also with the stigma and discrimination that contribute largely to the hidden burden of the disease. Due to the prevailing stigma, these disorders often are hidden by the society and consequently persons with mental disorders lead a poor quality of life. As a result, people with mental illnesses do not disclose their problems to others, including at times to family members. Further, they are deprived of social opportunities that define quality life in several areas like housing, employment, marriage, help seeking, satisfactory health care, and affiliation with a diverse group of people (NMHS, 2015-16).

NMHS survey further highlights that the rights and rehabilitative aspects of a person with mental illness are hardly discussed in the media. The overall portrayal of mental illness and its stigma by the media is quite discouraging and calls for immediate action.

Even today, after many decades of mental health programme implementation in India, discrimination, negative attitudes, neglect, stigma and social separation hinder the care of the homeless mentally ill. Studies from India have reported that primary health-care professionals are often inadequately trained, and reluctant or unable to detect, diagnose, or manage common mental disorders (Iyer et.al, 2011; Cowan et.al, 2012). Many people with mental health problems even experienced stigma within the health care services by health care providers (Sreevani, 2012).

A national survey report, "How India perceives mental health" (TLLF, 2018) concluded that stigma and awareness are two separate issues that need to be addressed in order to tackle the burden of mental illness in India. If individuals continue to view mental illness with apprehension and resistance, it will remain difficult for people with mental health concerns to seek the support that they require. Therefore, to create a better mental health landscape in the country, a two-pronged approach will be required to increase awareness and to reduce stigma.

Mental Health Services in India

Resources and services for mental and behavioural disorders are disproportionately low compared to burden caused by these disorders the world over. In most developing countries, care programmes for the individuals with mental and behavioural problems have a low priority. Provision of care is limited to a small number of institutions usually over-crowded and under staffed. Two significant developments heralded the integration of mental health into primary care in India: the launch of the National Mental Health Programme in 1982, and the revision of the National Health Policy, which specified the inclusion of mental health in general health services, in 2002. The National Mental Health Programme envisaged integration through the introduction of mental health services at four levels: primary care services at the village level; primary care centres; district hospitals; psychiatric units in medical colleges.

In 1982, the National Institute of Mental Health and Neuro Sciences (NIMHANS), in collaboration with the director of medical services and district administration in the State of Karnataka, piloted mental health integration in the Bellary District of Karnataka**.** This model was adopted subsequently by the government of India for nationwide integration of mental health services into primary care. The District Mental Health Programme, launched in 1995 as part of the National Mental Health Plan, has been extended to all districts in India as part of its 2007–2012 Plan. The model is seen as the main mechanism for integrating mental health into primary care, although in reality integration has not occurred in many of the districts around the country (Murthy, 2004).

Rationale of Present Study: Though initiated nearly three decades back, the programme implementation under the National Mental Health Programme has been slow. Only lately, changes have been noticed in coverage, resource allocation, and other areas. The development of the National Mental Health Policy (2014), a new Mental Health Bill (2016), recent judicial directives, initiatives by the National Human Rights Commission (2016), increase in resource allocation, expansion of the District Mental Health Programme (DMHP) establishment of new Centers of Excellence, improvement of care in mental hospitals are a few examples in this direction.

M.P. was one of the first states in India to organise a state level mental health policy and planning workshop in March 2015 under the aegis of National Health Mission and took a visionary decision to scale up mental health services across all districts, and establishing "Mann Kaksh" in all 51 district hospital facilities covering a population of around 75 million. This initiative was christened as SOHAM (Scaling up Opportunities for Healthy and Active Minds).

Mental health care in Madhya Pradesh has not expanded even two years after a national policy on the problem was unveiled as insufficient number of psychiatrists and lack of awareness prevent patients from seeking help due to the social stigma. There are only 0.05 psychiatrists for 7 crore peoplein the state. However, the implementation of programmes are expected to be augmented at the state level in terms of access to care, availability of services, utilisation by communities and awareness about mental health issues and collecting data for future planning. Therefore it is essential to understand the steps adopted by the state to expedite the process of implementing the DMHP in M.P. which is a flagship programme under National Mental Health Programme (NMHP).

The study comprises of seven sections. Section one presents the introductory part including the rationale of the study. Section two outlines the objectives of the study whereas, section three presents the study design. Section four presents the current review of district mental health programme and a situation analysis of the mental health programme in the state and the districts. Section five presents the awareness of and attitude towards mental health disorders among university and college teachers and awareness about avaibality of services, functionality of counselling centres etc.The sixth section presents the service providers perspective and the concluding section presents the summary and recommendations of the study.

2. Objectives

1. To assess the preparedness of district level health facilities to provide mental health services through 'mankaksh' in all districts of the state.

2. To ascertain the adequacy of available infrastructure (medicine, OPD and IPD services) for providing mental health services in these hospitals.

3. To identify availability of trained doctors and other paramedical staff available in the DHs for providing mental health services in the district hospitals.

4. To explore the knowledge and awareness among university and college teachers regarding mental health disorders, their attitude towards mental illness and their knowledge about availability and place for treatment of mental disorders.

3. Data and Methodology

The study is based on both primary and secondary data. Secondary data was collected at both the state and district level.

At the first stage information was obtained from secondary sources from state NHM office and district hospitals. Detailed information included , availability of budget, infrastructure trained doctors/ psychiatrists/ clinical psychologists for providing OPD and IPD services and medicines available for treating different mental disorders.

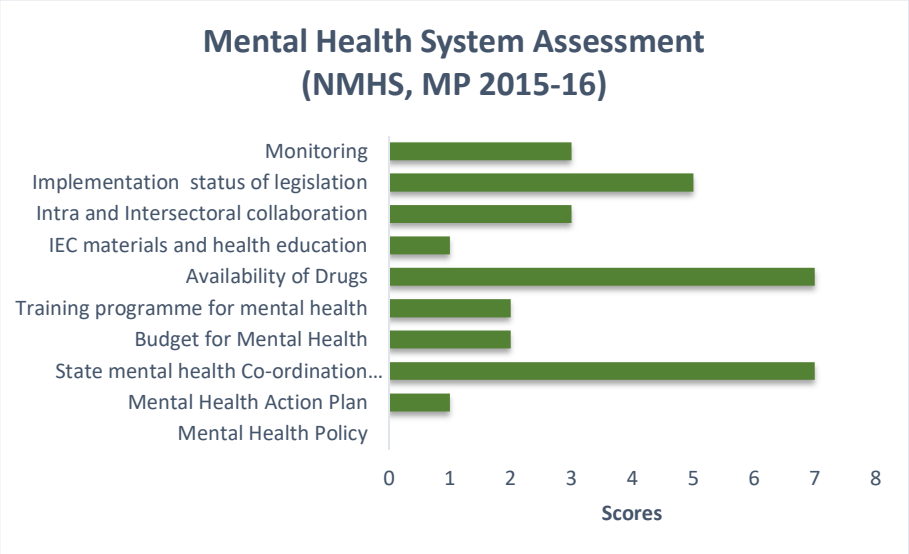
Semi-structured in-depth interviews were conducted to collect the information from the state and district heads to obtain information regarding progress made in implementation of mental health services, and barriers to implementation of the DMHP.

At the second stage items from mhGAP master chart (WHO, 2010, &2015) which is currently being used in DMHP programme in MP, were used in a structured questionnaire and administered to 134 university and college teachers in Sagar district. This was done to explore the awareness of teachers in identifying the symptoms of different mental, neurological and substance (MNS) use disorders as outlined in the mhGAP chart. A total of 46 statements describing nine types of disorders were canvassed, which included symptoms of depression (11), psychosis (6), epilepsy (6), developmental disorder (3), dementia (4), drug use and drug use disorder (5), behavioural disorder (5), alcohol use disorder (4), and self-harm/ suicide disorder. A three- point scale including 10 items gauged the perception and attitude of the respondents towards mental disorders.

Qualitative questions pertaining to knowledge about causes of mental disorders, age of onset, its curability, awareness of mental health services available in the city or district, availability of such services in other cities, awareness about 'mankash', stigmas and taboos related to mental health, and feasibility of providing mental health services with other services were also canvassed.

University and college teachers interviewed regarding mental health in Sagar District	
University / Colleges	**Total Respondents**
Dr.H.S. Gour Central Universty Sagar	81
Government PG College (Co-Ed.), Rahatgarh	8
Rajeev Gandhi Govt.PG College (Co-Ed.), Banda	12
Deendayal Govt. Arts and Commerce PG College(Co-Ed.), Sagar	15
Government PG Excellence Girls College, Sagar	18
Total	**134**

The figure below shows the scores received by the state during the mental health assessment survey carried out in 2015- 2016 in M.P. The scores achieved by the state are low for components like budget for mental health, monitoring, IEC and health education, mental health action plan and training and intersectoral coordination. Components such as availabilty of drugs, implementation status of legislation and state mental health coordination received better scores. M.P. needs to do much more in the area of mental health.



Box 1. Status of mental health in M.P. (NMHS, 2015-16)

The number of mental health professionals in Madhya Pradesh was 0.2 per one lakh population. However, the proportion of psychiatrist was 0.05 per lakh population.

The limited availability of specialist mental health human resources (psychiatrists, clinical psychologists and psychiatric social workers (existing ones are also mostly in urban areas) has been one of the barriers in providing essential mental health care to all.

The number of medical officers at the state and district levels trained to deliver mental health services 0.1 (per lakh population) in Madhya Pradesh during last 3 years prior to the survey.

The prevalence of depression in state was 1.4 (6.1 lakh persons). It was found that those more than 50 years, females and resident of urban metro had highest burden of depression.

Overall, the weighted prevalence of Mental Morbidity in adults was 13.9% (nearly 1 crore). This prevalence is higher than the national prevalence of mental morbidity.

The burden of any psychoactive substance use was 36.6%, with tobacco use disorder being 34.9% and alcohol use disorder being 10.3%. The prevalence of psychoactive substance use is threefold higher than the national prevalence.

More than one third population in the state is indulging in tobacco use. The prevalence was highest among persons with age more than 40 years, male and resident of rural areas.

The incidence rate of suicide was 11.9 per 1,00,000 and was higher among males and amongst persons from economically productive age group i.e; 18 to 45 years.

The suicide risk in state was 0.8% which was comparable with the national rate and it was found higher among age group 30 to 49 years, males and people living in urban metros which coincides with the national findings.

Overall, for all mental health problems treatment gap (not consulting health provider despite of having mental health problem) is as high as 91% in the state.

The median duration of illness was found to be 132 months and the median interval between onset of illness and consultation was found to be one year.

There are only two public mental hospitals and 14 medical colleges to provide mental health care in the state.

The health care professionals who had undergone training in mental health in last three years are 99 (i.e. 0.1 per lakh population).

There were no rehabilitation workers or special education teachers available under the public health spectrum.

4. Review of current status of District Mental Health Programme in M.P. (2017-18)

Mental disorders are a diverse group of conditions varying in their presentation ranging from acute to recurrent to chronic, mild to severe, multiple disorders to single illness. After the NMHS survey of 2015-16 it was pertinent to review the progress made in implementation of the DMHP programme in the state.

The Mental Health Program in Madhya Pradesh was earlier run by Department of Medical Education in 1996, when two mental health hospitals at Gwalior and Indore provided services. In the year 2014-15 the Mental Health Program has been taken up by Department of Public Health & Family Welfare (DPH&FW), Government of Madhya Pradesh (GoMP). After NMHS survey in M.P. (2015) a policy decision was taken to run the Mental Health Program in all 51 Districts of Madhya Pradesh. It was decided to work on all the components as envisages in DMHP program under NMHP simultaneously.

Box 2. Goals of District Mental Health Program in M. P.

The District Mental Health Program (DMHP) was launched under NMHP in the year 1996.The main objective of DMHP is to provide Community Mental Health Services and integration of mental health with general health services through decentralization of treatment from Specialized Mental Hospital based care to primary health care services. The DMHP envisages a community based approach to the problem, which includes:

- Training of mental health team at identified nodal institutions.
- Increase awareness & reduce stigma related to Mental Health problems.
- Provide service for early detection & treatment of mental illness in the community (OPD/ Indoor & follow up).
- Provide valuable data & experience at the level of community at the state & center for future planning & improvement in service & research.

NHM, MP 2018

Implementation of DMHP: Table 1 shows the status of implementation of DMHP in 2017-18. Twenty districts out of 51 have been identified for DMHP in 2017-18, although it has been implemented in all 51 districts with psychiatric OPD and drugs.

Box 3. Status of implementation of Mental Health Programme in M.P. (2017-18)

20 Districts Mental Health Programme Implemented (2017-18)

Gwalior, Morena Sheopur, Bhopal, Betul Hoshangabad, Rajgarh, Jabalpur, Blaghat, Katni Rewa, Shahdol Singrouli, Indore Dhar, Khandwa Ujjain, Neemuch, Sagar Chhattarpur

31 Districts Mental Health Programme (2017-18, under process)

Shivpuri, Guna Bhind, Ashoknagar, Datia, Sehore,Raisen, Vidisha Harda, Chindwara, Mandla, Narsinghpur, Seoni Dindori, Satna, Sidhi,Umaria, Annupur, Badwani,Burhanpur, Jhabua, Khargone, Alirajpur, Dewas, Ratlam, Shajapur, Mandsour, Agar-Malwa, Damoh, Tikamgarh, Panna

NHM, MP 2018

4.1 Financial Outlay: Table 2 shows the financial status of the programme. Total budget received by the state for DMHP is Rs. 1, 27, 83,500 out of which the total expenditure was Rs. 91,59,623 (72 percent) and 28 percent funds remained unutilized. Each district approximately received Rs. 2.5 lakhs during 2017-18 for mental health activities.

4.2 Human Resource: Table 3 shows that in the 20 DMHP districts trained Medical Officer (MO) in Mental Health are available in 9 districts Betul, Hoshangabad, Katni, Rewa, Shahdol, Dhar, Khandwa, Neemuch and Chhattarpur. Jabalpur has a regular MO for DMHP. In Balaghat regular psychiatrist from state service is available for providing services. In Sagar district Bundelkhand Medical College is providing mental health services. MOs at Rajgarh and Sheopur have been given charge of DMHP and are monitoring the prograame in the two districts. This indicates that there is still paucity of trained psychiatrists' and medical officers in the 20 DMHP districts. Seven posts of clinical psychologists, psychiatric social worker, psychiatric nurse, monitoring and evaluation officer, case register entry assistant and ward assistant have not been currently sanctioned in all these districts. Regular staff nurse from the district from the DH have been identified and provided training in mental health in these districts.

The status of human resources available in the 31 non DMHP districts as seen in Table 4 is similar to that in DMHP districts. In Guna, Dewas and Ratlam districts trained psychiatrists are available for mental health. Out of the three districts Sehore, Umaria and Jhabua which have a trained MO, Sehore has a regular MO monitoring mental health. The District Program Unit and Monitoring and Evaluation officer are reporting data on mental illness. Ward assistant and Data Entry Operator (DEO) of NCD programme compiles data for mental health. Seven posts of clinical psychologists, psychiatric social worker, psychiatric nurse, community nurse, monitoring and evaluation officer, case register entry assistant and ward assistant have not been currently sanctioned in these districts. Regular staff nurse from the DH have been identified and provided training in mental health in these districts.

Table 5 shows that at the CHC level in the 20 DMHP districts there are no sanctioned posts for Medical Officer or clinical psychologist or psychiatric social worker. at CHC level. There are no Community Health Worker for PHCs presently. Only medicines are available for mental illness.

4.3 Trained HR for DMHP: Table 6 shows that, in the 20 DMHP districts there are total 28 trained medical doctors (Av. 1.4 MOs per district) and 51 trained staff nurses (Av. 2.56 SNs per district). Pharmacists, paramedical workers, ASHAs/ ANMs/ Community Health Workers and other panchayat leaders have not received any trainings in mental health. Apart from MOs and SNs, other staff have not been assigned for MH programme.

Table 7 shows that in 31 non DMHP districts total 42 trained medical doctors (Av. 1.3 MOs per district) and 94 trained staff nurses (Av.3.0 SNs per district). Three clinical psychologists available in Dewas, Satna and Damoh districts, have been appointed recently and are undergoing mental health training at the designated training centres.

One Medical officer and two SNs were trained in common psychiatric disorders from each District Hospital of Madhya Pradesh. The training was conducted at Bhopal Memorial Hospital & Research Centre (BMHRC), Bhopal, Mental Hospital, Indore, Rewa Medical College and Maansik Arogyashala, Gwalior. In 2015-16, 2016-17 & 2017-18 total 49, 46 & 42 (till date) medical officers were trained (1 month and refresher training of 14

days) at the same time in 2015-16 total 121 staff nurse, 2016-17 112 staff nurse & 2017-18, 110 staff nurses were trained in mental health (M.P. PIP 2018-19).

Availability of beds for In-Patient Services in Mental Health: Table 8 and 9 show that in all the 51 districts both DMHP and non DMHP there are no separate psychiatric wards. But each district has four beds ear marked in the DH for inpatient services in MH.

4.4 Targeted Interventions at Community Level

MP became one of the first states in India to organise a state level mental health policy and planning workshop in March 2015 under the aegis of National Health Mission. The state took a decision to scale up mental health services across all districts, and establishing "ManKaksh" in all the 51 district hospitals. A team comprising of a trained medical officer and two nurses are provisioned for psycho-social interventions, to be supervised by a psychiatrist .

Availability of District Counselling Centre: Among the DMHP districts in 10 districts mankash is sanctioned for providing services. Currently 4 districts Bhopal, Jabalpur, Dhar and Ujjain have 'mankaksh'counselling centres and in two districts Morena and Hoshangabad 'mankaksh' is under construction. In all the DMHP districts one room has been made functional for screening and one room for counselling (Table 10).

Among the 31 non DMHP districts, seven districts Shivpuri, Guna, Sehore, Chhindwara, Satna, Dewas, Ratlam and Damoh have a counselling centre in the DH. In two districts Mandla and Badwani 'mankaksh' is under construction. In all the non-DMHP districts one room has been made functional for screening and one room for counselling (Table 11).

Counselling session in schools: These are being conducted in 13 DMHP districts, Gwalior, Morena, Bhopal, Betul, Hoshangabad, Jabalpur, Rewa, Shahdol, Singrauli, Indore, Dhar, Ujjain and Sagar. These sessions are being conducted in 11 non DMHP districts Guna, Sehore, Chindwara, Satna, Sidhi Umaria, Burhanpur, Jhabua, Dewas, Ratlam and Damoh.

Training of master trainers and school teachers in life skills: These trainings have been conducted in three DMHP districts Bhopal, Shahdol, Indore and Sehore and in four non DMHP districts of Guna, Sehore, Umaria and Burhanpur.

Counselling services in colleges: These counselling services have been conducted in nine DMHP districts including Morena, Bhopal, Rewa, Shahdol, Singrauli, Indore, Ujjain Neemuch, Sagar. Nine non DMHP districts Guna, Sehore, Satna, Sidhi, Umaria Anuppur, Badwani, Dewas and Ratlam.

Number of workplace stress management sessions: These have been conducted in one DMHP district of Shahdol and 7 non-DMHP district Guna Sehore Chindwara, Badwani, Dewas and Ratlam.

Suicide prevention camps: These camps have been conducted in seven non DMHP districts of Guna, Sehore, Chindwara, Badwani, Dewas, Ratlam and Mandsour.

4.5 Psyhco-tropic drugs included in DH & Essential Drug list: Psycho tropic drugs have been included at DH level in all 51 districts including DMHP and non DMHP. Thirteen types of psychotropic drugs are included in essential drug list (EDL). There is availability of all the required psychotropic drugs at DH and CHC level health facilities but availability of drugs is partial in all the PHCs of 51 districts (Table 12 & 13). Drugs include anti-psychotics, anti-depressants, stimulants, mood stabilizers for bipolar disorders, benzodiazepines for anti anxiety disorders, and selective serotinin for depression.

4.6 Information Education and Communication (IEC)

IEC activities are crucial for increasing public awareness about mental health issues amongst general public. All types of IEC activities conducted during 2017-18 are stated below.

Procuring and translation of IEC material and distribution: IEC material has been distributed in all 51 districts. Translation of IEC material are being carried out.

Mass media activities: Mass media activities have been mobilized in all the 19 DMHP districts except Singrouli. Mass media activities have also been mobilized in 29 non-DMHP districts except, Annuppur and Alirajpur(Table 14 & 15).

Outdoor media activities: Outdoor media activities have been reported in ten out of 20 DMHP districts of Morena, Bhopal, Hoshangabad, Rewa, Shahdol, Indore, Dhar, Khandwa, Neemuch and Sagar. Among non DMHP districts 15 districts, Guna, Datia, Sehore, Vidisha, Seoni, Satna, Sidhi, Badwani, Burhanpur, Jhabua, Khargone, Ratlam, Mandsour, Agar-Malwa and Damoh have organized outdoor media activities in their respective districts.

Folk media: IEC through folk media have been reported in eight DMHP districts of Morena, Bhopal, Rewa, Indore, Dhar, Khandwa, Neemuch and Sagar districts. Nine non-

DMHP districts. Guna, Sehore, Satna, Badwani, Burhanpur, Jhabua, Khargone, Ratlam and Damoh.

Interpersonal Communication: All twenty DMHP districts have carried out IEC through inter- personal communication. Twenty non DMHP districts Shivpuri, Guna, Bhind, Sehore, Raisen, Vidisha, Harda, Chhindwara, Mandla, Narsinghpur, Satna, Sidhi, Badwani, Burhanpur, Jhabua, Khargone, Dewas, Ratlam, Mandsour and Damoh. Twenty out of 31 non-DMHP districts have carried out IEC through inter-personal communication.

Other IEC activities: Other IEC activities have been carried out by 19 out of 20 DMHP districts with the exception of Gwalior.

Twenty out of 31 non-DMHP districts Guna, Bhind, Sehore, Raisen, Vidisha, Harda, Chhindwara, Mandla, Narsinghpur, Satna, Sidhi, Umaria, Badwani, Burhanpur, Jhabua, Khargone, Dewas, Ratlam, Mandsour and Damoh have carried out other IEC activities.

4.7 Mental Health Service Delivery

Mental Health service delivery is being carried out through OPDs and IPDs in all 51 disticts in the state. Details of service delivery including patients treated, followup services provided, IPD services given are mentioned below.

MH Service Delivery at DH: Data obtained and separately aggregated for 20 DMHP districts shows that in total 5508 new OPD patients and 4787 follow up cases were treated for mental illness at the district hospitals and 67 cases were referred in tertiary hospital. Overall, 466 cases of suicidal risk out of total OPD and 820 IPD cases were reported during 2017-18. Rewa has reported treatment of 1173 new OPD patients followed by Bhopal 665 cases, Jabalpur 519 and Betul 354 cases (Table 16).

Data obtained and separately aggregated for 31 DMHP districts shows that in total 3946 new OPD patients were treated for mental illness at the district hospitals, 2013 follow up cases in OPD and 44 cases were referred in tertiary hospital. Overall, 892 cases of suicidal risk out of total OPD and 340 IPD cases were reported during 2017-18. Ratlam reported maximum 645 OPD cases, followed by Chindwara (375) and Guna (340). Agar-malwa, Mandsaur, Damoh and Sehore have reported cases in the range of 200-300 (Table 17).

The aggregated data reported by the state shows a total of 85577 mental illness cases during April to March 2017-18, (43622: new cases; 41407 follow up cases; 548:

cases referred to tertiary hospital). Total 6129 cases of suicidal risk out of total OPD and 820 IPD cases were reported during the year 2017-18 (Table 18). Whereas prevalence of high suicide risk is 0.8 percent (NMHS,2016) only 0.071 percent suicide risk cases visiting hospitals were reported in thequarterly report of 2017-18 . In M.P. overall suicide rate is higher than at the national level (M.P. 11.9; India:10.6, NMHS, 2016). Under reporting is observed from the quarterly data obtained.

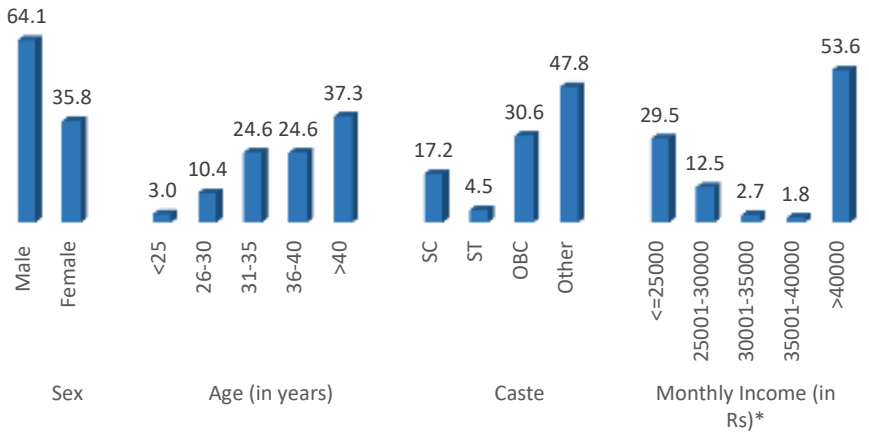
It may be mentioned that there is a large gap in district level data reported by 51 districts and state level quarterly data for 2017-18. State level quarterly data reporting is much higher than the number of cases reported by the individual districts. HMIS data element 14.1.5 (NCD) shows the total 'outpatient mental illness'as 88515 cases and 14.1.6 (NCD) shows 'outpatient epilepsy' as 12482 cases.Total reporting of cases in HMIS is 100997, from 1077 facilities including PHCs and SHCs and private medical colleges, which again indicates data gap.Maximum 61 percent data of mental illness has been reported from Bhopal district alone indicating data repoting anomaly.

5. Awareness and Attitude towards Mental Disorders

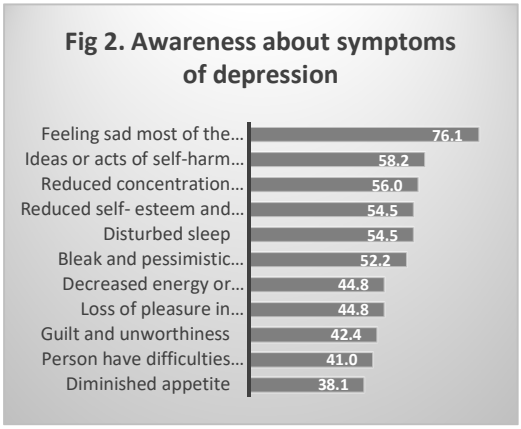
A primary survey was conducted among 134 University and College teachers in Sagar district. This was done to explore their awareness, about different mental, neurological and substance use disorders as outlined in the mhGAP chart, and their attitude towards mental disorders.

Profile of Respondents: Figure 1 shows the profile of respondents. The figure shows that nearly two-thirds respondents were males and a little above one-third

Fig 1. Profile of respondents

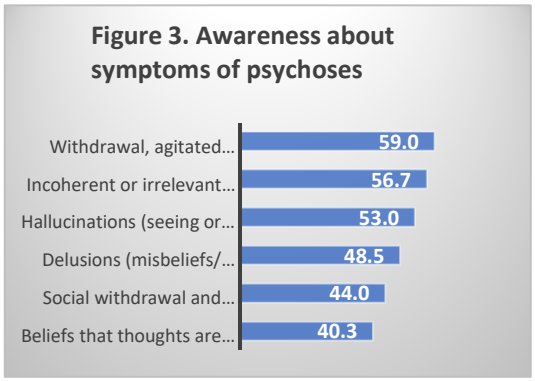


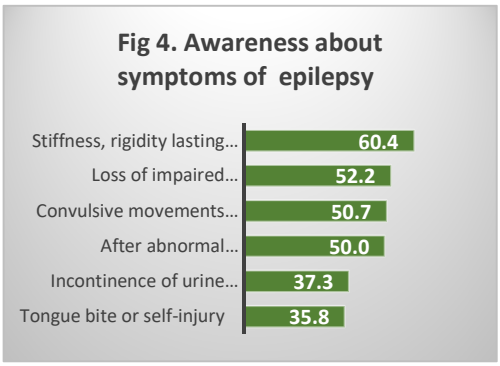
respondents were females. More than one-third of the respondents were of age 40 and above, belonged to other category (48 percent). More than half of the respondents have a monthly income of Rs. 40,000 and above.



Symptoms of Depression: Table 19 and Figure 2 shows that out of the eleven symptoms of depression, feeling sad most of the day or almost every day was perceived as the most important symptom of depression (76 percent), followed by ideas or acts of self- harm (58 percent) and reduced concentration (56 percent). Diminished appetite as sign of depression ranks last (38 percent) among all the symptoms. Those belonging to the age category 31-35 years, with income ranging between Rs.31000-35000 (100 percent), belonging to ST caste (100 percent) stated feeling sad as the most important symptom of depression.

Symptoms of Psychosis: Table 20 and Figure 3 shows that out of the six symptoms of psychosis, withdrawal, agitated and disorganized behaviour was ranked as the most important symptom (59 percent), followed by incoherent or irrelevant speech (57 percent). Respondents in the age category 36-40 years (68 percent), earning Rs. 25000-30000 (71 percent) ranked withdrawal, agitated and disorganized behaviour as the most important symptom of psychoses.

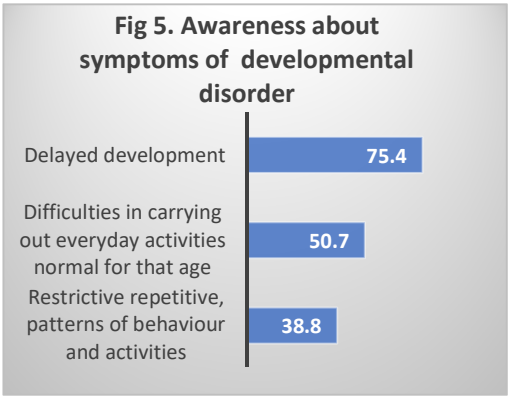


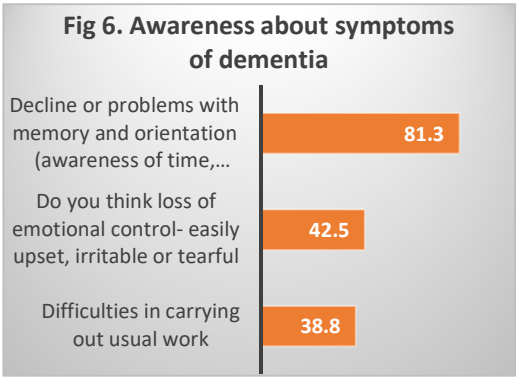


Symptoms of Epilepsy: Table 21 and Figure 4 indicates that out of the six symptoms of epilepsy, rigidity and stiffness was ranked first as three-fifths expressed awareness about this symptom of epilepsy. Loss of consciousness and convulsive movements were stated by 52

and 51 percent respondents respectively. Only 36 percent respondents stated tongue bite or self-injury as symptom of epilepsy. Respondents in the age category 31-35 years (66 percent) and earning Rs. 31000-35000(100 percent) specified rigidity and stiffness as the most important symptom of epilepsy.

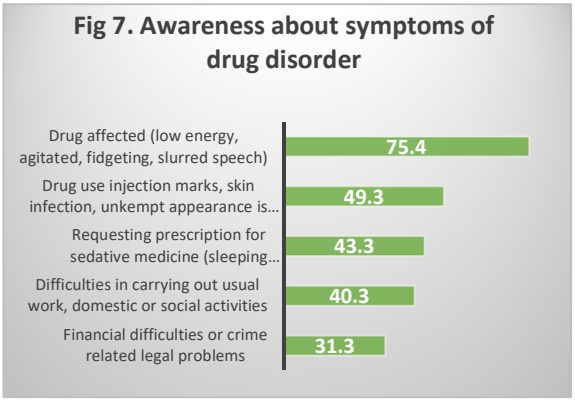
Symptoms of Development Disorder: Table 22 and Figure 5 shows that out of the three symptoms, delayed development ranked first (75 percent) followed by difficulties in carrying out every day normal activities (51 percent) and restrictive pattern of behaviour and activities. Proportionately more female respondents (83 percent), those in the age group 31-35 years (94 percent), belonging to ST category (100 percent) ranked delayed development as the most important symptom of development.





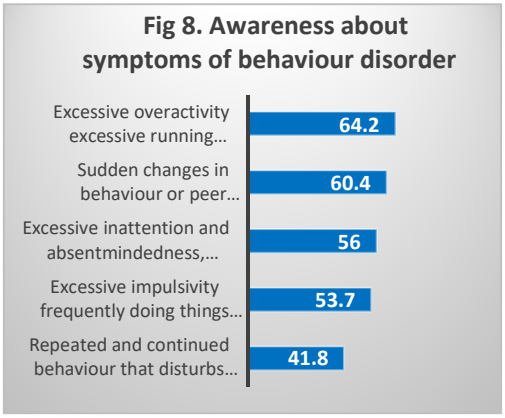
Symptoms of Dementia: Table 23 and Figure 6 majority respondents (81 percent) stated that decline or problems with memory and orientation (awareness of time, place and person) is the primary symptom of dementia. Loss of emotional control (43 percent), mood or behavioural problems (37 percent). Proportionately all respondents in the age 26-30 years, earning Rs. 30000-35000 and 93 percent OBC respondents stated decline or problems with memory and orientation (awareness of time, place and person) as the main symptom of dementia.

Symptoms of Drug Disorder: : Table 24 and Figure 7 shows that drug affected (low energy, agitated, fidgeting, slurred speech) was stated as the primary symptom of drug disorder (75 percent). Drug use injection marks, skin infection, unkempt appearance is drug use

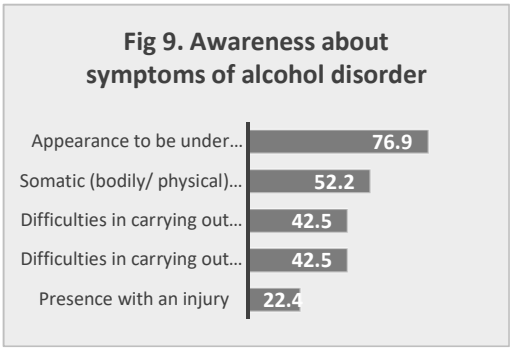


disorder ranks second (49 percent), followed by requesting prescription for sedative medicine (sleeping tablets, opiods, 43 percent). Proportionately all respondents (100 percent) earning Rs. 30000-35000, 87 percent of age 31-35 years, from SC and other category (82 percent each) and males (80 percent) stated drug affected state as the main symptom of drug use disorder.

Symptoms of Behaviour Disorder: Table 25 and Figure 8 shows that more than three-fifths respondents reported excessive overactivity, excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting (64 percent), as the primary symptom of behaviour disorder, followed by sudden changes in behaviour or peer relations, including withdrawal and anger (60 percent) and excessive inattention and absentmindedness, and repeatedly stopping tasks before completion and switching to other activities (56 percent**).** Behaviour disorders are also indicated by excessive impulsivity and (54 percent) and reapeated and continued behaviour (42 percent).



Symptoms of Alcohol Disorder: Table 26 and Figure 9 indicates that more than three-fourths respondents opined that appearance to be under the influence of alcohol (smell of alcohol, looks intoxicated, hangover) best defines alcoholic behaviour, followed by somatic bodily/ physical symptoms (52 percent). Proportionately all respondents (100 percent) earning Rs. 30000-35000, females (87 percent), those in the age group 26-30 years (86 percent) and belonging to 'other' category (85 percent) are more likely to report about appearance as the main indication of alcohol disorder.

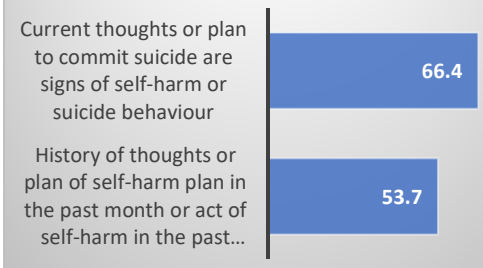


Symptoms of Suicide/Self Harm Behaviour : Table 27 and Figure 10 show that two-thirds respondents stated that current thoughts or plan to commit suicide are signs of self-harm or suicide behaviour, and more than half stated history of thoughts or plan of self-harm

plan in the past month or act of self-harm in the past year are signs of self-harm or suicide behaviour .

It is evident that all 46 statements pertaining to signs and symptoms of different mental, neurological and substance use disorders were ranked according to level of awareness of respondents.

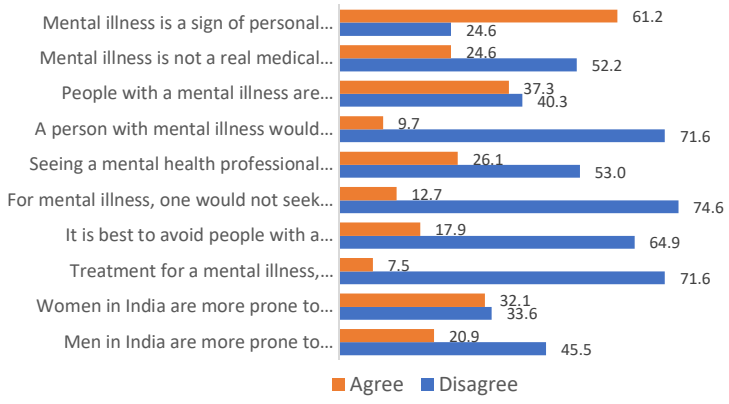
Fig 10. Awareness about symptoms of suicide /self harm behaviour



Attitude towards Mental Disorders

Attitude towards mental disorders was also elicited from 134 teachers which is illustrated in Table 28 and Figure 11 below. More than three- fifths respondents (61 percent) stated that mental illness is sign of personal weakness, 52 percent disagree that mental illness is not real medical illness, two-fifths disagree that people with mental illness are dangerous but more than one- third agree that people with mental illness are dangerous. Nearly three fourths respondents (72 percent) disagree that if you had mental illness you would not tell anyone. More than half of the respondents (53 percent) disagreed that seeing a mental health professional means you are not strong enough to manage/ control your own difficulties but more than one fourth agreed about it (26 percent). Three-fourths respondents disagree that 'If you had a mental illness, you would not seek help from a mental health professional'. Regarding maintaining relations with a mentally ill person nearly two- thirds respondents(64 percent) disagreed that 'It

Fig 11. Attitude towards mental disorders

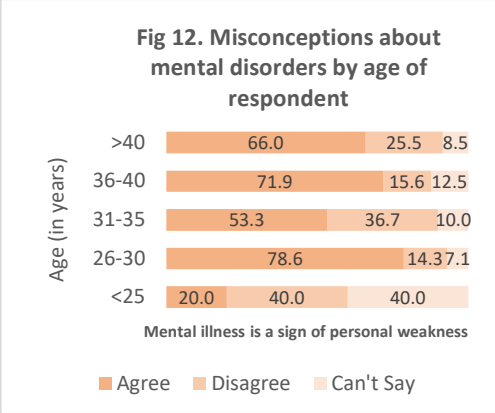


is best to avoid people with a mental illness so that you don't become ill" There is also disagreement regarding treatment for a mental illness, provided by a mental health professional, would not be effective as expressed by 72 percent respondents.

Whereas one-third respondents disagree (34 percent) that women in India are more prone to mental disorder than men, and more than two-fifths respondents (46 percent) disagree that men in India are more prone to mental disorder than women 25 percent respondents responded 'can't say' for either of the two statements.

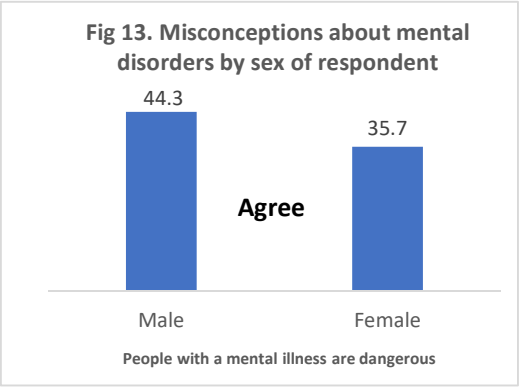
Certain Misconceptions about Mental Disorders

Inspite of respondents' representing a relatively high educational level, some misconceptions regarding persons with mental disorders are observed among them which is discussed below.



Mental illness is a sign of personal weakness: Figure 12 shows that misconception regarding mental illness as a sign of weakness was observed among respondents across all age categories specially among respondents in the age group 26-30 years (79 years) followed by those in the age group 36-40 years (72 percent) and above 40 years of age (66 percent).

People with a mental illness are dangerous: More than two-fifths males (44.3 percent) and 36 percent females suffer from this misconception (Figure 13).



It is however certainly evident that for majority of the statements pertaining to mental disorders the respondents agree that the intervention of mental health professionals is necessary, and that it is not essential to avoid mentally ill persons.

Qualitative Analysis:Source of information and treatment of mental disorders

Open ended questions were canvassed to respondents for their opinion on issues pertaining to causes of mental illness, age of occurrence of mental illness, curability of mental disorders and sources of information and services pertaining to mental illness which are outlined below.

Perceived Causes of Mental illness: Health problems (32 percent), social environment (31 percent), lifestyle (30 percent), family problems (17 percent), and work pressure were cited as the major cause of mental illness. Neurological problems, genetic disorders, drug abuse and financial problems could cause different types of mental illness. Some respondents opined that there are multiple causes of mental illness such as:

"Environment in which one has been brought up, failure in career and social life, depression due to extra work load in office, and non availability of timimng for get together"

"Genetics, poverty, medication, family dispute casue mental illness".
"Aswathkar jeevan paddati, tanav, avsaad adi ke karan manski bimari hoti hai".

Age of occurrence of mental illness: Regarding age of occurrence of mental illness nearly half the respondents (46 percent) said that mental illness may occur at any age, 38 percent stated that illness occurs during adult hood, followed by young age and childhood. Some of their observations are given below:

" I don't think there is any age for any mental illness. It can occur any time".
"It does not have any specific age, it could happen any time, however it could be easily ignited by spurt of hormones like puberty etc."

Perception that mental disorders are curable **:**Majority respondents stated that mental disorders are curable as specified by respondents and seen in Figure 14.

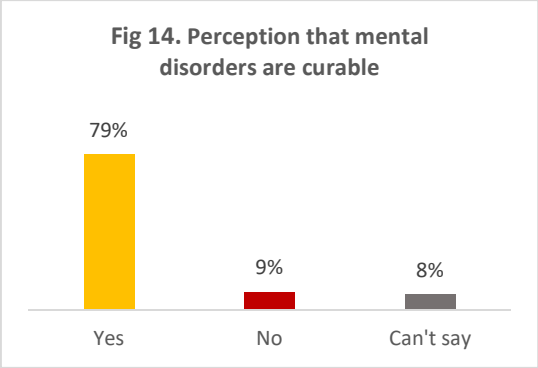


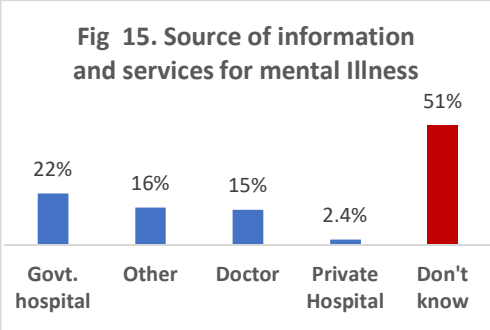
Fig 14. Perception that mental disorders are curable

"*Mansikrog saadhya hai, kintu uske liye vaatavaran vaartalaap rogi mein anukool hona chaiye"*

"Yes it can be cured, depends upon the social behaviour and surroundings".

"Yes, depends upon the conditions and measures taken to cure it".

Information and services for mental illness: It is surprising that atleast half of the respondents do not know the place for seeking information and services for mental illness. Twenty two percent respondents are aware that services are available at government hospital (Figure 15).

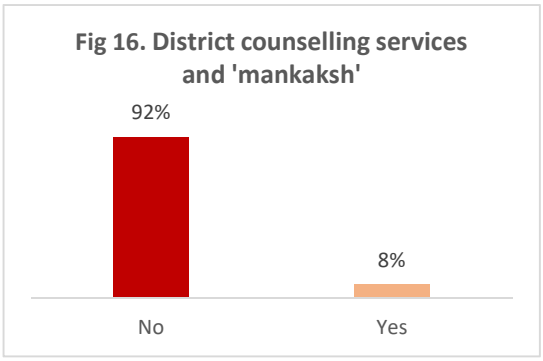


Some respondents who are aware about a place for couselling opined *"Mano vigyan vibhag , Dr HS Gour University Sagar, evam mano chikita sak gopal ganj Sagar."*

Respondents were asked where to seek information and services about mental disorders outside the city where they resided, half of them expressed ignorance about places outside the city for seeking treatment:

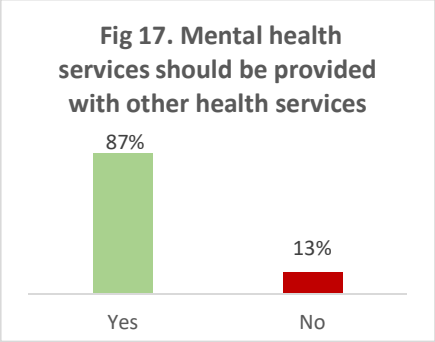
"Aajkal mano chiktsak pratyek jila hospital kendra mein chikitsakiye paramarsh deta hai"
"Mental rehabilitation centre, in Indore".
"Jahan tak anumaan ke anusaar mansik rogiyon ka upchaar Jabalpur, Gwalior Agra, aadi sheron mein upchaar kendra hai".

District counselling 'mankaksh' services: Majority respondents (92 percent) were not aware about mankash services (Figure 16). Some respondents who had heard about mankash specified:



"Haan, mankaksh mein chetna jaagriti ki jaati hai".
"Yes mankash telepathy, reiki ki jagha hai".
Three-fourths respondents also said that they were not aware about any counselling centres for providing services for mental disorders outside the city .

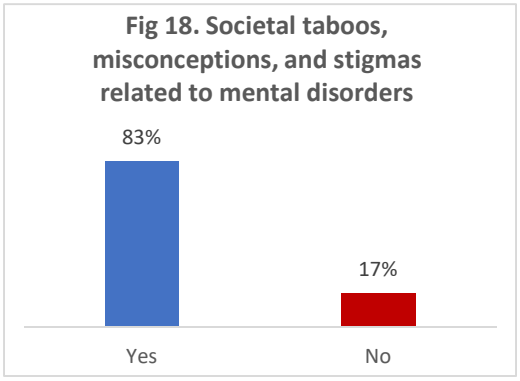
Mental health services should be provided with other health services: As seen in Figure 17 majority respondents agreed that mental services should be provided along with other health services so that different health services are readily available under one roof.



"Yes, every individual has some mental health problems which need to be counselled prior to its severity.

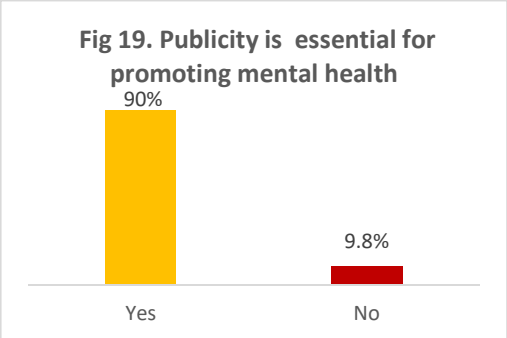
"Haan yeh sabhi hospital mein hona chhaiye, yadi sabhi mein sambhav na ho kam se kam jila hospital mein hona chaiye."

Societal taboos, misconceptions, and stigmas related to mental disorders: Majority respondents (83 percent) believed and replied in the affirmative that societal taboos, misconceptions and stigmas related to mental disorder are far reaching in the society (Figure 18). Respondents suggested ways of reducing stigmas as given below:



" *Giving orientation to the youths about mental illness".*
"Taboos and stigmas related to mental health can be removed by spreading the awareness about the mental health."
"For removing these taboos there should be held many seminars and workshops.''
"Make them understand that mental illness is not contagious and have to treat ill people equally like others."

Publicity essential for promoting mental health: There is common understanding among respondents that publicity and information, education and communication for promoting mental health (Figure 19).



"Mansik rog sambandhi prachaar prsaar ki aavyshkta hai, iske liye nukkad natkon ka sanchaalan hona chhaiye".

"Siksha, media, samachaar patr, jaagrookta karykmo se".

"Publicity helps people realize that it is a world wide problem, asituation which can be more difficult if not treated on time.It also helps the patient to believe that he/ she is not the only person having such problems, which normalizes him/ her earlier".

6. Service Providers' Perspective

The state is one of the first states in India to organise a state level mental health policy and planning workshop in March 2015 and brought under the overall aegis of NHM, prior to which mental health programme was under the department of medical education. With a shift in paradigm to bring all 51 districts in the state it became essential to seek service provider's perspective on issues pertaining to mental health like, personnel, training, sufficiency of buget, infrastructure, and overall functioning. The state nodal officer, district nodal officers of DMHP, SNs and clinical psychologists were interviewed for this purpose.The section below highlights these issues.

Availabilty of Personnel for DMHP: There is one Deputy Director for mental health appointed as a nodal officer DMHP. Although DMHP has been sanctioned in only 20 districts initially, yet all 51 districts have a MO designated as a nodal officer for DMHP programme. All the 51 districts have a trained MO and two to three staff nurses. The state nodal officer detailed that there are very few technical staff like psychiatrist, clinical psychologist, and psychiatric nurse.

"An independent psychiatrist or clinical psychologist is required who can provide the complete set of treatment." (Nodal officer MH, DH Sagar)

"According to proposed norms, there should be one psychiatrist for every 100,000 people, three clinical psychologists for every 200,000 people, two psychiatric social workers for every 100,000 people, and one psychiatric nurse for every 10 psychiatric beds". (Sahu HT, 2018).

"*Most of the psychiatrists in the state are located in urban centres. Rural centres do not really have any mental health care facilities. There are only about a dozen psychiatrists in government hospitals and roughly 20-25 in the private sector, " (Psychiatrist, Guna DH, 2018).*

Infrastructure for DMHP programmes: The state nodal officer speicified that the M.P. is in the process of augmenting mental health services to clients. All 51 district hospitals are providing services through mhGAP chart and followup services through the MO and SNs trained in providing mental health services. All 51 hospitals have allocated two beds each for male and female inpatients in all the district hospitals. The state has just two psychiatric hospitals — Manasik Arogyasala in Gwalior (25 beds each in male and female ward, and 4 & 2 emergency beds for males and females respectively) and Mental Hospital Indore which has 155 inpatient beds and 30 psychiatric beds. Inpatient beds are

also available in the tertiary care centres in psychiatric wards of the state medical colleges The beds are not sufficient for inpatient services and there is lack of privacy for such patients.

Box 4. Infrastructure and services available in Gwalior Mansik Aarogya Shala (GMA)

- **Emergency Services**- GMA has 10 bedded emergency ward for the crisis intervention.
- **Psychiatric Specialty Clinics** -
- **Disability Certificates** - Disability certificates are issued to patients of GMA as per need and diagnosis of patients.
- **Lab Services** - GMA is running pathology and biochemistry test lab. It has facilities for all basic blood, sputum and urine investigation including serum lithium level.
- **Radiodiagnosis and Electrophysiological Investigation** - GMA has facilities for X-Ray, EEG and ECG done as per patient's need.
- **Modified ECT** –Elector-convulsive Therapy
- **Counselling/ Psychotherapy** - GMA has facility for counselling and psychotherapy, through clinical psychologist and psychiatric social worker. Counselling and psychotherapy is giving to patients both on OPD and IPD basis.
- **Psychosocial rehabilitation** - Psychosocial rehabilitation is done as a part of Secondary and Tertiary prevention through Behavioural therapy principals through a multidisciplinary approach involving Psychiatrist, Clinical Psychologist, Psychiatric Social Worker, Occupation therapist, Psychiatric nursing. Psychosocial rehabilitation
- **Community based camps** – GMA organizes regular out reach camps and camps for issuing disability certificate for mentally retarded patient in Gwalior zone.
- **De-addiction center** – GMA is running 10 bedded de-addiction center in the campus premises. It has all facilities to deal with Acute withdrawal and maintenance treatment.
- **Other Patient Services**

gwaliormentalhospital.org

"*There is tremendous pressure on the two hospitals to serve mental patients."(Training coordinator, Mental Hospital Indore).*

Training in MH: The state has been continuously training MOs and SNs 2015-16. The nodal officer of MH programmes prepares a yearly training calender and coordinates with different districts as well as the institutions identified to provide training at Mansik Aarogyashala Gwalior, Mental hospital Indore, BMHRC Bhopal. In 2016-17, 6 batches of SNs were provided orientation for 15 days, as well as refresher training and in 2017-18, 7 batches received refresher training in Indore and Gwalior. Thus training has been a continous process which was verified by MOs of Guna, Ratlam and Sagar districts.

Budget: The yearly budget plan is submitted PIP which and the state allocates funds to the district. In 2017-18 one- fourth of the budget could not be spent. Some districts have been allocated funds for mankaksh and all 51 districts have received contingency grants.

"Mental patients require privacy which it is not possible to provide currently as a separate counselling room is required and there is provision in the budget for it"(State Nodal officer,MH).

Thirteen types of medicines are available in the EDL stock. Medicines are not a problem. But they are to be provided only on prescription. "(State Nodal officer,MH).

Constraints in Implementation of DMHP: DMHP is part of the regular health services. There is very limited budget for augmentation of DMHP programme.Initially each district has been provided a contigency amount of Rs. one lakh for purchase of necessary infrastructure for 'mankaksh'. Certain constraints pertaining to trained manpower, training, services and followup of clinical cases are impediments.

"The state is facing an acute shortage of psychiatrists, psychologists and psychiatric nurses" (Nodal officer, MH NHM)

"A fulltime nodal officer specialised in mental health is a prerequisite for augmentation of theMH programme".

" The current module for training doctors for one month initial training and a 14 day refresher is grossly inadequate"(MO,Dhar District Nodal officer, NHM).

Regarding services the doctor opined that *"One tries to fit the myriad of symptoms into a measly nine pre-prepared diagnosis, even which he sometimes gets jumbled. That is not only unjust to the patients but is actually bordering on to negligence. The patient doesn't know that the Mann-Kaksh doctor who is usually his last resort after countless quaks/ babas/ ojhas is only marginally better than them"* (MO, Dhar District Nodal officer, NHM).

MO, Sagar District Nodal officer, NHM also expressed apprehensions that with multi- tasking at the district hospital and huge case load of general patients in the DH the diagneostic part is mostly left to the staff nurse which is not desirable. Mental health requires time, patience and privacy and the environment in the district hospital setting is not conducive to providing mental health services.

"Maintaining constant interaction with the patient and family is a challenge as they need eight to ten visits and follow-ups from diagnosis to recovery. Many a times family members are unwilling to understand the seriousness of the problem, and fail to return for a follow-up visit after the initial assessment. Moreover the visits for mental health cannot be kept limited to the OPD timings of DHs".

7. Conclusions

The study suggests that the DMHP is a strong step in the right direction. Mental hospitals, district hospital 'mankaksh' and communiy based clinics are important 'agents' for delivery of mental health sevices. Some significant changes towards improvement have occured, but impetus must be given to increase in mental health awareness, manpower and facilities, recruiting trained personnel budgetary allocation.

The primary health centers (PHCs) and the community health centres (CHCs), have no psychosocial interventions because of no trained health personnel in mental health.Therefore the onus of providing MH services is upon the DH, where case loads for OPD and IPD services are high. There is lack of psychiatric nurses, psychiatric social workers and occupational therapists. There is no evidence of training PHC medical officers and non-specialist health workers such as ANMs, Anganwadi workers and ASHAs. The MOs and SNs have to provide multiple services in the different sections of DH and are unable to provide dedicated services to MH patients. MH remains a low priority area in comparison to maternal and child health services.

Although mental illness is included in the existing HMIS but availability of data related to this is limited. There are many illness which come under the overall umbrella of mental health and this data is not being compiled separately for evidence based planning. DH data is being separately compiled by the state which does not present a complete picture. Currently, no mechanism exists for registering, tracking, and following up mental disorder cases at the facility level, beyond DH. Moreover, there is a gap in the data regarding the referral mechanism because there is no specific referral mechanism in place from the community to PHC and further up to the district hospital.

The study also highlights the lack of awareness amongst university and college level teachers about the enormity of challenges pertaining to mental health problems and availability of mental health services. If they are to be facilitators in information sharing, education and communication, and providing life skill education to adolescents and youth they need to be actively engaged in delineating all facets of mental health. Suicide rate is high in M.P in the adolescence age group (14 & above and below 18 years) in comparison to national average (M.P.:15 ; India:9.5) and amongst youth (18 & above

and below 30 years) in comparison to national average (M.P.: 25 ; India: 17) and can be managed through active intervention of the teachers.

Recommendations

- The present findings suggest that accurate need assessment of mental health disorders and services for all the disticts of M.P. is crucial for optimum implementation of MH programme.
- Total catchment of the district should be taken into account. The number of PHCs / CHCs the district is catering to and the total number of caseload annually at the tertiary referral center must be estimated correctly.
- Dedicated psychiatric nurses, psychiatric social workers and occupational therapists per district for providing MH services is a prerequisite, because inspite of the present MH training module, multitasking by MOs and SNs dilutes MH service delivery.
- The training for the doctors in MH should at the least be at diploma level or degree. Doctors who consistently provide good output under DMHP should be given priority.
- The funding for mental health programmes needs to be increased with good planning. More budget can be granted under the NCD flexipool and ensure proper utilization of funds.
- Public Private partnership at the district level is a plausible option for treating drug abuse and alcoholic disorders. For developmental disorders, the DEIC and DRC services can be enroped. Clear roles and functions must be outlined between government and non-governmental organizations.
- IEC activities through intense media activity is critical to develop programmes for the advancement of mental health and promote community care.
- Mental health in work places and educational institutions using life skills techniques can aim at health promotion, early detection as well as awareness programmes on mental health.
- Intersectoral coordination between the health and other departments inpatient or out patient service, specialists and non-specialists, social and community workers, providers and outreach care workers will provide impetus to the programme.
- Emphasis on reliable data generation is essential for effective MH service delivery.

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Table 1: Status of mental health programme in M.P.	
District Mental Health Programme in M.P.	**2017-18**
State consultant/M&E officer/Coordinator in position	No*
No. of total districts in state	51
No. of districts approved DMHP up till 2017-18	20
Number of Non DMHP districts in 2017-18	31
Number of districts with functional DMHP (those with psychiatric OPD and drugs)	51
* Dy Director is currently in-charge of DMHP, ***Source: NHM, MP2018***	

Table 2: Financial outlay (in Rs.) for MH in M.P. (2017-18)	
Budget Received- State	127,83,500
Expenditure incurred	91,59,623
Balance	36,23,877

Table 3: Human resource available in 20 DMHP districts of M.P.

DMHP Districts	Psychiatrist	Clinical Psyhcologist /Trained Psychologist	Psychiatric Social Worker /Trained Social Worker	Psychiatric Nurse/Trained Nurse	Community Nurse	Monitoring & Evaluation Officer	Case Registry Assistant	Ward Assistant /Orderly
Gwalior	Yes	NS	NS	NS	NS	NS	NS	NS
Morena	Yes	NS	NS	NS	NS	NS	NS	NS
Sheopur[@]	Yes	NS	NS	NS	NS	NS	NS	NS
Bhopal	Yes	NS	NS	NS	NS	NS	NS	NS
Betul	No*	NS	NS	NS	NS	NS	NS	NS
Hoshangabad	No*	NS	NS	NS	NS	NS	NS	NS
Rajgarh[@]	Yes	NS	NS	NS	NS	NS	NS	NS
Jabalpur[%]	Yes	NS	NS	NS	NS	NS	NS	NS
Balaghat[$]	No	NS	NS	NS	NS	NS	NS	NS
Katni	No*	NS	NS	NS	NS	NS	NS	NS
Rewa	No*	NS	NS	NS	NS	NS	NS	NS
Shahdol	No*	NS	NS	NS	NS	NS	NS	NS
Singrouli	Yes	NS	NS	NS	NS	NS	NS	NS
Indore	Yes	NS	NS	NS	NS	NS	NS	NS
Dhar	No*	NS	NS	NS	NS	NS	NS	NS
Khandwa	No*	NS	NS	NS	NS	NS	NS	NS
Ujjain	Yes	NS	NS	NS	NS	NS	NS	NS
Neemuch	No*	NS	NS	NS	NS	NS	NS	NS
Sagar[#]	Yes	NS	NS	NS	NS	NS	NS	NS
Chhatarpur	No*	NS	NS	NS	NS	NS	NS	NS

* Trained MO in Mental Health is available in 9 districts Betul, Hoshangabad, Katni, Rewa, Shahdol, Dhar, Khandwa, Neemuch, Chhattarpur [%] Jabalpur (Regular) & MO under DMHP [$]Balaghat Regular Psychiatrist from state service available. [#] Sagar Other department/BMC [@]MO at Rajgarh and Sheopur ***Source: NHM MP, 2018***

Table 4: Human resources available in 31 non DMHP districts of M.P.

Non DMHP Districts	Psychiatrist	Clinical Psyhcologist /Trained Psycholo gist	Psychiatric Social Worker/ Trained Social Worker	Psychiatric Nurse/Trained Nurse	Community Nurse	Monitoring & Evaluation Officer	Case Registry Assistant	Ward Assistant/Orderly
Shivpuri	No	NS	NS	NS/2	NS	NS	NS	NS
Guna	Yes	NS	NS	NS/4	NS	NS	NS	NS
Bhind	No	NS	NS	NS/3	NS	NS	NS	NS
Ashoknagar	No	NS	NS	NS/3	NS	NS	NS	NS
Datia	No	NS	NS	NS/3	NS	NS	NS	NS
Sehore	Yes	NS	NS	NS/4	NS	NS	NS	NS
Raisen	No	NS	NS	NS/2	NS	NS	NS	NS
Vidisha	No	NS	NS	NS/3	NS	NS	NS	NS
Harda	No	NS	NS	NS/2	NS	NS	NS	NS
Chindwada	No	NS	NS	NS/4	NS	NS	NS	NS
Mandla	No	NS	NS	NS/2	NS	NS	NS	NS
Narsingpur	No	NS	NS	NS/3	NS	NS	NS	NS
Seoni	No	NS	NS	NS/3	NS	NS	NS	NS
Dindori	No	NS	NS	NS/3	NS	NS	NS	NS
Satna	No	NS	NS	NS/3	NS	NS	NS	NS
Sidhi	No	NS	NS	NS/2	NS	NS	NS	NS
Umaria	Yes	NS	NS	NS/3	NS	NS	NS	NS
Anuppur	No	NS	NS	NS/6	NS	NS	NS	NS
Badwani	--	NS	NS	NS/1	NS	NS	NS	NS
Burhanpur	No	NS	NS	NS/2	NS	NS	NS	NS
Jhabua	Yes	NS	NS	NS/2	NS	NS	NS	NS
Khargone	No	NS	NS	NS/2	NS	NS	NS	NS
Alirajpur	No	NS	NS	NS/4	NS	NS	NS	NS
Dewas	Yes	NS	NS	NS/7	NS	NS	NS	NS
Ratlam	Yes	NS	NS	NS/5	NS	NS	NS	NS
Shajapur	No	NS	NS	NS/2	NS	NS	NS	NS
Mandsour	No	NS	NS	NS/3	NS	NS	NS	NS
Agar-Malwa	No	NS	NS	NS/2	NS	NS	NS	NS
Damoh	No	NS	NS	NS/2	NS	NS	NS	NS
Tikamgarh	No	NS	NS	NS/3	NS	NS	NS	NS
Panna	No	NS	NS	NS/3	NS	NS	NS	NS

In Sehore regular & trained Medical Officer in Mental Health is Available, in Umaria and Jhabua trained MO in Mental Health is also available, District Program Unit M & E Reporting. Use Out source of ward assistant (NCD) Data Entry Operator maintain report. NS: not sanctioned

Source: NHM MP, 2018

Table 5: Human resource for DMHP at CHC level facilities in 20 DMHP districts of M.P.

DMHP Districts	Medical Officer at CHC	Clinical Psychologist/ Psychiatric Social Worker at CHC	Community Health Worker at PHC
Gwalior	NS	NS	No
Morena	NS	NS	No
Sheopur	NS	NS	No
Bhopal	NS	NS	No
Betul	NS	NS	No
Hoshangabad	NS	NS	No
Rajgarh	NS	NS	No
Jabalpur	NS	NS	No
Balaghat	NS	NS	No
Katni	NS	NS	No
Rewa	NS	NS	No
Shahdol	NS	NS	No
Singrouli	NS	NS	No
Indore	NS	NS	No
Dhar	NS	NS	No
Khandwa	NS	NS	No
Ujjain	NS	NS	No
Neemuch	NS	NS	No
Sagar	NS	NS	No
Chhatarpur	NS	NS	No

Source: NHM MP, 2018

Table 6: Trained staff available in 20 DMHP districts of M.P.

DMHP Districts	Medical Officer	Psychologist	Social worker	Nurse	Pharmacists	Paramedical workers	ASHAs/ANMs/Community Health Worker	Others (panchayat leaders)
Gwalior	2	0	0	3	0	0	0	0
Morena	2	0	0	2	0	0	0	0
Sheopur	1	0	0	2	0	0	0	0
Bhopal	1	0	0	3	0	0	0	0
Betul	1	0	0	2	0	0	0	0
Hoshangabad	1	0	0	2	0	0	0	0
Rajgarh	1	0	0	2	0	0	0	0
Jabalpur	1	0	0	2	0	0	0	0
Balaghat	1	0	0	2	0	0	0	0
Katni	1	0	0	3	0	0	0	0
Rewa	2	0	0	2	0	0	0	0
Shahdol	1	0	0	2	0	0	0	0
Singrouli	2	0	0	3	0	0	0	0
Indore	1	0	0	3	0	0	0	0
Dhar	2	0	0	4	0	0	0	0
Khandwa	1	0	0	3	0	0	0	0
Ujjain	2	0	0	2	0	0	0	0
Neemuch	1	0	0	2	0	0	0	0
Sagar	2	0	0	3	0	0	0	0
Chhatarpur	2	0	0	4	0	0	0	0
Total	**28**	**0**	**0**	**51**	**0**	**0**	**0**	**0**

Source: NHM MP, 2018

Table 7: Trained staff available in 31 non DMHP districts of M.P.				
Non DMPH Districts	**Medical Officer**	**Psychologist**	**Social worker**	**Nurse**
Shivpuri	2	0	0	5
Guna	1	0	0	4
Bhind	2	0	0	2
Ashoknagar	1	--	0	2
Datia	2	--	0	3
Sehore	2	0	0	7
Raisen	1	0	0	2
Vidisha	1	0	0	2
Harda	1	0	0	2
Chindwada	4	0	0	6
Mandla	2	0	0	2
Narsingpur	1	0	0	2
Seoni	1	--	0	2
Dindori	2	--	0	3
Satna*	1	0	0	3
Sidhi	1	0	0	2
Umaria	1	0	0	2
Anuppur	1	--	0	4
Badwani	1	--	0	4
Burhanpur	1	0	0	2
Jhabua	2	0	0	2
Khargone	1	0	0	2
Alirajpur	1	0	0	4
Dewas	1	0	0	5
Ratlam	1	0	0	5
Shajapur	2	0	0	2
Mandsour	1	0	0	2
Agar-Malva	1	--	0	2
Damoh*	1	0	0	4
Tikamgarh	1	0	0	2
Panna	1	0	0	3
Total	**42**	**0**	**0**	**94**

Source: NHM MP, 2018 * Satna Damoh districts have clinical psychologist after March 2018

Table 8: Beds available for IPD for20 DMHP district hospitals	
Infrastructure at DH	**No. of beds allotted**
Gwalior	4
Morena	4
Sheopur	4
Bhopal	4
Betul	4
Hoshangabad	4
Rajgarh	4
Jabalpur	4
Balaghat	4
Katni	4
Rewa	4
Shahdol	4
Singrouli	4
Indore	4
Dhar	4
Khandwa	4
Ujjain	4
Neemuch	4
Sagar	6
Chhatarpur	4
Source: NHM MP, 2018	

Table 9: Beds available for IPD for 31 non DMHP district hospitals	
Infrastructure at DH	**No. of beds allotted**
Shivpuri	4
Guna	4
Bhind	4
Ashoknagar	4
Datia	4
Sehore	4
Raisen	4
Vidisha	4
Harda	4
Chindwada	4
Mandla	4
Narsingpur	4
Seoni	4
Dindori	4
Satna	4
Sidhi	4
Umaria	4
Anuppur	4
Badwani	4
Burhanpur	4
Jhabua	4
Khargone	4
Alirajpur	4
Dewas	4
Ratlam	4
Shajapur	4
Mandsour	4
Agar-Malwa	4
Damoh	4
Tikamgarh	4
Panna	4
Source: NHM MP, 2018	

Table 10: Targeted interventions at community level in 20 DMHP districts of M.P.							
DMHP Districts	**District counselling centre @**	**Crisis helpline$**	**Counselling session in schools**	**Training of master trainers and school teachers in life skills**	**Counselling services in colleges**	**Number of suicide prevention camps**	**Number of Work place stress management sessions**
Gwalior*	No	No	Yes	No	No	No	No
Morena#	Yes	No	Yes	No	Yes	No	No
Sheopur*	No	No	No	No	No	No	No
Bhopal*	Yes	No	Yes	Yes	Yes	No	No
Betul*	No	No	Yes	No	No	No	No
Hoshangabad#	Yes	No	Yes	No	No	No	No
Rajgarh*	No	No	No	No	No	No	No
Jabalpur	Yes	No	Yes	No	No	No	No
Balaghat *	No	No	No	No	No	No	No
Katni*	No	No	No	No	No	No	No
Rewa*	No	No	Yes	No	Yes	No	No
Shahdol*	No	No	Yes	Yes	Yes	No	Yes
Singrouli*	No	No	Yes	No	Yes	No	No
Indore*	No	No	Yes	Yes	Yes	No	No
Dhar	Yes	No	Yes	No	No	No	No
Khandwa*	No	No	No	No	No	No	No
Ujjain	Yes	No	Yes	No	Yes	No	No
Neemuch*	No	No	No	No	Yes	No	No
Sagar*	No	No	Yes	No	Yes	No	No
Chhatarpur*	No	No	No	No	No	No	No

* Functional 1 room for screening and 1 Room available counselling, #under construction $ At district level not functional but state level helpline under process. District counselling centre (sanctioned in 10 districts) ***Source: NHM MP, 2018***

Table 11: Targeted interventions at community level in 31 non DMHP districts of M.P.

Non DMHP Districts	District counselling centre	Crisis helpline#	Counselling session in schools	Training of master trainers and school teachers in life skills	Counselling services in colleges	Number of suicide prevention camps	Number of Workplace stress management sessions
Shivpuri	Yes	No	No	No	No	No	No
Guna	Yes	No	Yes	Yes	Yes	Yes	Yes
Bhind@	No	No	No	No	No	No	No
Ashoknagar@	No	No	No	No	No	No	No
Datia@	No	No	No	No	No	No	No
Sehore	Yes	No	Yes	Yes	Yes	Yes	Yes
Raisen@	No	No	No	No	No	No	No
Vidisha@	No	No	No	No	No	No	No
Harda@	No	No	No	No	No	No	No
Chindwada	Yes	No	Yes	No	No	Yes	Yes
Mandla	Yes	No	No	No	No	No	No
Narsingpur@	No	No	No	No	No	No	No
Seoni@	No	No	No	No	No	No	No
Dindori@	No	No	No	No	No	No	No
Satna	Yes	No	Yes	No	Yes	No	No
Sidhi@	No	No	Yes	Yes	Yes	No	Yes
Umaria@	No	No	Yes	No	Yes	No	No
Anuppur@	No	No	No	No	No	No	No
Badwani	Yes	No	No	No	No	Yes	Ys
Burhanpur@	No	No	Yes	Yes	Yes	No	No
Jhabua@	No	No	Yes	No	No	No	No
Khargone	No	No	No	No	No	No	No
Alirajpur@	No	No	No	No	No	No	No
Dewas	Yes	No	Yes	No	Yes	Yes	Yes
Ratlam	Yes	No	Yes	No	Yes	Yes	Yes
Shajapur@	No	No	No	No	No	No	No
Mandsour@	No	No	No	No	No	Yes	No
Agar-Malva@	No	No	No	No	No	No	No
Damoh	Yes	No	Yes	No	Yes	No	No
Tikamgarh@	No	No	No	No	No	No	No
Panna@	No	No	No	No	No	No	No

@ one room made functional for screening and 1 room available for counselling #At district level not functional but state level helpline under process *Badwani, Mandla 'mankash' under construction ***Source: NHM MP, 2018***

Table 12: Availability of psychotropic drugs in 20 DMHP districts of M.P.				
DMHP Districts	**Psyhcotropic drugs included in DH level essential drug list**	**Psyhcotropic drugs at DH**	**Psyhcotropic drugs at CHC**	**Psyhcotropic drugs at PHC**
Gwalior	Yes	Yes	Yes	Partial
Morena	Yes	Yes	Yes	Partial
Sheopur	Yes	Yes	Yes	Partial
Bhopal	Yes	Yes	Yes	Partial
Betul	Yes	Yes	Yes	Partial
Hoshangabad	Yes	Yes	Yes	Partial
Rajgarh	Yes	Yes	Yes	Partial
Jabalpur	Yes	Yes	Yes	Partial
Balaghat	Yes	Yes	Yes	Partial
Katni	Yes	Yes	Yes	Partial
Rewa	Yes	Yes	Yes	Partial
Shahdol	Yes	Yes	Yes	Partial
Singrouli	Yes	Yes	Yes	Partial
Indore	Yes	Yes	Yes	Partial
Dhar	Yes	Yes	Yes	Partial
Khandwa	Yes	Yes	Yes	Partial
Ujjain	Yes	Yes	Yes	Partial
Neemuch	Yes	Yes	Yes	Partial
Sagar	Yes	Yes	Yes	Partial
Chhatarpur	Yes	Yes	Yes	Partial
Source: NHM MP, 2018				

Table 13: Availability of psychotropic drugs in 31 non DMHP districts of M.P.				
Non DMHP Districts	**Psyhcotropic drugs included in DH level essential drug list**	**Psyhco tropic drugs at DH**	**Psyhco tropic drugs at CHC**	**Psyhco-tropic drugs at PHC**
Shivpuri	Yes	Yes	Yes	Yes (Partial)
Guna	Yes	Yes	Yes	Yes (Partial)
Bhind	Yes	Yes	Yes	Yes (Partial)
Ashoknagar	Yes	Yes	Yes	Yes (Partial)
Datia	Yes	Yes	Yes	Yes (Partial)
Sehore	Yes	Yes	Yes	Yes (Partial)
Raisen	Yes	Yes	Yes	Yes (Partial)
Vidisha	Yes	Yes	Yes	Yes (Partial)
Harda	Yes	Yes	Yes	Yes (Partial)
Chindwada	Yes	Yes	Yes	Yes (Partial)
Mandla	Yes	Yes	Yes	Yes (Partial)
Narsingpur	Yes	Yes	Yes	Yes (Partial)
Seioni	Yes	Yes	Yes	Yes (Partial)
Dindori	Yes	Yes	Yes	Yes (Partial)
Satna	Yes	Yes	Yes	Yes (Partial)
Sidhi	Yes	Yes	Yes	Yes (Partial)
Umaria	Yes	Yes	Yes	Yes (Partial)
Anuppur	Yes	Yes	Yes	Yes (Partial)
Badwani	Yes	Yes	Yes	Yes (Partial)
Burhanpur	Yes	Yes	Yes	Yes (Partial)
Jhabua	Yes	Yes	Yes	Yes (Partial)
Khargone	Yes	Yes	Yes	Yes (Partial)
Alirajpur	Yes	Yes	Yes	Yes (Partial)
Dewas	Yes	Yes	Yes	Yes (Partial)
Ratlam	Yes	Yes	Yes	Yes (Partial)
Shajapur	Yes	Yes	Yes	Yes (Partial)
Mandsour	Yes	Yes	Yes	Yes (Partial)
Agar-Malva	Yes	Yes	Yes	Yes (Partial)
Damoh	Yes	Yes	Yes	Yes (Partial)
Tikamgarh	Yes	Yes	Yes	Yes (Partial)
Panna	Yes	Yes	Yes	Yes (Partial)
Source: NHM MP, 2018				

Table 14: IEC and community mobilization activities in 20 DMHP districts of M.P.						
DMHP Districts	**Procuring and translation of IEC material and distribution**	**Mass media**	**Outdoor media**	**Folk media**	**Interpersonal communication**	**Others**
Gwalior	Yes	Yes	No	No	Yes	No
Morena	Yes	Yes	Yes	Yes	Yes	Yes
Sheopur	Yes	Yes	No	No	Yes	Yes
Bhopal	Yes	Yes	Yes	Yes	Yes	Yes
Betul	Yes	Yes	No	No	Yes	Yes
Hoshangabad	Yes	Yes	Yes	No	Yes	Yes
Rajgarh	Yes	Yes	No	No	Yes	Yes
Jabalpur	Yes	Yes	No	No	Yes	Yes
Balaghat	Yes	Yes	No	No	Yes	Yes
Katni	Yes	Yes	No	No	Yes	Yes
Rewa	Yes	Yes	Yes	Yes	Yes	Yes
Shahdol	Yes	Yes	Yes	No	Yes	Yes
Singrouli	Yes	No	No	No	Yes	Yes
Indore	Yes	Yes	Yes	Yes	Yes	Yes
Dhar	Yes	Yes	Yes	Yes	Yes	Yes
Khandwa	Yes	Yes	Yes	Yes	Yes	Yes
Ujjain	Yes	Yes	No	No	Yes	Yes
Neemuch	Yes	Yes	Yes	Yes	Yes	Yes
Sagar	Yes	Yes	Yes	Yes	Yes	Yes
Chhatarpur	Yes	Yes	No	No	Yes	Yes
Source: NHM MP, 2018						

Table 15: IEC and community mobilization activities in 31 non DMHP districts of M.P.

Non DMHP Districts	Procuring and translation of IEC material and distribution	Mass media	Outdoor media	Folk media	Interpersonal communication	Others
Shivpuri	Yes	Yes	No	No	Yes	No
Guna	Yes	Yes	Yes	Yes	Yes	Yes
Bhind	Yes	Yes	No	No	Yes	Yes
Ashoknagar	Yes	Yes	No	No	No	No
Datia	Yes	Yes	Yes	No	No	No
Sehore	Yes	Yes	Yes	Yes	Yes	Yes
Raisen	Yes	Yes	No	No	Yes	Yes
Vidisha	Yes	Yes	Yes	No	Yes	Yes
Harda	Yes	Yes	No	No	Yes	Yes
Chindwada	Yes	Yes	No	No	Yes	Yes
Mandla	Yes	Yes	No	No	Yes	Yes
Narsingpur	Yes	Yes	No	No	Yes	Yes
Seoni	Yes	Yes	Yes	No	No	No
Dindori	Yes	Yes	No	No	No	No
Satna	Yes	Yes	Yes	Yes	Yes	Yes
Sidhi	Yes	Yes	Yes	No	Yes	Yes
Umaria	Yes	Yes	No	No	Yes	Yes
Anuppur	Yes	No	No	No	No	No
Badwani	Yes	Yes	Yes	Yes	Yes	Yes
Burhanpur	Yes	Yes	Yes	Yes	Yes	Yes
Jhabua	Yes	Yes	Yes	Yes	Yes	Yes
Khargone	Yes	Yes	Yes	Yes	Yes	Yes
Alirajpur	Yes	No	No	No	No	No
Dewas	Yes	Yes	No	No	Yes	Yes
Ratlam	Yes	Yes	Yes	Yes	Yes	Yes
Shajapur	Yes	Yes	No	No	No	No
Mandsour	Yes	Yes	Yes	No	Yes	Yes
Agar-Malva	Yes	Yes	Yes	No	No	No
Damoh	Yes	Yes	Yes	Yes	Yes	Yes
Tikamgarh	Yes	Yes	No	No	No	No
Panna	Yes	Yes	No	No	No	No

Source: NHM MP, 2018

Table 16: Service delivery in 20 DMHP districts (2017-18), M.P.						
DMHP Districts	**New OPD patients**	**Follow up cases in OPD**	**Referred cases to tertiary hospital**	**Total OPD cases**	**Cases with suicidal risk out of total OPD cases**	**IPD**
Gwalior	216	132	3	351	1	0
Morena	254	0	0	254	0	4
Sheopur	177	0	31	208	7	2
Bhopal	665	196	16	877	18	2
Betul	354	21	1	376	33	12
Hoshangabad	84	7	3	94	10	3
Rajgarh	12	3	0	15	0	0
Jabalpur	519	604	0	1123	1	18
Balaghat	0	0	0	0	32	0
Katni	143	66	0	209	22	0
Rewa	1173	2012	0	3185	0	416
Shahdol	95	1	0	96	46	60
Singrouli	125	36	0	161	42	3
Indore	99	0	0	99	37	1
Dhar	198	716	2	916	4	21
Khandwa	702	380	0	1082	125	248
Ujjain	220	558	7	785	2	0
Neemuch	67	2	0	69	0	0
Sagar	298	49	0	347	27	0
Chhatarpur	107	4	4	115	59	30
Total	**5508**	**4787**	**67**	**10362**	**466**	**820**
Source: NHM MP, 2018						

Table 17: Service delivery in 31 non DMHP districts (2017-18), M.P.						
Non DMHP Districts	**New OPD patients**	**Follow up cases in OPD**	**Referred cases to tertiary hospital**	**Total OPD cases**	**Cases with Suicidal Risk out of**	**IPD**
Shivpuri	66	0	0	66	11	0
Guna	304	674	0	978	34	95
Bhind	34	39	5	78	0	0
Ashoknagar	10	7	0	17	0	0
Datia	170	0	0	170	40	5
Sehore	247	483	19	749	2	18
Raisen	5	35	0	40	4	5
Vidisha	23	0	1	24	13	0
Harda	54	0	0	54	30	0
Chindwada	375	301	1	677	131	0
Mandla	44	9	0	53	7	0
Narsingpur	69	6	1	76	1	0
Seoni	149	0	0	149	47	0
Dindori	2	0	1	3	0	0
Satna	92	7	0	99	26	59
Sidhi	43	0	0	38	43	
Umaria	37	0	0	37	5	0
Anuppur	78	0	0	78	51	5
Badwani	49	115	0	164	76	8
Burhanpur	168	78	2	248	44	31
Jhabua	0	0	0	0	0	0
Khargone	115	9	2	126	42	61
Alirajpur	54	0	0	54	6	0
Dewas				0		
Ratlam	645	135	0	780	59	41
Shajapur	122	0	0	122	16	9
Mandsour	224	51	12	287	63	0
Agar-Malva	297	8	0	305	32	0
Damoh	272	56	0	328	71	3
Tikamgarh	62	0	0	62	38	0
Panna	36	0	0	36	0	0
Total	**3846**	**2013**	**44**	**5898**	**892**	**340**
Source: NHM MP, 2018						

Table 18: Quarterly service delivery during 2017-18 in M.P.					
Service delivery at DH (numbers)	**1st Quarter (April to June 2017-18)**	**2nd Quarter (July to Sept 2017-18)**	**3rd Quarter (Oct to Dec 2017-18)**	**4th Quarter (Jan to March 2017-18)**	**(1st April to 31 march 2018)**
New OPD patients	7364	12236	14668	9354	**43622**
Follow up cases in OPD	2883	11340	20384	6800	**41407**
Referred cases to tertiary hospital	104	234	99	111	**548**
Total OPD cases	10351	23810	35151	16265	**85577**
Cases with Suicidal Risk out of total OPD cases	1694	1837	1240	1358	**6129**
IPD	872	2511	1033	1160	**5576**
Source: NHM MP, 2018					

Table 19: Awareness among university and college teachers about symptoms of depression, Sagar (M.P.)												
Sex	**N**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Male	85	76.5	56.5	40.0	36.5	55.3	40.0	37.6	49.4	51.8	51.8	41.2
Female	48	77.1	56.3	54.2	41.7	64.6	47.9	58.3	58.3	60.4	60.4	41.7
Age (in years)												
<25	4	50.0	50.0	50.0	25.0	75.0	25.0	50.0	50.0	25.0	50.0	25.0
26-30	14	78.6	64.3	28.6	50.0	64.3	42.9	64.3	35.7	64.3	42.9	42.9
31-35	32	81.3	65.6	56.3	43.8	65.6	50.0	31.3	59.4	50.0	62.5	40.6
36-40	33	72.7	51.5	45.5	33.3	60.6	36.4	48.5	51.5	60.6	60.6	45.5
>40	49	77.6	51.0	40.8	34.7	49.0	42.9	44.9	53.1	53.1	51.0	38.8
Income (in Rs.)												
<=25000	33	72.7	48.5	33.3	33.3	54.5	30.3	33.3	48.5	45.5	57.6	21.2
25001-30000	14	85.7	57.1	57.1	28.6	57.1	50.0	35.7	50.0	35.7	35.7	42.9
30001-35000	3	100.0	100.0	100.0	66.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0
35001-40000	2	50.0	100.0	50.0	50.0	100.0	0.0	0.0	50.0	100.0	50.0	50.0
>40000	60	75.0	53.3	46.7	41.7	56.7	43.3	50.0	53.3	56.7	58.3	45.0
Caste												
SC	23	69.6	69.6	39.1	43.5	65.2	43.5	47.8	56.5	52.2	60.9	39.1
ST	6	100.0	33.3	33.3	33.3	33.3	33.3	33.3	33.3	33.3	33.3	50.0
OBC	40	67.5	55.0	47.5	35.0	62.5	42.5	42.5	47.5	57.5	57.5	40.0
Other	64	82.8	54.7	46.9	39.1	56.3	43.8	46.9	56.3	56.3	53.1	42.2
Total		**76.1**	**56.0**	**44.8**	**38.1**	**58.2**	**42.4**	**44.8**	**52.2**	**54.5**	**54.5**	**41.0**

1.Feeling sad most of the day or almost every day 2. irritability in behaviour among adults 3. adolescents and children 4 Loss of pleasure in activities that are normally pleasurable 5. Diminished appetite 6. Ideas or acts of self-harm or suicide 7. Guilt and unworthiness, 8. Decreased energy or easily fatigued 9. Bleak and pessimistic views of future 10. Disturbed sleep 11. Person have difficulties carrying out usual work, school, domestic, or social activities

Table 20: Awareness among university and college teachers about symptoms of psychosis, Sagar (M.P.)

Sex	**N**	**1**	**2**	**3**	**4**	**5**	**6**
Male	81	59.3	43.2	42.0	49.4	59.3	55.6
Female	48	58.3	39.6	52.1	52.1	64.6	54.2
Age (in years)							
<25	4	25.0	50.0	0.0	50.0	75.0	25.0
26-30	14	50.0	28.6	42.9	28.6	57.1	64.3
31-35	31	61.3	45.2	51.6	51.6	58.1	54.8
36-40	32	68.8	46.9	46.9	53.1	68.8	62.5
>40	47	55.3	38.3	44.7	55.3	59.6	51.1
Income (in Rs.)							
<=25000	32	40.6	40.6	25.0	53.1	46.9	59.4
25001-30000	14	71.4	28.6	21.4	64.3	50.0	42.9
30001-35000	3	66.7	100.0	33.3	100.0	100.0	66.7
35001-40000	2	50.0	100.0	0.0	50.0	50.0	100.0
>40000	57	64.9	36.8	63.2	47.4	66.7	57.9
Caste							
SC	22	59.1	45.5	54.5	50.0	54.5	68.2
ST	6	50.0	33.3	50.0	33.3	66.7	33.3
OBC	39	56.4	38.5	48.7	51.3	64.1	41.0
Other	62	60.3	42.9	39.7	50.8	60.3	60.3
Total		**56.7**	**40.3**	**44.0**	**48.5**	**59.0**	**53.0**

1. Incoherent or irrelevant speech 2. Beliefs that thoughts are being inserted or broad cast from one's mind
3. Social withdrawal and neglect of usual responsibilities related to work school, domestic or social activities
4. Delusions (misbeliefs/ false beliefs) 5. Withdrawal, agitated disorganized behaviour 6 Hallucinations (seeing or hearing when there is nothing)

Table 21: Awareness among university and college teachers about symptoms of epilepsy, Sagar (M.P.)

Sex	N	**1**	**2**	**3**	**4**	**5**	**6**
Male	78	57.7	33.3	60.3	50.0	48.7	39.7
Female	48	52.1	50.0	70.8	60.4	60.4	35.4
Age (in years)							
<25	4	0.0	50.0	50.0	50.0	50.0	50.0
26-30	14	42.9	50.0	57.1	50.0	35.7	57.1
31-35	29	65.5	41.4	75.9	55.2	51.7	44.8
36-40	31	64.5	41.9	61.3	54.8	58.1	29.0
>40	47	53.2	34.0	63.8	55.3	55.3	34.0
Income (in Rs.)							
<=25000	31	48.4	35.5	64.5	58.1	41.9	41.9
25001-30000	14	71.4	28.6	57.1	28.6	50.0	35.7
30001-35000	3	100.0	100.0	100.0	100.0	66.7	100.0
35001-40000	2	50.0	100.0	50.0	100.0	50.0	50.0
>40000	55	52.7	32.7	67.3	58.2	60.0	27.3
Caste							
SC	22	50.0	31.8	63.6	50.0	50.0	31.8
ST	5	60.0	20.0	40.0	40.0	60.0	20.0
OBC	38	55.3	50.0	60.5	60.5	52.6	52.6
Other	61	57.4	37.7	68.9	52.5	54.1	32.8
Total		**52.2**	**37.3**	**60.4**	**50.7**	**50.0**	**35.8**

1.Loss of impaired consciousness Incontinence of urine and/ or faeces 2. Stiffness, rigidity lasting 1-2 minutes
3. Convulsive movements lasting longer than 1-2 minutes 4. After abnormal movement: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, 5. Headache or muscles ache 6. Tongue bite or self-injury

Table 22: Awareness among university and college teachers about symptoms of development disorders, Sagar (M.P.)				
Sex	**N**	**1**	**2**	**3**
Male	78	79.49	47.44	46.15
Female	47	82.98	65.96	34.04
Age (in years)				
<25	4	25.00	75.00	25.00
26-30	14	78.57	50.00	35.71
31-35	31	93.55	51.61	35.48
36-40	32	75.00	62.50	46.88
>40	44	81.82	50.00	45.45
Income (in Rs.)				
<=25000	33	78.79	33.33	45.45
25001-30000	14	78.57	35.71	28.57
30001-35000	3	100.00	66.67	33.33
35001-40000	1	100.00	100.00	100.00
>40000	54	85.19	66.67	42.59
Caste				
SC	19	78.95	52.63	52.63
ST	6	100.00	33.33	33.33
OBC	40	85.00	60.00	37.50
Other	60	76.67	53.33	41.67
Total		**75.4**	**50.7**	**38.8**

1. Delayed development 2. Difficulties in carrying out everyday activities normal for that age 3. Restrictive repetitive, patterns of behaviour and activities

Table 23: Awareness among university and college teachers about symptoms of dementia, Sagar (M.P.)

Sex	N	1	2	3	4
Male	81	85.2	42.0	45.7	32.1
Female	47	85.1	31.9	42.6	55.3
Age (in years)					
<25	5	40.0	40.0	0.0	40.0
26-30	13	100.0	23.1	46.2	38.5
31-35	30	93.3	23.3	46.7	46.7
36-40	33	75.8	54.5	54.5	42.4
>40	46	87.0	39.1	39.1	34.8
Income (in Rs.)					
<=25000	31	77.4	25.8	29.0	35.5
25001-30000	13	60.0	33.3	53.3	33.3
30001-35000	3	100.0	100.0	66.7	100.0
35001-40000	2	50.0	100.0	50.0	50.0
>40000	58	93.1	32.8	43.1	41.4
Caste					
SC	22	68.2	45.5	59.1	45.5
ST	6	83.3	33.3	33.3	33.3
OBC	38	92.1	39.5	39.5	47.4
Other	62	87.1	35.5	43.5	35.5
Total		**81.3**	**36.6**	**42.5**	**38.8**

1. Decline or problems with memory and orientation (awareness of time, place and person) 2. Mood or behavioural problems such as apathy (appearing uninterested) or irritability 3. Think loss of emotional control- easily upset, irritable or tearful 4. Difficulties in carrying out usual work

Table 24: Awareness among university and college teachers about symptoms of drug disorders, Sagar (M.P.)						
Sex	**N**	**1**	**2**	**3**	**4**	**5**
Male	80	46.3	35.0	45.0	27.5	80.0
Female	47	36.2	63.8	63.8	42.6	78.7
Age (in years)						
<25	4	25.0	50.0	25.0	25.0	75.0
26-30	14	35.7	42.9	64.3	21.4	78.6
31-35	31	32.3	48.4	51.6	29.0	87.1
36-40	31	54.8	38.7	51.6	29.0	77.4
>40	46	43.5	47.8	50.0	43.5	76.1
Income (in Rs.)						
<=25000	34	32.4	23.5	32.4	20.6	91.2
25001-30000	13	30.8	23.1	30.8	15.4	69.2
30001-35000	3	66.7	100.0	100.0	66.7	100.0
35001-40000	2	0.0	16.7	16.7	0.0	16.7
>40000	55	56.4	49.1	61.8	40.0	76.4
Caste						
SC	22	50.0	45.5	40.9	40.9	81.8
ST	6	50.0	33.3	50.0	50.0	50.0
OBC	39	51.3	56.4	61.5	33.3	79.5
Other	60	33.3	40.0	50.0	28.3	81.7
Total		**40.3**	**43.3**	**49.3**	**31.3**	**75.4**

1.Difficulties in carrying out usual work, domestic or social activities 2. Requesting prescription for sedative medicine (sleeping tablets, opiods) 3. Drug use injection marks, skin infection, unkempt appearance is drug use disorder 4. Financial difficulties or crime related legal problems 5. Drug affected (low energy, agitated, fidgeting, slurred speech).

Table 25: Awareness among university and college teachers about symptoms of behaviour disorders, Sagar (M.P.)

Sex	N	1	2	3	4	5
Male	81	56.8	50.6	70.4	44.4	61.7
Female	48	60.4	64.6	60.4	41.7	64.6
Age (in years)						
<25	5	20.0	40.0	40.0	20.0	60.0
26-30	14	50.0	64.3	57.1	57.1	64.3
31-35	31	71.0	58.1	74.2	38.7	64.5
36-40	32	65.6	56.3	65.6	40.6	62.5
>40	46	52.2	52.2	69.6	45.7	60.9
Income (in Rs.)						
<=25000	33	45.5	48.5	66.7	36.4	54.5
25001-30000	13	38.5	46.2	84.6	7.7	61.5
30001-35000	3	100.0	100.0	66.7	100.0	100.0
35001-40000	2	50.0	100.0	50.0	50.0	100.0
>40000	57	70.2	54.4	64.9	52.6	59.6
Caste						
SC	22	50.0	59.1	63.6	45.5	59.1
ST	6	66.7	33.3	66.7	50.0	33.3
OBC	39	64.1	56.4	69.2	48.7	61.5
Other	62	56.5	56.5	66.1	38.7	67.7
Total		**56.0**	**53.7**	**64.2**	**41.8**	**60.4**

1. Excessive inattention and absentmindedness, repeatedly stopping tasks before completion and switching to other activities 2. Excessive impulsivity frequently doing things without forethought
3. Excessive overactivity excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting 4. Repeated and continued behaviour that disturbs others (unusually frequent and severe temper tantrums, cruel behaviour, persistent and severe disobedience, stealing 5. Sudden changes in behaviour or peer relations, including withdrawal and anger

Table 26: Awareness among university and college teachers about symptoms of alcohol disorders, Sagar (M.P.)

Sex	**N**	**1**	**2**	**3**	**4**
Male	81	48.1	21.0	50.6	76.5
Female	47	38.3	27.7	61.7	87.2
Age (in years)					
<25	5	40.0	20.0	20.0	60.0
26-30	14	50.0	14.3	50.0	85.7
31-35	30	43.3	33.3	50.0	83.3
36-40	32	40.6	15.6	59.4	78.1
>40	46	47.8	26.1	58.7	80.4
Income (in Rs.)					
<=25000	34	41.2	29.4	50.0	88.2
25001-30000	13	30.8	15.4	53.8	76.9
30001-35000	3	33.3	66.7	100.0	100.0
35001-40000	2	0.0	0.0	50.0	50.0
>40000	55	52.7	16.4	50.9	78.2
Caste					
SC	22	50.0	31.8	63.6	77.3
ST	5	60.0	20.0	40.0	60.0
OBC	40	57.5	30.0	52.5	77.5
Other	61	32.8	16.4	54.1	85.2
Total		**42.5**	**22.4**	**52.2**	**76.9**

1. Difficulties in carrying out usual work, school domestic or social activities 2. Presence with an injury 3. Somatic (bodily/ physical) symptoms 4. Appearance to be under the influence of alcohol (smell of alcohol, looks intoxicated, hangover)

Table 27: Awareness among university and college teachers about sign of self-harm or suicidal behaviour, Sagar (M.P.)			
Sex	**N**	**1**	**2**
Male	74	74.3	63.5
Female	41	82.9	61.0
Age (in years)			
<25	5	100.0	20.0
26-30	13	69.2	61.5
31-35	28	89.3	50.0
36-40	29	75.9	65.5
>40	39	69.2	74.4
Income (in Rs.)			
<=25000	30	76.7	46.7
25001-30000	12	66.7	58.3
30001-35000	3	100.0	100.0
35001-40000	2	100.0	50.0
>40000	48	75.0	72.9
Caste			
SC	21	71.4	57.1
ST	5	80.0	40.0
OBC	37	86.5	56.8
Other	52	73.1	71.2
Total		**66.4**	**53.7**

1. Current thoughts or plan to commit suicide are signs of self-harm or suicide behaviour 2. History of thoughts or plan of self-harm plan in the past month or act of self-harm in the past year are signs of self-harm or suicide behaviour

Table 28: Attitude towards mental disorders among university and college, Sagar (M.P.)			
Attitude towards mental disorders	**Agree**	**Disagree**	**Can't Say**
Mental illness is a sign of personal weakness	61.2	24.6	10.4
Mental illness is not a real medical illness	24.6	52.2	15.7
People with a mental illness are dangerous	37.3	40.3	12.7
If you had mental illness you would not tell anyone	9.7	71.6	11.9
Seeing a mental health professional means you are not strong enough to manage/ control your own difficulties	26.1	53.0	14.2
If you had a mental illness, you would not seek help from a mental health professional	12.7	74.6	6.7
It is best to avoid people with a mental illness so that you don't become ill	17.9	64.9	10.4
Treatment for a mental illness, provided by a mental health professional, would not be effective	7.5	71.6	14.2
Women in India are more prone to mental disorder than men	32.1	33.6	25.4
Men in India are more prone to mental disorder than women	20.9	45.5	25.4

***Information given by you will be kept confidential** *Confidential: For research purpose only*

* **Please read the question carefully before giving your answer** **ANNEXURE**

जनसंख्या अनुसंधान केन्द्र

POPULATION RESEARCH CENTRE

स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार, नईदिल्ली

(Ministry of Health and Family Welfare, Government of India, New Delhi)

डॉ. हरीसिंह गौर विश्वविद्यालय, सागर म.प्र.

Dr. Harisingh Gour Vishwavidayalaya, Sagar

Awareness and Attitude towards Mental Health Disorders

A. Personal Information	
1. Name of the Respondent_____	
2. Place of Residence_____	
3. Age in Years_____	
4. Sex: 1. Male 2. Female (Place the code in the box)	
5. Marital Status: 1. Unmarried 2. Married 3. Divorced/ Separated 4. Widowed	
6. Type of Family: 1. Joint Family 2. Nuclear Family	
7. Religion: 1. Hindu 2. Muslim 3. Sikh 4. Christian 5 Other	
8. Caste: 1.SC 2. ST 3. OBC 4. Other	
9. Education Level of Respondent: 1. Graduate 2. Post graduate 3. Other	
10. Occupation: Government Service 2. Private Service 3. Business 4. Other	
11. Monthly Income in Rs. _____	

Consent

Population Research Centre, Dr. H.S. Gour Central University Sagar is conducting this study in in M.P. to understand the general awareness and attitude towards mental disorders and mental health issues. Results of this study will help the state government to strengthen the mental health programme in all districts of Madhya Pradesh and provide comprehensive mental health services. **This questionnaire is self-administered and all questions must be answered.** It will take 30-40 minutes to complete this questionnaire. Your participation is voluntary, which means you may accept or disagree to participate. The information given by you will be kept fully confidential. If you have any questions about the study you may ask me.

Are you willing to participate in the study? Yes/ No

If yes, proceed to the next section, if no return the questionnaire

Date of Interview_____ Sig. of Interviewer Sig of Respondent

Section B

Awareness about Mental Health Disorders

Given below are 46 statements which indicate symptoms of different types of mental health disorders.Please tick (✓) in the box on the right hand side for all those symptoms which you think specify a particular type of disorder.

Which of the following are signs of depression?		
1,	Feeling sad most of the day or almost every day, irritability in behaviour among adults, adolescents and children	
2.	Reduced concentration and attention	
3.	Loss of pleasure in activities that are normally pleasurable	
4.	Diminished appetite	
5.	Ideas or acts of self-harm or suicide	
6.	Guilt and unworthiness	
7.	Decreased energy or easily fatigued	
8.	Bleak and pessimistic views of future	
9.	Disturbed sleep	
10.	Reduced self- esteem and self-confidence	
11.	Person have difficulties carrying out usual work, school, domestic, or social activities	
Which of the following are signs of severe metal disorder /psychosis?		
12.	Incoherent or irrelevant speech	
13.	Beliefs that thoughts are being inserted or broad cast from one's mind	
14.	Social withdrawal and neglect of usual responsibilities related to work school, domestic or social activities	
15.	Delusions (misbeliefs/ false beliefs)	
16.	Withdrawal, agitated disorganized behaviour	
17.	Hallucinations (seeing or hearing when there is nothing)	
Which of the following are signs of epilepsy?		
18.	Loss of impaired consciousness	
19.	Incontinence of urine and/ or faeces	
20.	Stiffness, rigidity lasting 1-2 minutes	
21.	Convulsive movements lasting longer than 1-2 minutes	
22.	After abnormal movement: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache or muscles ache	
23.	Tongue bite or self-injury	
Which of the following are signs of developmental disorder?		
24.	Delayed development: much slower learning than other children of same age in activities such as: smiling, neck holding, sitting, walking,	

	talking, communication, and other area of development, such as reading and writing	
25.	Difficulties in carrying out everyday activities normal for that age	
26.	Restrictive repetitive, patterns of behaviour and activities	
Which of the following are signs of dementia/ loss of memory?		
27.	Decline or problems with memory and orientation (awareness of time, place and person)	
28.	Mood or behavioural problems such as apathy (appearing uninterested) or irritability	
29.	Do you think loss of emotional control- easily upset, irritable or tearful	
30.	Difficulties in carrying out usual work	
Which of the following are signs of drug use disorder?		
31.	Difficulties in carrying out usual work, domestic or social activities	
32.	Requesting prescription for sedative medicine (sleeping tablets, opiods)	
33.	Drug use injection marks, skin infection, unkempt appearance is drug use disorder	
34.	Financial difficulties or crime related legal problems	
35.	Drug affected (low energy, agitated, fidgeting, slurred speech)	
Which of the following are signs of behavioral disorder?		
36.	Excessive inattention and absentmindedness, repeatedly stopping tasks before completion and switching to other activities	
37.	Excessive impulsivity: frequently doing things without forethought	
38.	Excessive overactivity: excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting	
39.	Repeated and continued behaviour that disturbs others (unusually frequent and severe temper tantrums, cruel behaviour, persistent and severe disobedience, stealing	
40.	Sudden changes in behaviour or peer relations, including withdrawal and anger	
Which of the following are signs of alcohol disorder ?		
41.	Difficulties in carrying out usual work, school domestic or social activities	
	Presence with an injury	
42.	Somatic (bodily/ physical) symptoms	
43.	Appearance to be under the influence of alcohol (eg. smell of alcohol, looks intoxicated, hangover)	
Which of the following are signs self harm or suicide ?		
45.	Current thoughts or plan to commit suicide are signs of self-harm or suicide behaviour	
46.	History of thoughts or plan of self-harm plan in the past month or act of self-harm in the past year are signs of self-harm or suicide behaviour	

Section C

Attitude towards Mental Disorders/ Illness

Write 1 if you agree, '2' disagree and '3' Can't Say for statements given below

1.	Mental illness is a sign of personal weakness	
2.	Mental illness is not a real medical illness	
3.	People with a mental illness are dangerous	
4.	It is best to avoid people with a mental illness so that you don't develop this problem	
5.	If you had mental illness you would not tell anyone	
6.	Seeing a mental health professional means you are not strong enough to manage/ control your own difficulties	
7.	If you had a mental illness, you would not seek help from a mental health professional	
8.	Treatment for a mental illness, provided by a mental health professional, would not be effective	
9.	Women in India are more prone to mental disorder than men	
10.	Men in India are more prone to mental disorder than women	

Section D

Source of Information and Treatment of Mental Disorders

1. What according to you are the causes of mental illness?

_____

_____

2. In which age does mental illness generally occur?

_____

_____

3. Are mental disorders completely curable? (Yes/No). If yes generally how long does it take to cure completely?

_____

_____

4. Do you know where to seek information and services about mental disorders in your city /district? Please provide details.

_____

_____

5. Do you know where to seek information and services about mental disorders outside the city where you reside? Please provide details.

_____

_____

6. Have you heard about 'mankaksh' services? (Yes/No). If Yes what services are being provided by 'mankaksh'?

   _____

   _____

7. Are you aware of some counselling centres for providing services for mental disorders (Yes/No)? If Yes what services are being provided by these?

   _____

   _____

8. Do you think that mental health services should be provided with other health services? Give reasons.

   _____

   _____

9. Do you think there are societal taboos, misconceptions, and stigmas related to mental health? (Yes/No). If Yes, give suggestions for removing these taboos and stigmas.

   _____

   _____

10. Is publicity and propaganda essential for mental health? (Yes/No). If Yes, why

    _____

    _____

District Mental Health Programme in M.P.