ABSTRACT

National Health Mission - Tamil Nadu State Mental Health Care Policy and Implementation Frame Work – Approved - Orders – Issued.

HEALTH AND FAMILY WELFARE (EAPI-2) DEPARTMENT

G.O.(Ms).No.301 Dated: 04.07.2019
Thiruvalluvar Aandu – 2050
Vihari, Aani – 19

Read :

From the Project Director, Reproductive Child Health / Mission Director, National Health Mission, letter Ref.No.4584/ P9/NHM/2018, dated: 15.02.2019

ORDER:

The Mental Health Care Policy envisages that Mental Health and promotion of well-being have been included as part of the sustainable development goals (SDGs) indicating a global thrust on allocating resources to the sectors a part of national development plans. In India, on February 2017, the Supreme Court of India has directed the Centre of frame a Policy for rehabilitation of people who recovered yet living for long periods in these facilities. The Centre has recently also notified progressive laws pertaining to both disability and mental health that attempt to be in consonance with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD), which offers an emphasis on rights, social security, access to services and equitable living in society. These developments offer an unparalleled opportunity to implement systematic plans that can convert the vision and objectives of this state Mental Health Care Policy into actual reality which would benefit all those affected by mental illnesses, their families and caregivers and deliver comprehensive solutions based on a recovery perspective emphasizing on meaningful inclusive and satisfying lives for people with mental illness.

The State Mental Health Policy's stated vision is:-

> " To promote mental health, prevent mental illness, enable recovery from mental illness, promote de stigmatization and desegregation, and ensure socio economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life span, within a rights based framework "

2. In the letter read above, the Project Director, Reproductive Child Health / Mission Director, National Health Mission has furnished the Draft Tamil Nadu State Mental Health Care Policy and Implementation Frame Work and has requested to approve the same.

3. The Government, after careful examination have decided to approve the Tamil Nadu State Mental Health Care Policy and Implementation Frame Work as annexed to this Government, order.

(BY ORDER OF THE GOVERNOR)

BEELA RAJESH
SECRETARY TO GOVERNMENT

To
The Director, State Health Society, Chennai-6
The Director, Institute of Mental Health, Chenai-10
The Member Secretary, State Mental Health Authority, Chennai-10
The State Commissioner for Disabled, Chennai-5
The Director of Medical Education, Chennai-10
Copy to
Health and Family Welfare (Z/ EAP-II/Data Cell) Department, Chennai-9
SF/SC

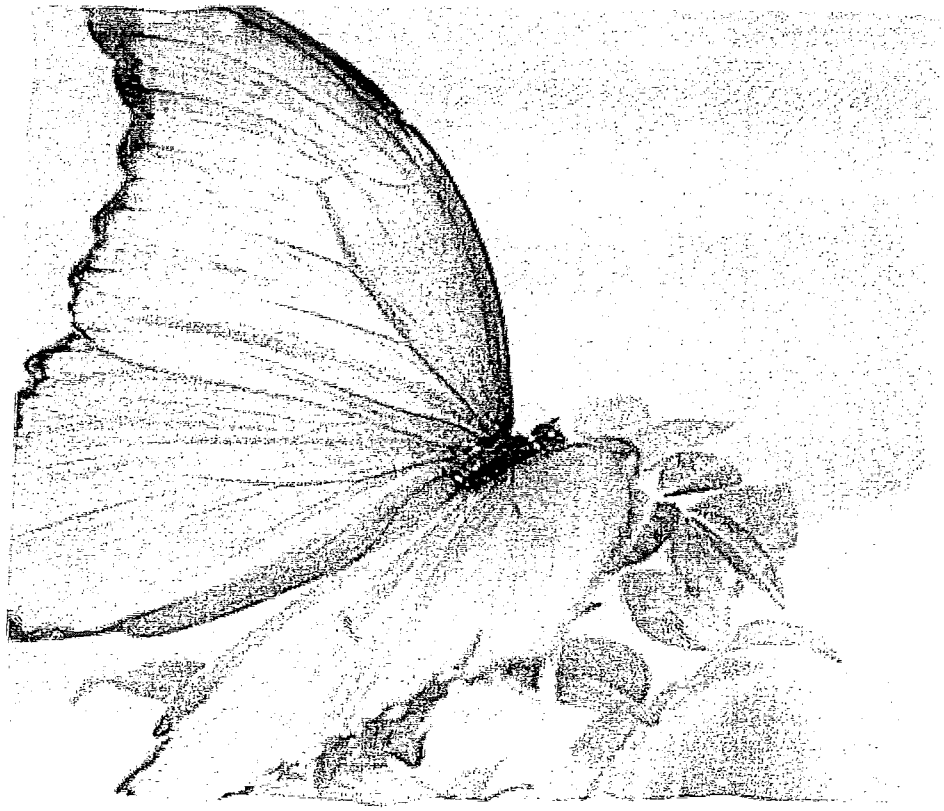
//FORWARDED BY ORDER //

SECTION OFFICER

ANNEXURE-I

G.O. (Ms) No.301, HEALTH AND FAMILY WELFARE (EAPI-2) DEPARTMENT, DATED: 04.07.2019

TAMILNADU MENTAL HEALTH CARE POLICY & IMPLEMENTATION FRAMEWORK



Abbreviation:

WHO – World Health Organisation

mhGAP – Mental health Gap Action Programme

DCC – Day Care Centre

DMHP - District Mental Health Programme

ECRC – Emergency Care and Recovery Centre

ICMR – Indian Council of Medical Research

IEC- Information, Education and Communication

NMHP – National Mental Health Programme

NMHS - National Mental Health Survey

IMH – Institute of Mental Health

COE – Centre Of Excellence

RBSK - Rashtriya Bal Swasthya Karyakram

RKSK - Rashtriya Kishor Swasthya Karyakram

SSA - Sarva Shiksha Abhiyan

UNCRPD – Convention on the Rights of Persons with Disabilities

YLL – Years of Life Lost

YLD – Years Lost due to Disability

IMR – Infant Mortality Rate

MMR – Maternal Mortality Rate

CONTENTS

EXECUTIVE SUMMARY

In recent years, mental health has gained prominence as a public health priority with mental disorders accounting for 13% of years lost due to disease worldwide.[1] The situation is particularly stark in low and medium income countries such as India with 90% of people with mental health issues not receiving interventions that they require to regain health.[2] According to the Indian Council of Medical Research (ICMR) report released in 2017, suicides account for the second highest in the top ten causes of years of life lost (YLL) in Tamil Nadu in 2016. Depressive disorders, anxiety disorders and schizophrenia account for top fourth, tenth and fifteenth causes of years lived with disability (YLD) in Tamil Nadu.[3]

For over thirty years, there has been a thrust on increasing access to mental health care through community based services. Yet in 2017, while there are an estimated 150 million Indians living with mental disorders,[4] less than 10% of people with common mental disorders and only 40-50% of people with schizophrenia are estimated to be accessing any form of care.[5] Chronicity of the disease, low work participation and high career burnout foment pervasive negative notions of mental ill health and stigmatizing attitudes that affect help seeking behaviour, to perpetuate a vicious cycle of prolonged therapy and suboptimal gains among people living with mental health issues.[6]

Mental health and promotion of well-being have been included as part of the Sustainable Development Goals (SDGs) indicating a global thrust on allocating resources to the sector as part of national development plans. In India, on February 2017, the Supreme Court of India has directed the Centre to frame a policy for rehabilitation of people who recovered yet living for long periods in these facilities. The Centre has recently also notified progressive laws pertaining to both disability and mental health that attempt to be in consonance with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD), which offers an emphasis on rights, social security, access to services and equitable living in society. These developments offer an unparalleled opportunity to implement systematic plans that can convert the vision and objectives of this State Mental Health Care Policy into actual reality which would benefit all those affected by mental illnesses, their families and caregivers.

The recently concluded National Mental Health Survey 2015-16 notes some redeeming features in Tamil Nadu, such as the availability of 68% of essential psychotropic medication at Primary Health Center level, higher density of health workforce and highest number of institutes offering postgraduates studies in Psychiatry.[7]

It is also formed a State Mental Health Authority (SMHA), Mental Health Review Board (MHRB), has implemented the District Mental Health Programme (DMHP) in all districts and has an apex training centre, the Institute of Mental Health in Chennai. However, despite making rapid strides in health indicators like IMR,

MMR, and control of communicable diseases, we are yet to register its foot print successfully on mental health. This is partly due to constraints in manpower and infrastructural facilities and partly due to other associated community factors such as stigma, discrimination and lack of awareness as explained elsewhere

To advance mental health in Tamil Nadu, there is a need for committed and concerted effort to accelerate changes in systems, state wide to enable conducive structure and environment that can spiritedly absorb and deliver comprehensive solutions based on a recovery perspective emphasizing on meaningful, inclusive and satisfying lives for people with mental illness. The state mental health policy's stated vision is:

"To promote mental health, prevent mental illness, enable recovery from mental illness, promote de stigmatization and desegregation, and ensure socio economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life span, within a rights based framework".

The following priority areas for action have been identified in keeping with the vision of the policy, the Mental Health Care Act 2017 and the emphasis on full participation and access to necessary support for independent living in the United Nations Convention on Rights of Persons with Disability (UNCRPD).

1.Vigo, Daniel, Graham Thornicroft, and Rifat Atun. "Estimating the true global burden of mental illness. "The lancet Psychiatry 3.2 (2016): 171-178

2.Demyttenaere, Koen, et al. "Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. "Jama 291.21 (2004): 2581-2590.

3.India: Health of the Nations's States, The India State level Disease Burden initiative, 2017

4.Gururaj, G., et al. "National Mental Health Survey of India, 2015-16: Summary. "Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication 128 (2016)

5.Patel, Vikram, et al."The magnitude of and health system responses to the mental health treatment gap in adults in India and China. " The Lancet 388 10063 (2016): 3074-3084.

6.Slade, Mike, Michaela Amering, and Lindsay Oades. "Recovery: a international perspective. " Epidemiology and Psychiatric Sciences 17.2 (2008): 128-137.

7.Gururaj, G., et al. "National Mental Health Survey of India, 2015-16: Summary. "Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication 128 (2016)

PRIORITY AREAS FOR ACTION

1. Creation of a coordination unit:

A dedicated unit at the State level is necessary to further improve mental health care in the state.. Hence, appointment of a dedicated coordinating unit with additional technical and administrative expertise to ensure adequate mental health care in the State shall be done.

2. Organisation of services and system strengthening:

Four regional centers of excellence will be established at Vellore, Coimbatore, Theni and Thanjavur. Steps will be taken to strengthen the mental health services at department of psychiatry at medical college hospital, district headquarters hospitals and Taluk hospitals. Relying solely on specialists to provide services for people would prevent millions of people from accessing the services they need. Hence, WHO mhGAP would be adopted and adapted according to the need of our population and the context of the state. Medical and non-medical personnel involved in primary health care services will be trained to identify mental health problems and refer patients appropritately to psychiatrists at Taluk level or district level. Steps will be taken to increase the number of Psychiatrists posted in peripheral areas.

3. Health promotion and prevention activities – promoting positive mental health:

Information, education and communication (IEC) activities will be undertaken to fight against stigma and bring awareness in the community about mental health and mental illness and eliminate discrimination against people with mental illness. Screening of vulnerable population will be done and intervention carried out, if necessary. Mental health promotion activities will be undertaken in schools, colleges and work places. This will be done in liaison with Education Department. Also Teams for IEC will be established with voluntary participation from local colleges and schools.

4. Treatment and Rehabilitation services:

Emergency care and recovery centres (ECRC) will be established to treat homeless mentally ill people who will be rescued, rehabilitated and reintegrated with their family. Evidence based effective suicide prevention strategies will be formulated and put in place to reduce mortality related to suicide. Day care centres (DCC), sheltered workshops, short term residential centres will be established. These will provide rehabilitation and recovery services to persons with mental illness so that the initial intervention with drug & psychotherapy is followed up and relapse is prevented. It will also provide opportunity for people recovering from mental illness for successful community living.

5. Making Mental Healthcare inclusive of all

Many vulnerable communities such as the LGBTI+ community have historically found mental health care discriminating and stigmatizing. Hence, efforts will be made, specific to each and every such vulnerable and underserved community to enable equal access to mental health.

6. Data for Mental Health:

Uniform and mandatory registry will be set up at all levels to capture data on the mental illness. This dedicated registry will be reviewed every 12 months and the data analyzed. This shall inform the policy makers to bring necessary changes in the delivery of mental health services by planning the programmes, allocating necessary budget and providing inclusive care for all affected by mental illness.

7.Research:

A comprehensive research agenda for mental health would be developed and implemented. Equitable funds for promoting mental health research shall be committed. Investment will be made in building research capacity. Mechanisms for dissemination of research findings and for translating research findings into action at the service delivery level shall be developed.

BACKGROUND

The World Health Organisation (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'* (WHO 2001).

According to WHO, mental health problems occur as a result of an interaction between genetic, biological, psychological, and adverse social and environmental factors that shape an individual's personal make-up and lead to poor quality of life, disability and even death (WHO 2005). Mental health problems affect a large number of people across all age groups in Tamil Nadu and hence constitute a significant public health burden.

The Tamil Nadu State Mental Health Care Policy and Implementation framework has been framed along the lines of the National Mental Health Policy of India *'New Pathways New Hope'*, 2014. India is a signatory of the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD), which aims at provision of all mental health services putting the patient first, placing emphasis on keeping human rights intact, focusing on a social model of disability in order to identify and remove social barriers (rather than the conventional way of medical model of disability – where the impairment is seen as a barrier) and emphasizes the need for equality in provision of services.

The evidence is strong across all the recent activities, such as the National Mental Health Policy and India being a signatory participant of the UNCRPD that the burden of mental illness is huge and continues to rise in our country. The Tamil Nadu State Mental Health care policy and Implementation Framework will guide our implementation strategies for the next seven to ten years in Tamil Nadu.

SITUATION ANALYSIS

Global scenario:

Mental, neurological and substance abuse disorders affect more than 20% of all people at some point during their life time. In addition, it is estimated that about 10% of adult and child population at any given time suffer from at least one mental disorder, as defined in the International Statistical Classification of Diseases and related Health problems (WHO 2001). Mental disorders account for nearly 12% of the global burden of disease. By 2020 they will account for nearly 15% of disability-adjusted life-years lost to illness. It is also found that the burden of mental disorders is maximal in young adults who are the most productive section of the population. Moreover, developing countries are likely to see a disproportionately large increase in the burden attributable to mental disorders in the coming decade which raises huge concern.

Indian context:

According to National Mental Health Survey of India conducted in 2015-2016, the prevalence of mental morbidity is 10.6% among adults and 7.3% among adolescents in India. This indicates that 1 among 10 people are suffering from mental health problems. Accordingly, an estimated 150 million Indians require mental health care at any given point of time and this includes both acute care and long term rehabilitation services. High suicidal risk is also an increasing concern in India. Nearly 1% of population is at high suicidal risk, warranting the need for multi sectorial actions.

According to "India: Health of the Nation's States report" released by Indian Council of Medical Research in 2017, depressive disorders & anxiety disorders are the 7th & 9th most common cause respectively in causing most years lived with disability in Empowered Action Group(EAG) states and north east states.Whereas depressive disorders stand 5th in causing most years lived with disability in other states. At least half of those with a mental disorder reported disability in all three domains of life such as work, social and family life.

The productive age groups of 30 – 49 years are affected most. Even though mental disorders are seen in all age groups, the weighted prevalence in the age group of 30 – 39 years and 40 – 49 years was higher, to the extent of 11.58 % and 14.48 %, respectively. Moreover, the median expenditure for each visit to a health care provider ranged from Rs.500 for psychoses and alcohol use disorders to Rs.1200 for Bipolar affective disorder. For any category of mental disorder Rs.1000 and above had to be spent for care and treatment which is a significant amount in the light of the relationship between poverty and mental illness. All these factors contribute to increased economic burden due to mental illness.

High treatment gap:

In such a scenario, treatment gap for mental disorders still remains very high which is found to be 83%. There are various barriers that are attributed to the wide treatment gap.

The key demand side barriers include low perceived need due to limited awareness, socio-cultural beliefs, values and stigma, while the supply side barriers include insufficient, inequitably distributed, and inefficiently used resources. Studies from India have reported that primary health care professionals are often inadequately trained, and reluctant or unable to detèct, diagnose, or manage common mental disorders. Most of the people with mental health problems usually underwent unnecessary treatment mainly faith healing before getting professional care. Cost and distance factors (20-40 kilometers for treatment) are also as important barriers for mental health help seeking. All these factors contribute to a delay in help-seeking.

Context in Tamil Nadu:

According to National Mental Health Survey of India 2015-16, the prevalence of mental morbidity in Tamil Nadu is 11.8% among adults which is above the national average. According to "India: Health of the Nation's States report" released by Indian Council of Medical Research (ICMR) in 2017, suicide is the 2nd leading cause of most years of life lost. Depressive disorders & anxiety disorders are the 4th & 10th most common cause respectively in causing most years lived with disability.

Nearly 67 lakh adults (18 years and above) and 3.8 lakh adolescents are likely to be suffering from one or more mental health problems in Tamil Nadu. Schizophrenia and other Psychotic disorders are higher in females than among males (0.4% vs. 0.3%) and it is in the age group of 30-39 years (0.7%). Prevalence of mood disorders was found to be 4.5 % and substance use disorders was found to be 11.3%.

In view of the above, the Tamil Nadu State Mental health policy will provide the strategies and time bound plans with implementation framework which is aimed at expansion of services that promote greater efficiency and coverage with most appropriate interventions that promote social and economic inclusion. The policy will be firmly rooted in the principles of preserving the human rights of both the patient and caregivers.

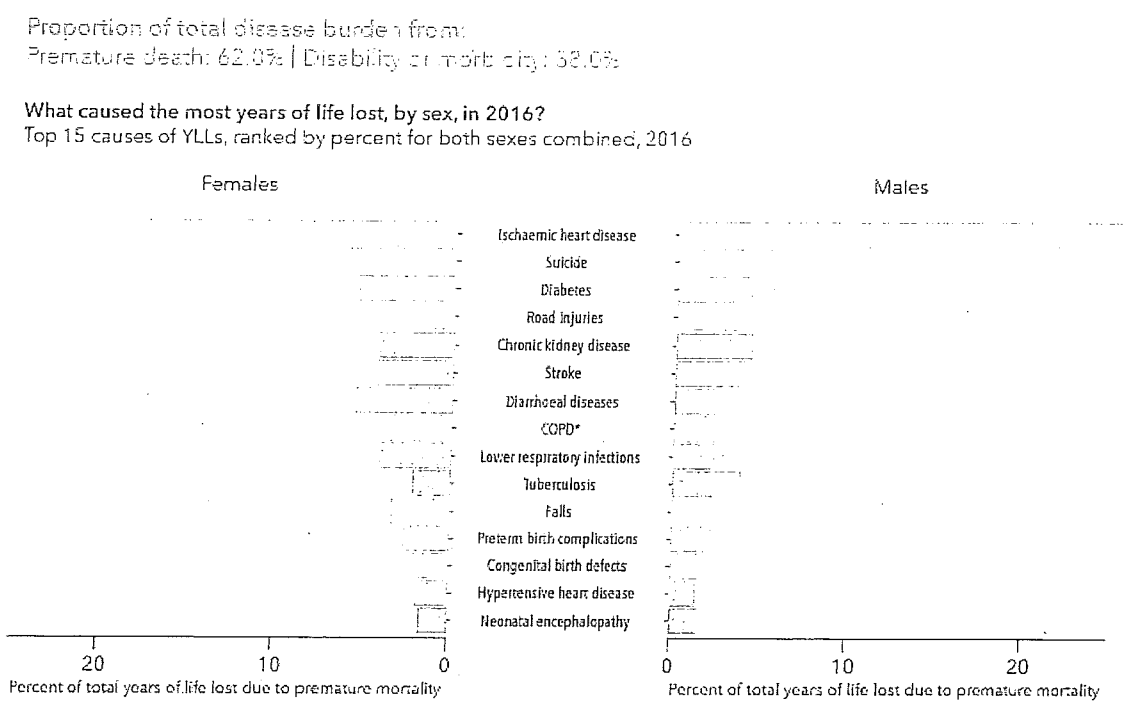


Figure 1: Global Burden of Diseases study in Tamil Nadu shows that mental health disorders contributing to many Years of life lost (YLLs) in 2016, ***India: Health of the Nation's States, The India State level Disease Burden initiative, 2017***

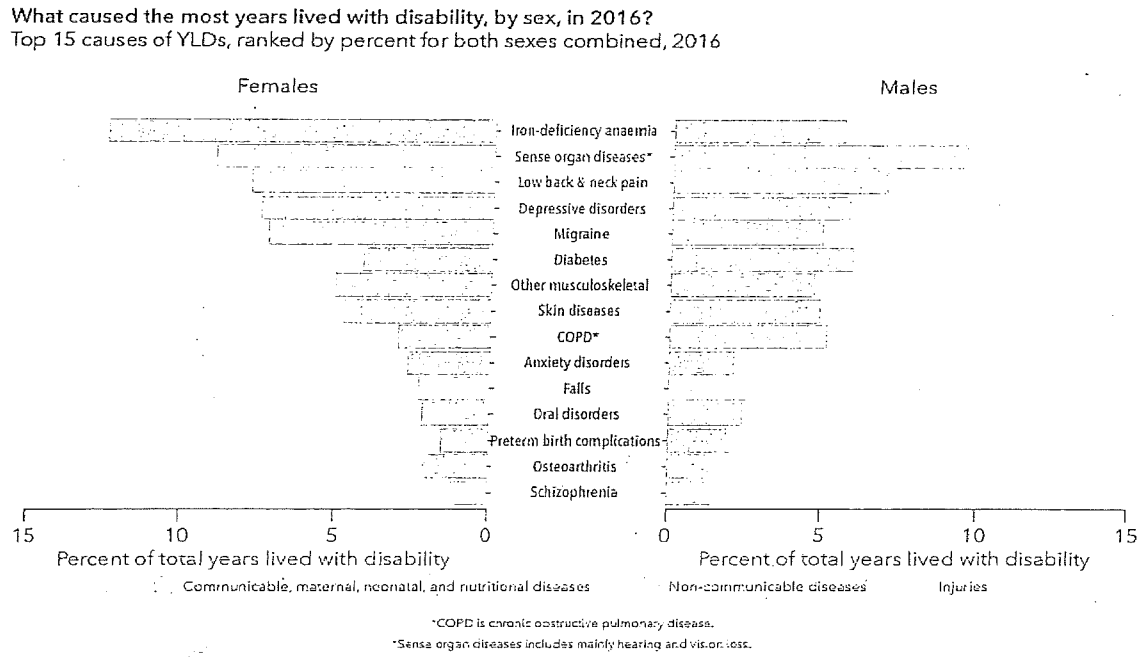


Figure 2: Global Burden of Diseases study in Tamil Nadu shows that 3-4 mental health disorders contribute to many Years Lived with Disability (YLD) in 2016. ***India: Health of the Nation's States, The India State level Disease Burden initiative, 2017***

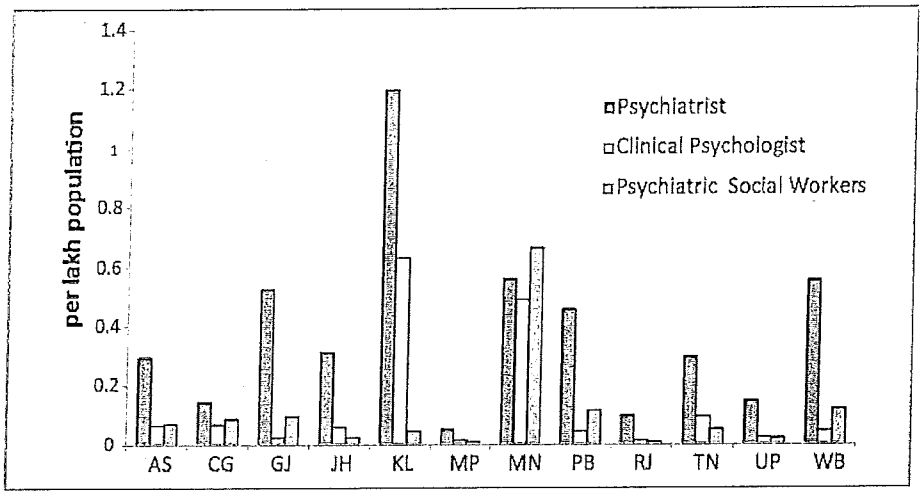


Figure 3:Mental health specialist human resources in NMHS States (per lakh population)

- *National Mental Health Survey, NIMHANS, 2016*

Key barriers to increasing mental health services:

Challenges at the level of population	Challenges at the level of health provider
❑ Lack of awareness about disease. Questions such as 'When to seek treatment and where?' does not arise among public ❑ Stigma and discrimination against patients and families ❑ Variation in access to mental health facilities	❑ Inadequate human resources for mental health: lack of sufficient number ofpsychiatrists in rural areas, clinical psychologists, counselors, psychiatric social workers and mental health trained nurses. ❑ Inadequate facilities for mental health including psychosocial rehabilitation settings ❑ Lack of community-oriented mental health care ❑ Lack of integration with primary care, especially in psychiatric medical education(both UG and PG) ❑ Lack of public mental health leadership ❑ Absence of mental health from the public health agenda and the implications for funding

Access	Human Resources for Health (HRH)	Availability of data
- Sparse distribution of mental health facilities and health providers. - In spite of many steps taken towards district hospital strengthening, uniform availability of dedicated beds for psychiatric care is not seen in all District hospitals.	- Unavailability of trained psychiatrists, clinical psychologists, psychiatric social workers - All taluk hospitals need to be equipped to provide basic psychiatric care.	- Good quality data is required to understand diseases burden in different districts, monitor health services and to reallocate Human Resource and funding respectively. At present, this is a challenge to implement our activities in a successful manner.

VISION

In line with the National Mental Health Policy, the vision of Tamil Nadu Mental Health Care Policy is to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life span, within a rights-based framework, as envisaged in the Mental Health Act, 2017.

Values and principles:

1.1. **Equity:** The principle of equity is meant to ensure universal health coverage for all. Services shall be provided equally to all individuals in a community irrespective of their age, gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or geographical location or any other basis. Focus will be on inclusiveness, non-discrimination, social accountability, and gender equality. It would also be provided in a manner that is acceptable to persons with mental illness and their families and care-givers.

1.2. **Justice:** The needs of vulnerable and excluded members of the community shall receive particular attention.

1.3. **Integrated care:** Mental health services shall be provided within the existing health care system using the primary health care approach. Some mental illnesses are chronic in nature. Persons suffering from chronic illness would require provisions for medium and long term, in some cases even lifelong care. The provision of services shall keep this requirement in consideration. These services will espouse the principles of universal access, equitable distribution, community participation, inter sectoral coordination and use of appropriate technology. It is essential to make mental health services universally available and accessible in a time bound manner. Mental health services shall be comprehensive and address the needs of persons with mental illness, their care providers and health care professionals.

1.4. **Evidence based care:** Decision-making shall be based on various evidences for instance: findings from research, practice-based evidence and feedback from clients.

1.5. **Quality:** Mental health services would meet quality standards as mandated globally and perceived suitable by local users and caregivers.

1.6. **Participatory and rights-based approach:** Service users and caregivers shall be involved in the planning, development, delivery, monitoring and evaluation of mental health services. Human rights and dignity of persons with mental health problems will be respected, protected and promoted. Mental health care will promote and protect the autonomy and liberty of persons with mental health problems. The rights of the caregiver and service provider will also be respected by ensuring good working conditions, adequate training and support.

1.7. **Governance and effective delivery:** The State Government has a major role in taking action for promotion of mental health, prevention and treatment of mental illness in the country. However, Government alone cannot ensure effective delivery. Other stakeholders such as private care providers, civil

society organisations, user groups, academic and research institutions also have a crucial role in delivery and guiding policy. Services and professionals involved in health care planning and delivery whether in public, private or non-governmental sector, shall at all times display the utmost devotion to duty and be responsible for their actions. Services and service providers are ultimately accountable to persons with mental illness and their caregivers.

1.8. **Value base in all training and teaching programs**: The state shall aspire to build in core values such as quality, integrity, justice, accountability and empathy into all forms of training and academic teaching.

1.9. **Holistic approach to mental health:** A holistic approach to health including recognition of the relationship between mind, body and soul is more effective in dealing with mental health problems. Cultural ethos, Indian tradition and their impact on behavioral patterns shall be recognized and leveraged to achieve policy goals and objectives.

Objectives:

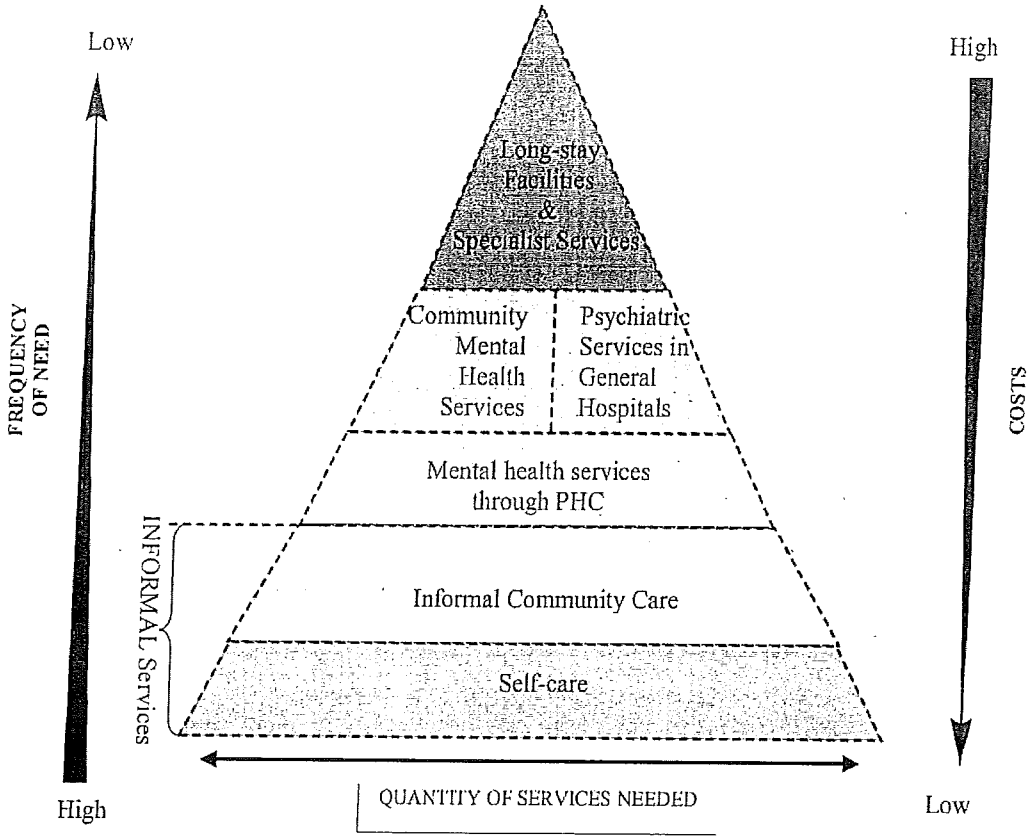
- To enable early identification, treatment, recovery and rehabilitation of the people with mental illness and to enable them to participate meaningfully in society
- Provide adequate infrastructure and easy access to public for receiving mental health services
- Ensure adequate availability of human resource, encourage training and capacity building of manpower to provide mental health services to public
- Ensure availability of adequate essential drug stock for treating mental health problems
- Promote awareness and improve care seeking behavior in community through effective communication and to take proactive steps to reduce stigma
- To ensure care in the community (instead of hospitals) over extended periods
- To address needs of most vulnerable, who are often victims of physical and sexual abuse

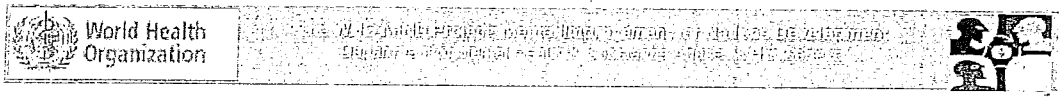
2. AREAS FOR ACTION

2.1. Coordinating Unit:

A coordinating unit will be created with additional technical and administrative expertise to ensure adequate mental health care in the State. Comprehensive mental health care and particularly mental health reform is unlikely to occur effectively unless there is a dedicated unit at the State level, or at the very least a mental health focal point, appointed to drive and steward this process. The coordinating unit will do close supervision and assistance on an ongoing basis to realize the objectives of the policy and plan close monitoring on a regular basis and evaluation from time to time.

2.2. Organisation of Services:





According to the World Health Report 2001, the three major strategies for facilitating the development of an effective network of mental health services are shifting care away from large psychiatric hospitals, developing community mental health services and integrating mental health care into general health services. In line with these recommendations, the state will include an array of settings and levels including primary care, community-based settings, general hospitals (secondary care) and specialized psychiatric service hospitals as illustrated in the picture above. Links between primary care teams and secondary level services will be strengthened. Screening and early treatment for depression, suicidal risk, psychosis and alcohol abuse needs to be implemented in primary care with the support of community mental health teams. Patients and family members need to be psycho-educated about the illness, its causation, risk factors and warning signs for relapse and about importance of adherence to medicines.

2.3. Financing:

Provision of adequate funds is crucial to realize the vision and goals of the policy. Allocation to activities for mental health promotion, prevention and treatment will be

increased. Ongoing activities under the district mental health programme shall continue in a strengthened and more responsive manner. New activities especially in the area of community-based rehabilitation and continuing care will be supported with adequate funding. The work of non-governmental organizations will be encouraged and supported, in order to achieve a collaborative and sustainable response system. The policy encourages funds to be allocated for mental health in various other departments such as social welfare, women and child development, school education. Additional funds for the need in mental health has to be allocated to primary health care in order to strengthen mental health interventions which are accessible to the community.

The sources of funds shall include funding from the

- National Health Mission,
- State Government health budget,
- Non-Governmental Organizations,
- Corporate Social Responsibility funds and
- Funds from other Departments such as Revenue dept., Social Welfare dept. etc.

2.4. Human Resource and Training

Human resources are the most important assets of the mental health system. The performance of the health care system depends ultimately on the knowledge and skills of those who deliver mental health services who will be able to deliver effective mental health interventions.

Because of the shortage of mental health professionals in rural areas, primary care workers will be trained in mental health. Links will be developed with traditional faith based mental health service provider. Nurses will be trained in community psychiatry so that they can work in conjunction with primary care teams.

2.5. Promotion, Prevention, Treatment and Rehabilitation:

Mental health promotion, prevention and treatment of mental disorders and rehabilitation are complementary strategies, that are essential for achieving positive outcomes. However, mental health promotion is, even more than care and the prevention of mental disorders, an inter-sectoral responsibility, where education, work, justice, housing and other social areas along with press and media shall play a major role

2.5.1. Mental health promotion at individual level:

- Programmes shall be designed to strengthen a person's ability to identify and cope with stress, manage life-changing situations and equip them to

fulfill a meaningful place within society, that include communication, maintaining positive relationships and parenting.

- Activities such as physical exercise, volunteering and relaxation can all help to promote a sense of wellbeing and promote mental health.
- Involving people with experience of mental health problems, particularly serious mental health problems, is important in actively shaping work to reduce stigma and promote inclusiveness. This has to start from the school level itself.

2.5.2. Mental health promotion at community level:

- Enabling people to live and work together positively, through promoting social networks, social life and engagement and offering meaningful opportunities for participation in society.
- Improving the local environment, community safety and promoting mental health in schools and work places.
- Strengthening social ties, assigning important role to family members, friends and other significant groups towards achieving positive mental health in individuals.
- Establishing social networks and social clubs, for proactive look with necessary sensitization.
- Increasing understanding and tolerance through education
- Establishing guidelines for responsible reporting of suicide and mental health disorders in media

2.5.3. Mental health promotion at Macro level:

- Encouraging NGOs and active citizen participation in various mental health promotion activities including advocacy groups as stake holders to help bridge gap between mental health professionals and community
- Roping in celebrities as brand ambassadors, for promoting positive mental health with promising returns and outcomes
- Promoting Yoga and other relaxation techniques as a measure towards wellbeing.
- Improving awareness and literacy through use of electronic and print media.
- Holding periodic campaigns like **Defeat Depression Campaign/Shatter the Stigma/Mend the Mind** to educate the public about mental health.

2.6. Essential Drug Procurement and Distribution:

Given the significant progress that has been achieved in the management of severe and disabling mental disorders through the utilization of psychotropic drugs, their continuous availability of drugs will be ensured in all hospitals ranging from tertiary hospitals to PHCs. Their use has not only contributed to a significant reduction in hospitalization but has also considerably reduced human suffering and

improved the quality of life. Drugs shall be restricted to those proven to be therapeutically effective, acceptably safe and affordable in accordance with the level of resources of the region concerned. Continuous availability in end user clinics will be ensured. Frequent quality checks will also be done.

2.7. Information Systems:

A mental health information system will be developed in consultation with consumers and families to meet concerns about confidentiality and to develop sensible procedures for accessing information. Common standards in information technology allow local information systems to communicate across agency and geographical boundaries as people with mental disorders move around. A good database is necessary to analyze the disease burden and make decisions at policy level.

2.8. Research and Evaluation:

A key challenge to prioritize research is that of a lack of capacity and resources to implement it. Hence, the State shall take efforts to fill the existing gaps such as funding for research, capacity building, encouraging dedicated research organizations, facilitating research in academic institutions etc. Necessary action shall be taken to ensure the same.

2.9. Intersectoral Collaboration:

The needs of persons with mental illness cannot be met by the health sector alone. Hence, there is need for inter sectoral collaboration. Several sectors outside health provide services that affect people's mental health. They include services provided by welfare, religious, education, housing, employment, criminal justice, police and other social services. Inter sectoral collaboration also includes services within workplaces, such as those for human resource management, training and occupational health and safety, all of which influence mental health. Collaboration is needed within the health sector too.

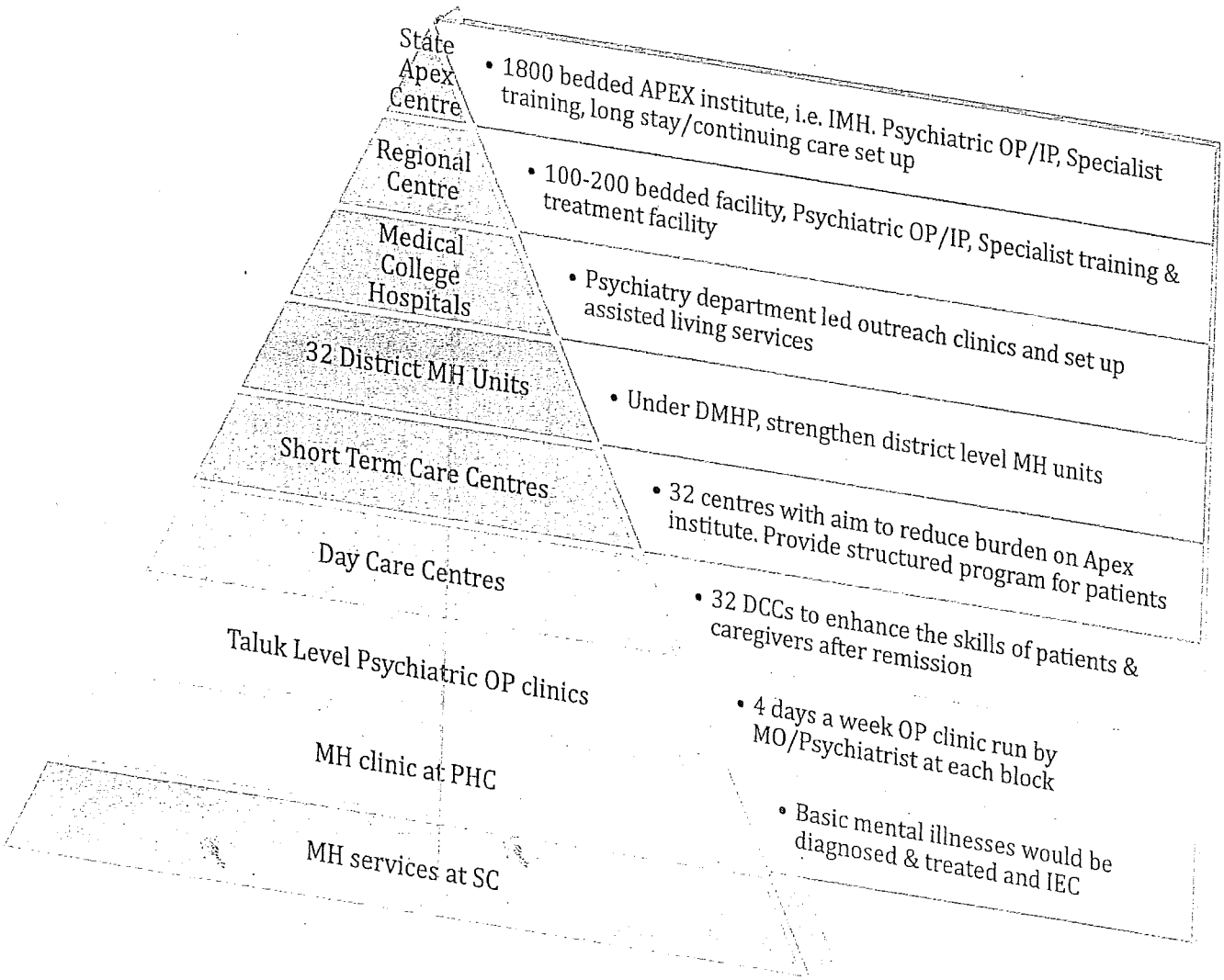
3. MENTAL HEALTH ACTION PLAN

STRATEGIES

3.1. COORDINATING UNIT:

A dedicated coordinating unit with additional technical and administrative expertise to ensure adequate leadership and coordination for mental health care in the State will be set up.

3.2. ORGANIZATION OF SERVICES



3.3. SYSTEM STRENGTHENING:

3.3.1. Medical Education in Psychiatry:

Medical education for Psychiatric studies is given at two levels; Under Graduate and Post Graduate. In both these levels, the State will endeavor to ensure that the students gain an understanding of psychiatry in primary, secondary and tertiary level institutions, including the legal framework as well as programmes such as the District Mental Health Programme. In addition, seats will be increased at Post Graduate level in accordance to the Medical Council of India norms to address the growing need for psychiatrists in the State.

3.3.2. Regional Centers of Excellence:

Efforts will be taken to establish four regional centers of excellence, which will be established at Vellore, Coimbatore, Theni and Thanjavur. These centres will carry out same mandate as apex institute at regional level thereby monitoring and managing a cluster of districts.

3.3.3. Strengthening the psychiatric units at medical college hospital and district headquarters hospitals:

Steps will be taken to strengthen the department of psychiatry at medical college hospital and district headquarters hospitals in the following manner. Dedicated funds will be channeled to strengthen these units. Staff in these units, including nurses and hospital workers shall be trained exclusively for psychiatry and posted exclusively in psychiatric department as much as possible.

As mandated in the Mental Healthcare Act, the minimum quality standards of mental health services shall be as specified by regulations made by the State Authority. This shall include a list standard for minimum essential manpower required for a functional Medical College Psychiatric Unit of different bed strengths.

3.3.4 District Mental Health Programme at District level:

District Mental Health Programme is led by a team of trained mental healthcare personal operating out of the district headquarter hospital. It shall be implemented in an integrated manner by the Directorate of Medical Education, Directorate of Medical and Rural Health Services and Directorate of Public Health and Preventive Medicine.

In order to prevent dilution of the services provided by the DMHP staff, they shall be exempted from performing general night duties, post mortem duties and general medical camps as far as possible.District Head Quarters hospital shall have a 10 bedded ward exclusively for psychiatry. It shall provide treatment for all mentally ill people including de-addiction services. These services shall be available on all days and round the clock.

Composition of the personnel involved in psychiatric care in District Head Quarters hospital:

S.NO	STAFF	NUMBER
1	Psychiatrist (District psychiatrist & District programme officer)	1
2	Clinical psychologist	1
3	Psychiatric social worker	1
4	Psychiatric nurse	4
5	Monitoring and evaluation officer	1
6	Ward assistants	4
7	Case Registry Assistant	1
	TOTAL	13

3.3.5 At Taluk level – Outreach services by DMHP team:

A separate DMHP team shall do outreach services in all Taluk hospitals. They shall visit each Taluk hospital once in 2 weeks to once a week depending on the patient load & number of Taluks in a district. Later on, steps will be taken to post one psychiatrist and one clinical psychologist/psychiatric social worker in each Taluk hospital to provide mental health services daily at Taluk level. This will help in managing referrals from PHCs regularly at Taluk level itself.

Composition of DMHP team for outreach visits shall be:

S.NO	STAFF	NUMBER
1	Psychiatrist	1 per Health Unit District
2	Clinical psychologist	1
3	Psychiatric social worker	1
4	Psychiatric nurse	1
	TOTAL	4

3.3.6. Strengthening Community Psychiatry

Adequate man power will be made available for meeting the mental health needs of the community. Relying solely on psychiatrists to provide services for people would prevent millions of people from accessing the services they need. Hence, we will train non-specialist doctors, paramedical workers and non-medical workers in mental health.

Medical officers involved in primary health care services shall be trained to identify and treat common mental health problems while knowing when and how to refer patients with increased severity of illness to psychiatrists at Taluk level or district level. They shall also be trained to manage patients with long-term mental illnesses with specialist care only when necessary.

Paramedical workers such as staff nurses, Village Health Nurse (VHN) and Auxiliary Nurse Midwife (ANM) involved in primary health care services will be trained to screen for mental illnesses, identify common mental illnesses and refer appropriately to the local PHC medical officer.

Primary care workers argue that psychiatric syndrome labels are unsuitable because most of their patients have mild, subsyndromal, and mixed presentations. Moreover, use of psychiatric labels lead to issues like medicalization of distress, spontaneous remission and placebo response. Primary care workers are better placed to understand the contextual and psychosocial aspects of clinical presentations. Hence, efforts will be taken to explore the use of primary care friendly disease classifications in primary care psychiatry, including in the training of non-specialist doctors placed in the community as well.

Training will include:

a. Training of paramedical workers of DMHP team
b. Training of medical officers at PHC level
c. Training of paramedical workers such as staff nurses, Village Health Nurse (VHN), Auxiliary Nurse Midwife (ANM)
d. Training of non-medical workers such as Accredited Social Health Activist (ASHA), Women Health Volunteers (WHV), Anganwadi Workers (AWW), Community mental health workers.
e. Sensitization of members of the Gram Panchayat, Taluk/ Block Panchayat such as Zila Parishad and elected representatives of the districts

These measures will help to:

- Screen, diagnose at early stage and refer cases to nearest PHC or DMHP unit
- Redistribute disease burden and encourage task shifting to involve physicians in primary health care settings
- Involve non-specialist doctors to provide care in community settings

Training schedule:

NAME OF PERSONNEL	DURATION OF TRAINING	LOCATION OF TRAINING	NUMBER OF TRAINING PROGRAMS
Clinical psychologist	12 weeks	Centre of excellence/ medical college	1st year (whenever new people are appointed, who have not been trained previously)
Psychiatric Social worker			
Staff nurse of DMHP team	6 weeks		
Medical officer of Block PHC/ PHC including those of Mobile Medical Unit / RBSK/ RKSK (30 per batch)	1 day Refresher training for 1 day for those who have already been trained - after 6 months	District Head Quarters hospital/ Medical college	Two per year
Paramedical workers of Block PHC/ PHC including pharmacists, RBSK nurses/VHN (50 per batch)	1 day		
Non-medical workers	1 day	District / Taluk hospital/ Block PHC/ Local	
Sensitization for selected representatives from community	Half a day		

3.4. HEALTH PROMOTION AND PREVENTION ACTIVITIES:

1. Increasing awareness in the community by IEC
2. Screening of vulnerable population and intervention
3. School mental health program
4. Colleges
5. Work places
6. Mental health helpline & Suicide prevention helpline

3.4.1. IEC:

IEC is an integral part of any public health program. The community will be sensitized by the DMHP team or trained VHN/ASHA/WHV/AWW/ANM/Community mental health workers about the clinical features of mental illness, factors involved in its causation, availability of treatment in PHC/ Block PHC/ Taluk hospitals/ District hospitals, benefits of treatment, etc.

It may be done through:

- Posters in hospitals, public places such as bus stand, railway station
- Wall paintings, hoardings
- Flip charts
- Mass media: TV / Newspaper /YouTube/ WhatsApp / Facebook /Radio
  - Videos by famous actors – raising awareness about mental illness
  - Testimony by treated patients without disclosing their identity
- Folk dances, street plays, puppet shows & debates in community
- Essay writing, painting & sports competition in schools
- Exhibition
- Helpline numbers & health advisory to be exhibited in serials and movies when they include content related to mental illness or suicide
- Mental health festivals
- Mental health campaigns
- Rallies
- Celebration of mental health day
- Sensitization programme – village elders, people involved in law enforcement, self-help groups, religious leaders, faith healers, children's homes, old age homes, refugee camps, etc.
- Mental health app – which provides information about the availability of mental health services in the vicinity – both public and private

3.4.2. Screening of vulnerable population and intervention:

Screening of vulnerable population such as prisoners, children in borstal schools and juvenile homes, people in refugee camps, commercial sex workers, victims of human trafficking & abuse, family of people with mental illness will be conducted and necessary intervention will to be done.

3.4.3. School mental health program:

- Medical officers and staff nurses of RBSK who are trained by psychiatrists shall be involved in screening and referral of children with mental health needs from schools to a psychiatrist.
- Efforts will be taken to include mental health in teacher training curriculum in order to educate them to identify early signs and symptoms of mental health illness among their students.
- Efforts will also be taken to include lessons on mental health in the syllabus of students to educate and create awareness on the issues surrounding mental health.
- Health clubs with science teacher as coordinators shall be established in which mental health shall also be emphasized.
- Involvement in extra-curricular activities would be emphasized in all schools as most of the schools are focused only on academics and doesn't allow children to involve in arts/ sports.
- Even, private schools would be instructed to involve mental health screening as a part of annual health checkup.

Each School must take efforts to

- Promote positive mental health among the whole student population.
- Raise awareness of mental health issues and provision and reduce stigma so that students in difficulty are encouraged to seek help and staff are confident in their response.
- Provide consistent and effective support to students experiencing mental health difficulties, with a coordinated approach across colleges, academic departments and central student support services and timely referral to hospitals.
- Create an ethos in which confidentiality and dignity are respected

Teacher Training: Master trainers (teachers) will be trained by district psychiatrists / NGO on identifying emotional problems, scholastic and substance use problems and referring them to psychiatrist. They shall also be trained on life skills education (LSE) who in turn train other teachers. Finally, these teachers impart life skills to students in 8^{th}, 9^{th} and 11^{th} std. They shall have a separate period allotted for this purpose. The children/ adolescents will be encouraged to use these skills in problems related to family relationships, development crisis, substance abuse, violence, bullying, sexuality and career choice etc.

Strategy for Screening Coverage – Age Wise:

AGE GROUP	HEALTH PROGRAMMES	FACILITATORS	COMMON DISEASES
0-10	RBSK	RBSK nurses	Specific learning disorders, intellectual disability, dyslexia, Attention Deficit Hyperactivity Disorder (ADHD), Autism spectrum disorders
<14	SSA	School Teachers	
10-19	RKSK	RKSK nurses, VHN, RKSK coordinators	Mood disorders, Borderline personality disorder (BPD), anxiety disorder, preventing adolescent suicide and self-harm behavior
19 and above	Non-communicable Diseases (NCD)	NCD nurses	Major depressive disorder (MDD), anxiety disorders, alcohol dependence, substance abuse, Psychosis
All age groups comprehensive	DMHP	Psychiatric social workers, nurses and clinical psychologists	All mental disorders and illnesses

Peer education through RKSK:

Both school going children and school drop outs are focused in this program through peer education. Mental health is a major component under this programme. Master trainers (VHN) are trained by psychiatrist / NGO involved in delivering services to children. VHNs choose 4 children/ 1000 population and train them on various components such as nutrition, sexual and reproductive health, injuries and violence, mental health, substance misuse. Among the four children, 2 are male and 2 are female. Two of them are school goers and two of them are non-school goers. They in turn educate their peer groups on weekly basis with resource material. The children with needs are referred to medical officers in Adolescent Friendly Health Clinics (AFHC) in Block PHC. The peer educators meet the VHN on monthly basis. DMHP team shall coordinate with AFHC and extend services whenever necessary.

3.4.4. Colleges:

- College teachers may be trained to work as counselors in their own colleges.
- Sensitization of college lecturers on mental health and mental illness must be done.

- A dedicated free and confidential in-house counselling service with professionally qualified counsellors and psychotherapists must be established by each college/university as much as possible. Information about counseling services must be published in the college prospectus, college website and every new student must be orientedto it.
- Student accomodation shall be designed to foster more interaction and less isolation.
- On-campus health centre must be equipped to deal with mental health issues as well, and be able to arrange appointments with psychiatrists whenever necessary.

Each College must take efforts to

- Promote positive mental health among the whole student population.
- Raise awareness of mental health issues and provision and reduce stigma so that students in difficulty are encouraged to seek help and staff are confident in their response.
- Provide consistent and effective support to students experiencing mental health difficulties, with a co-ordinated approach across colleges, academic departments and central student support services and timely referral to hospitals.
- Create an ethos in which confidentiality and dignity are respected.

Teacher Training: This training will be conducted at the district hospital. District psychiatrist / clinical psychologist will organize the training in district hospital. At least 2 teachers from each college will be trained. About 25 -30 teachers will be trained in a batch. These teachers shall provide referral and counseling services to those students who suffer from psychosocial problems and mental illness. All the trained teachers from the district will attend half a day support group meeting every month at district hospital to discuss problems they encountered in their work in the past 1 month.

3.4.5. In Workplaces:

"The development and implementation of a workplace mental health policy and programme will benefit the health of employees, increase productivity for the company and will contribute to the wellbeing of the community at large."- WHO

- Mental health screening shall be made as part of annual health checkup.
- Sensitization of employers and employees on mental health shall be done.
- Stress management by counselors shall be made available.
- At least once annually, a session on stress management must be taken by a psychiatrist.

Each workplace must take efforts to

- Develop a workplace mental health policy that complies with existing laws

- Train managers to recognize mental illness and make referrals
- Offer mental health wellness programs, such as stress reduction and mental health awareness trainings and mental health screening tools
- Address employees' concerns about their co-workers, including providing support services in the event of a mental health-related emergency or death (e.g., attempted or completed suicide)
- Communicating with employees about mental health to allay their concerns about job loss, stigma, etc., and encourage them to get help

3.4.6. Mental Health Helpline &Suicide Prevention Helpline:

Mental Health Helpline: It provides information about mental illness, substance use problems, availability of mental health services along with counseling services for people with depression, substance use problems through well-trained counselors.

Suicide Prevention Helpline: A centralised exclusive suicide prevention helpline will be started in view of increasing suicide rates. This service shall be run by psychologists/ psychiatric social workers trained in suicide prevention techniques. The helpline will collaborate with local psychiatrists for continued care of identified patients with their approval, so that solutions are localized.

These counselors shall be trained for 6 weeks in Centre of Excellence / Medical College in delivering mental health services followed by regular refresher courses.

3.5. REHABILITATION SERVICES

Models of Care that will be adopted:

3.5.1. Day Care Centre(after remission to give rehabilitation services)

- Provides rehabilitation and recovery services to persons with mental illness so that the initial intervention with drug & psychotherapy is followed up and relapse is prevented
- Helps in enhancing the skills of the family/caregiver in providing better support.
- Provides opportunity for people recovering from mental illness for successful community living.
- Run by DMHP.
- Located at District level (outside hospital campus)

3.5.2. Sheltered Workshop

- Wage earning activity runs own workshop or activity which priovides a wage for the patient.
- Can be run by Self Help Groups (SHGs) of patients/families under the existing schemes available for the disabled

3.5.3. Vocational Training

- Trains the patient for work related - need based skills such as computer operation. if patient is from rural area- animal husbandry, farming or other skills training will be given
- Done based on advise of occupational therapist
- With an objective of training the person with which he/she can earn a living
- Vocational training shall be decided locally based on the resources available within each.
- Agencies involved in livelihood activities shall be roped in to provide their expertise in devising training programs which would be sustainable and financially remunerative to the patients being trained in the same.

3.5.4. Long Term Residential Centres

- Chronically mentally ill individuals, who have achieved stability with respect to their symptoms & have not been able to return to their families and are currently residents of the mental hospitals, will be shifted to these centers.
- These shall function as *'half-way homes'* and shall be located within the general community facilitating the integration of the patients into the society.
- These patients would be attending the sheltered workshop or will be taking up part time jobs in the community.
- These centers shall not become an extension of the mental hospital.
- Any patient staying longer than 6 months will be reviewed by DMHP.
- Residential patients in these centers will go through a structured program which will be executed with the help of multidisciplinary team consisting of clinical psychologists, social workers, nurses, occupational therapists, vocational trainers and support staff.
- Shall be run by DMHP located at district level

For those accessing acute care services who are unable to be discharged even after remission of symptoms and continue to occupy these beds because of non-availability of family, alternate living arrangements in the community will be arranged and initiated through employment combined with independent living in hostels or rented homes, group homes or shared housing arrangement with support from onsite/visiting staff based on level of need and rehabilitation homes set up to mimic therapeutic communities with residential and common congregation spaces

Wherever needed, student interns from Departments of Social Work, Occupational therapy, psychology, etc will be involved by collaborating with colleges offering these courses in the respective regions.

DCC can be combined with Vocational training centres.

Family federation at district level: Will function as a part of the District Mental Health committee, which will manage and assist the mental health care related activities at district level throughself-help group involvement

Local Mental Health Review Boards are being set up under the new Mental Healthcare Act 2017 which shall be responsible for offering oversight for the Emergency Care and Recovery Centers (ECRCs) and the Long term care options proposed to be set up.

3.6. CARE FOR HOMELESS MENTALLY ILL PATIENTS: EMERGENCY CARE AND RECOVERY CENTER

In compliance with the Mental Health Care Act 2017, the policy recommends establishment of more "*Emergency Care and Recovery Center*" either by the state health department or through a reputed NGO hired through NGO selection guidelines of Government of India. The proposed transit care centre will be a 50-beddedfacility, which includes dedicated five beds for patients who opt for voluntary stay along with caregiver.Efforts will be made to make physicians available at these centres on a rotation basis.

The primary objective of these centres would be to rescue homeless ill patients, stabilize them, rehabilitate and reintegrate them with the family as early as possible.

3.7. PREVENTION OF SUICIDES:

Suicide Prevention Strategies:

1. **Identifying and assisting persons at risk:** Family members, friends, teachers, co-workers can play an important role in recognizing that someone is at risk or in crisis and then connecting the person with the most appropriate sources of care. Providing appropriate training is a requisite.
2. **Access to effective mental health and suicide care and treatment.** Ensuring timely access to evidence based treatment delivered by trained providers.
3. **Suicide prevention helpline:** An exclusive suicide prevention helpline shall be started in view of increasing suicide rates. This service shall be run by psychologists/ psychiatric social workers trained in suicide prevention techniques.
4. **Follow up of suicide attempt survivors:** People who have attempted suicide once will be followed up through tele-counselling for a period of 18months
5. **Reducing access to means of suicide**: Prevent individual in suicidal crisis from obtaining and using highly toxic sources such as pesticides by establishing community storage centres for pesticides.
6. **Framing guidelines for media**: Media reporting suicide shall have self-regulations and set of guidelines.
7. **Post-vention**: Support services to the families affected by suicide and to persons with suicide attempt(s) will be provided.
8. **Full continuum of care** including mobile crisis team, hospital based psychiatric emergency services and peer support programme.
9. **Creation of database** in the respect of suicide and para-suicide at state and district levels will be done.

10. **Suicide counseling centers** will be established and linked with treatment centres.
11. Awareness about suicides will be created with special attention to adolescents and youth. Emotional distress behaviors shall be identified by trained school and college teachers and intervention will be done.
12. Alcohol abuse and dependence and depression will be addressed as key risk factors for suicide and attempted suicide.

3.8.MENTAL HEALTH NEEDS OF SPECIFIC GROUPS

3.8.1. Mental health needs of children:

- Allocation of special schools next to government schools, preferably within the same campus so as to help student continue mainstream education.
- Training and recruiting special educators who are specialized in teaching kids with special needs.
- Development of guidelines which will help parents and caregivers on how to train and teach these kids at home.
- Investment in overall development of these children in academics, art, sports, etc. in a holistic manner.
- Special attention will be given to the mental health needs of children in conflict with law, children in juvenile homes, adverse social situations, conflict families etc. Juvenile homes will also be taken care by the DMHP team. Other such children will be identified by VHN or RBSK nurses and given priority while providing support.

3.8.2. Mental health needs of LGBTI+ community

The Mental Healthcare Act, 2017 states that every person shall have a right to access mental healthcare and treatment without discrimination on the basis of gender, sex, sexual orientation, etc. Hence, efforts will be taken to make mental healthcare accessible to traditionally excluded groups such as the communities marginalized on account of sexual orientation, gender identity, expression and sex characteristics (SOGIESC). They will not be discriminated against and will have equal access to mental healthcare in a non-judgemental, non-stigmatising environment.

1. ***Terminology***: The use of terms like 'transgender' and 'homosexuals' conceals the range of gender and sexual identities that are prevalent and possible. This includes gender identities such as transman, transwoman, intersex, gender-fluid, non-gender-binary, and sexual orientations such as lesbian, gay, bisexual, asexual, etc. Hence, a broad term such as communities marginalized on account of sexual orientation, gender identity, expression and sex characteristics (SOGIESC) may be used as far as possible.
2. ***Gender Dysphoria or Gender Incongruence***: As stated by the APA's Diagnostic and Statistical Manual (DSM - 5) and WHO's International Classification of Diseases (ICD - 11), the term Gender Identity Disorder is

replaced by Gender Dysphoria and Gender Incongruence respectively. Hence, people whose emotional and psychological identity as male or female is not confirming to one's biological sex will no longer be considered to have a disorder that needs intervention but as a condition, that is merely a normal variation.

3. ***Homosexuality***: In line with the Supreme Court's judgement on Section 377 of the Indian Penal Code, the stand of the Indian Psychiatric Society, the July 1994 statement of the American Psychological Association on homosexuality(Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts), and WHO's removal of homosexuality from ICD-10 in 1992, homosexuality will no longer be considered as either a mental illness or a moral depravity. It is simply the way a segment of the population expresses human love and sexuality.
4. ***Conversion Therapy & Sexual Orientation Change Efforts (SOCE)***: Conversion therapy in its traditional sense is unwarranted and unscientific as a tool for changing sexual or gender identity.
5. ***Medical & Surgical Gender Affirmation***: Mental health professional's role will be limited to diagnosing gender dysphoria and ensuring that the person has the capacity to make a decision.
6. ***Accessibility***: Mental health issues in the SOGIESC-marginalised community does not arise through a causal relationship with the non-conformant gender and sexual identities but as a separate issue. However, the societal response and associated stigma can act as a trigger for mental health issues(minority stress). Complete confidentiality, privacy and utmost sensitivity will be shown in their care. As much as possible, mental health care needs of the community will be part of the mainstream to avoid possible ghettoisation.
7. ***Medical education***: LGBTI+ related training/orientation for health professionals at all levels (primary to tertiary) both during pre-service (MBBS, DPM, MD) and in-service (via CME) will be done.
8. ***IEC*** at all levels indicating that LGBTI+ is not a disorder and the providers, including mental health providers will not discriminate based on the clients' sexual orientation, gender identity or sex characteristics.

3.8.3. Geriatric mental healthcare:

- Separate ward for elderly are being established which will include beds for mentally ill patients.
- Rehabilitation centres shall have beds for geriatric patients also.

3.8.4. Memory Clinics

Memory clinics for patients with dementia will be established at all district hospitals. This shall be done along with physicians and neurologist where possible. Rehabilitation for these patients shall be linked with NGO if needed.

3.9. OTHER SERVICES:

3.9.1. Support for caregivers:

- Globally, 70 – 80 million care givers are usually family members and most of them are females.
- '*Caring for the carer*' is a neglected area. Caregivers shall be supported and involved in running 'Family Federations' at district level. Respective DMHP units will provide medical care.
- The Mental Healthcare Act also mentions the inclusion of mental health services to support family of person with mental illness.
- Community based programs to support care givers/family to foster early recovery is necessary
- Addressing the economic needs of the care giver – providing monetary and tax benefits taking into account the age of care giver, family income, hours of care giving, type of care – family or hospital based, did the caregiver have to give up his/her job,etc.
- Psychiatric social workers will be trained to provide technical support and organize family support group meetings for caregivers.

3.9.2. Substance abuse:

- Exclusive de-addiction centres will be established in all medical college hospitals and all DHQHs
- All PHC medical officers will be trained in providing de-addiction services
- Efforts shall be made to make it mandatory for vendors of addictive substances to display information on location and 'how to enroll' to the nearest de-addiction center in the locality.

3.9.3. Tele-psychiatry:

Tele-psychiatry will be utilized as a model to review patients who are already diagnosed and on medications, by the psychiatrists from the district hospitals while the client remains in his/her PHC. This could be facilitated with the help of medical officer present in the PHC.

3.9.4. Population Based Screening:

Population based screening will be done along with non-communicable diseases and suspected cases shall be referred to PHC/ Taluk hospitals. A short two to four question format has been worked out for this purpose.

3.9.5. Ambulance Services:

The Mental Healthcare Act mandates that "emergency facilities and emergency services for mental illness shall be of the same quality and availability as those provided to persons with physical illness" and that "persons with mental illness shall be entitled to the use of ambulance services in the same manner, extent and quality as provided to persons with physical illness". Hence, for transporting mentally ill patients to the district hospital in an emergency, 108 ambulance services will be made available. This service can be requisitioned by the psychiatrist at the district hospital or by the PHC/ Taluk hospital doctor in consultation with the psychiatrist at the district hospital. Provision for operational costs based on certain number of trips per district will be made. The

DMHP team at the district shall provide training to ambulance staff in managing persons with mental illnesses in an emergency.

3.10. PROVISION OF DRUGS:

All patients seeking treatment shall have access to essential medicines, free of cost, from the dispensary in every PHC/ Taluk hospitals/ District hospitals at all times. These drugs shall be procured every 6 months in required quantity. The drugs shall be procured through the established channels of the Government drug logistic society/ rate contract.

The dispensing procedure shall be monitored and audited. Only authorized persons such as nurse/ pharmacist will be allowed to dispense medicines. Take home medicines shall not be provided for longer than 2 weeks in a single visit.However, in stable patients it can be given for not longer than 4 weeks. The DMHP psychiatrist shall review the drug position in PHC/ Taluk / District hospitals every month. He shall review monthly reports and carry out random checks periodically during the field visits and report the same to District Programme Officer.

List of drugs that shall be available in PHC/ Taluk hospitals:

1. T. Haloperidol 5 mg and 1.5 mg
2. T. Risperidone 2 mg
3. T. Olanzapine 5 mg
4. T. Chlorpromazine 100 mg and 50 mg
5. T. Imipramine 25 mg
6. T. Escitalopram 10 mg
7. C. Fluoxetine 20 mg
8. T. Phenobarbitone 30 mg
9. T. Diphenylhydantoin 100 mg
10. T. Clonazepam 0.5 mg
11. T. Lorazepam 2 mg
12. T. Trihexyphenidyl 2 mg
13. Inj. Fluphenazine 25 mg
14. Inj. Lorazepam 4 mg
15. Inj. Promethazine 50 mg
16. T. Sodium valproate 500 mg
17. T. Carbamazepine 200 mg

List of drugs that shall be available in District hospitals:

1. T. Haloperidol 5 mg
2. T. Risperidone 2 mg
3. T. Olanzapine 5 mg and 2.5 mg
4. T. Chlorpromazine 100 mg
5. T. Imipramine 25 mg
6. T. Escitalopram 10 mg

7. C. Fluoxetine 20 mg
8. T. Lithium carbonate 300 mg
9. T. Sodium valproate 500 mg
10. T. Phenobarbitone 30 , 60 mg
11. T. Diphenylhydantoin 100 mg
12. T. Carbamazepine 200 mg
13. T. Clonazepam 0.5 mg
14. T. Lorazepam 1 mg and 2 mg
15. T. Zolpidem 10 mg
16. T. Trihexyphenidyl 2 mg
17. Inj. Haloperidol 5 mg, 50 mg
18. Inj. Risperidone
19. Inj. Fluphenazine 25 mg
20. Inj. Lorazepam 2 mg and4 mg
21. Inj. Promethazine 50 mg
22. Inj. Naloxone 400 mcg/ml
23. Tab. Sertraline 50 mg
24. Tab. Topiramate 50 mg
25. Tab. Allopurinol 100 mg
26. Tab. Clozapine 50 mg
27. Tab. Lamotergine 25 mg
28. Tab. Levitiracetam 250 mg
29. Tab. Prochlorperazine 5 mg
30. Tab. Quetiapine 50 mg
31. Tab. Tadalafil 20mg
32. Varenicline tartarate 1 mg and 0.5 mg
33. Tab. Acamprosate 333 mg and 666 mg
34. Tab. Amisulpride 100 mg
35. Tab. Atomoxetine 10 mg
36. Tab. Cloimipramine 25 mg
37. Tab. Disulfiram 250 mg
38. Tab. Divalproate sodium 250 mg and 500 mg
39. Tab. Donepezil 5 mg
40. Tab. Mirtazipine 15 mg
41. Tab. Sildenafil 50 mg
42. Inj. Cerebroprotein hydrolysate 30 mg and 60 mg
43. Tab. Clozapine 100mg
44. Tab. Divalrate sodium 200mg and 500 mg
45. Inj. Phenobarbitone 100mg
46. Syp. Phenobarbitone 30mg/5ml

3.11. DATA FOR MENTAL HEALTH:

The policy recommends setting up of uniform and mandatory registry which is functional at all levels to capture data on the mental illness. This dedicated registry shall be reviewed every 6 months and the data shall be analyzed. This shall inform the policy makers to bring necessary changes in the delivery of mental health service by

planning the programmes, allocating necessary budget and providing inclusive care for all affected by mental illness.

3.12. RESEARCH

A comprehensive research agenda for mental health incorporating epidemiological, clinical and health systems research together with sociological, ethnographic and other multi disciplinary methods shall be developed and implemented. Equitable funds for promoting mental health research with a target consistent with the burden of mental health problems in the country shall be committed. Investment shall be made in building research capacity. Mechanisms for dissemination of research findings and for translating research findings into action at the service delivery level shall be developed.

3.13. PUBLIC PRIVATE PARTNERSHIPS:

Wherever necessary, partnership may be established with NGO or other organisations which are involved in delivering services to the target population.

LEVELS	AREAS OF PARTICIPATION OF NGO
District	Local IEC, Short term Residential/ Long term residential continuing care centres, supplementation of Innovative Mental Health Services, training / sensitization of health workers, ambulance services
State	Advocacy, Local IEC, dedicated mental health helpline, training/sensitisation of health workers, ambulance services

3.14. TARGETS

The State aspires to achieve the following two targets:

1. Mental Health service coverage to be increased by 20% by 2025
2. Suicide Rate to be reduced by 10% by 2025

4. FINANCES

4.1. Cost of District Mental Health Programme for 1 district:

S.No	ACTIVITY	1ST YEAR	2ND YEAR	3RD YEAR	4TH YEAR	5TH YEAR	TOTAL
1	Salary	6624000	6955200	7302960	7668108	8051513	36601781
2	Non Recurring:	200000	0	0	0	0	200000

	Infrastructure for District DMHP Centre, . Counseling centre in district hospitals including mental health helpline: setting up the centre, furniture, computer facilities, telephone etc						
3	Training of PHC medical officers, RBSK medical officers, paramedical staff and non medical workers	50000	50000	50000	50000	50000	250000
4	**IEC and community mobilization activities:** a)Procuring/translation of IEC material and distribution	50000	50000	50000	50000	50000	250000
	b)Awareness generation activities in the community, schools, colleges, work places	50000	50000	50000	50000	50000	250000
5	Targeted intervention for police, judicial officials, prisoners & hiring the services of Psychiatrists , psychologists from private sector	50000	50000	50000	50000	50000	250000

6	Training of master trainers, school teachers in life skills education(LSE), training of college teachers in counseling skills	100000	50000	50000	50000	50000	300000
7	Mental health helpline	1000000	1000000	1200000	1500000	1500000	6200000
8	Drugs	300000	400000	500000	600000	600000	2400000
9	Equipments	500000	50000	50000	50000	50000	700000
10	Operational expense of the district centre: rent, telephone expenses, website etc	20000	20000	20000	20000	20000	100000
11	Ambulatory services	200000	250000	300000	350000	400000	1500000
12	Miscellaneous/ Travel/Contingency	400000	425000	450000	475000	500000	2250000
	TOTAL	**95,44,000**	**93,50,200**	**1,00,72,960**	**1,09,13,108**	**1,13,71,513**	**5,12,51,781**

4.2. Mental Health care roadmap (Infrastructure) related to centre of excellence and rehabilitation services:

ACTIVITIES	PRESENT STATUS	YEAR				
		1	2	3	4	5
Centre of excellence(IMH)	0	0	0	0	0	0
Regional centre of excellence	0	1	1	1	1	0
Deaddiction centres	3	3	3	3	3	3
Day care centres	0	2	2	2	2	2
Long term continuing centre	0	2	2	2	2	2
ECRC	10	3	3	3	3	3

4.3. Cost Summary & Sources of Funding:

(Rupees in lakhs)						
INSTITUTION	**DETAILS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**	**YEAR 5**
Centre of excellence (IMH)	Non recurring	109	0	0	0	0
	Recurring	11	11	11	11	11
	Total	**120**	**0**	**0**	**0**	**0**
Regional Centres of excellence	Non recurring	142	142	142	142	0
	Recurring	15	30	45	60	60
	Total	**157**	**172**	**187**	**202**	**60**

(Rupees in lakhs)						
ACTIVITIES	**DETAILS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**	**YEAR 5**
ECRC	Non recurring	75.45	75.45	75.45	75.45	75.45
	Recurring	195.84	391.68	587.52	783.36	979.2
	Total	**271.29**	**467.13**	**662.97**	**858.81**	**1054.65**
Deaddiction centre	Non recurring	199.95	199.95	199.95	199.95	199.95
	Recurring	195.84	391.68	587.52	783.36	979.2
	Total	**395.79**	**591.63**	**787.47**	**983.31**	**1179.15**
Day care centre	Non recurring	106.8	106.8	106.8	106.8	106.8
	Recurring	33.12	66.24	99.36	132.48	165.6
	Total	**139.92**	**173.04**	**206.16**	**239.28**	**272.4**
Long term residential	Non recurring	110.4	110.4	110.4	110.4	110.4

4.2. Mental Health care roadmap (Infrastructure) related to centre of excellence and rehabilitation services:

ACTIVITIES	PRESENT STATUS	YEAR				
		1	2	3	4	5
Centre of excellence(IMH)	0	0	0	0	0	0
Regional centre of excellence	0	1	1	1	1	0
Deaddiction centres	3	3	3	3	3	3
Day care centres	0	2	2	2	2	2
Long term continuing centre	0	2	2	2	2	2
ECRC	10	3	3	3	3	3

4.3. Cost Summary & Sources of Funding:

(Rupees in lakhs)						
INSTITUTION	**DETAILS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**	**YEAR 5**
Centre of excellence (IMH)	Non recurring	109	0	0	0	0
	Recurring	11	11	11	11	11
	Total	**120**	**0**	**0**	**0**	**0**
Regional Centres of excellence	Non recurring	142	142	142	142	0
	Recurring	15	30	45	60	60
	Total	**157**	**172**	**187**	**202**	**60**

(Rupees in lakhs)						
ACTIVITIES	**DETAILS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**	**YEAR 5**
ECRC	Non recurring	75.45	75.45	75.45	75.45	75.45
	Recurring	195.84	391.68	587.52	783.36	979.2
	Total	**271.29**	**467.13**	**662.97**	**858.81**	**1054.65**
Deaddiction centre	Non recurring	199.95	199.95	199.95	199.95	199.95
	Recurring	195.84	391.68	587.52	783.36	979.2
	Total	**395.79**	**591.63**	**787.47**	**983.31**	**1179.15**
Day care centre	Non recurring	106.8	106.8	106.8	106.8	106.8
	Recurring	33.12	66.24	99.36	132.48	165.6
	Total	**139.92**	**173.04**	**206.16**	**239.28**	**272.4**
Long term residential	Non recurring	110.4	110.4	110.4	110.4	110.4

centre	Recurring	157.42	314.84	472.26	629.68	787.1
	TOTAL	267.82	425.24	582.66	740.08	897.5
GRAND TOTAL		1074.82	1657.04	2239.26	2821.48	3403.7

TOTAL

YEAR	NON-RECURRINGCOST (in lakhs)	SOURCE OF FUNDING
Year 1	745.6	• NHM, MoHFW • State Government • Directorate General of Health Services
Year 2	634.6	
Year 3	634.6	
Year 4	634.6	
Year 5	492.6	
Grand Total	**3142**	

YEAR	RECURRING COST (in lakhs)	SOURCE OF FUNDING
Year 1	701.66	• NHM, MoHFW • State Government
Year 2	1298.94	
Year 3	1903.39	
Year 4	2509.01	
Year 5	3095.82	
Grand Total	**9508.82**	

BEELA RAJESH
SECRETARY TO GOVERNMENT

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SECTION OFFICER

ANNEXURE-II

G.O. (Ms) No.301, HEALTH AND FAMILY WELFARE (EAPI-2) DEPARTMENT, DATED: 04.07.2019

IMPLEMENTATION FRAMEWORK

TAMILNADU MENTAL HEALTH CARE POLICY

S. No.	Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs	Responsible officials/department	Timeline
1	Steering committee meeting to be held every two months to review the above steps in implementation framework	***MD NHM, SNO (Mental health), DMHP chairmen/representatives from all districts, Head of departments from regional centres***	Every two months
2. TRAINING			
2.1	Train all medical officers in the public health care establishments and in prisons to provide basic and emergency mental healthcare	***DPH, DME***	Once every 3 months
2.2	Providing psychiatric training to all staff members in position	***NHM, DPH, DMS, MRB***	2 years
3.IEC			
3.1	Campaigns to eradicate stigma - CSR activities with major firms across Tamil Nadu	***DPH- Health Education Bureau (HEB), DMS***	Once a year in the month of October (*World Mental Health Month*)
3.2	Wide publicity about the mental health care act 2017 and its provisions	***NHM TN, DPH – Health Education Bureau (HEB)***	Once a year as part of *Mental Health Month* celebration
3.3	Periodic sensitization and awareness programmes for	***NHM- TN***	Once every 3 months

	government officials, police officers and others as appropriate		
3.4	Campaign to promote positive mental health, suicide prevention and use of 104 HHL	**104 HHL, NHM-TN**	Once a year in the month of September (*World Suicide Prevention Month*)
4. HUMAN RESOURCES			
S. No.	**Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs**	**Responsible officials/department**	**Timeline**
4.1	Ensuring adequate staff in position in all districts • Psychiatrists	***DMS, MRB***	2 years
4.2	• Clinical psychologists	***DMS***	
4.3	• Psychologists	***MRB, DME***	
4.4	• Psychiatric trained medical officers	***DMS, DPH***	
4.5	• Psychiatric trained nurses	***DMS***	
4.6	• Psychiatric social workers	***DMS***	
4.7	• Anesthetists (ECT)	***DMS, DME, MRB***	
5. MATERIAL			

S. No.	Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs	Responsible officials/department	Timeline
5.1	Availability of essential psychotropic medicines	*DMHP, TNMSC*	5 years
5.2	Availability of equipments	*TNMSC, DMS, Deans of all MCHs*	
5.3	Strengthen department of psychiatry at MCH and DHQ • Ensuring adequate staff in position in all districts • Infrastructure in place	*DME, NHM-TN*	
5.4	Ensure a dynamic procurement and supply chain system which ensures availability of medicines in all these centers	*NHM, TNMSC*	
6. SCHOOL MENTAL HEALTH			
S. No.	**Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs**	**Responsible officials/department**	**Timeline**
6.1	Include systematic training on promotion of positive mental	*Teacher training syllabus*	4 years

	health and early identification of mental illness in children and adolescents in the teacher training course curriculum		
6.2	Make mental health screening mandatory as part of the annual health screening in schools	***Schools education Department, Department of Collegiate Education***	2 years
6.3	Develop a strategy to address the needs of children who have dropped out of school (quite possibly because of a mental disorder), migrants, homeless, working in unorganized sector, etc	***RBSK, RKSK, NHM***	2 years
7. LEGAL			
S. No.	**Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs**	**Responsible officials/department**	**Timeline**
7.1	Setting up local Mental Health Review boards to ensure compliance to Mental Health Care Act 2017	***SMHA, SNO, DMHP***	6 months
7.2	Linkage with scheme for homeless mentally ill run by Department of Social Welfare, Psychiatric rehabilitation center	***Department of Social welfare, NHM-TN***	1 year

	• Number of inmates in state department of social welfare run psychiatric rehabilitation centres		
7.3	Workplace stress: amendment to be made to include mental health programmes as a component in sec 135 of Companies Act 2013 to increase Corporate Social Responsibility (CSR) amount especially to emphasize on reducing workplace stress	*NHM*	1 year
8. OTHERS			
S. No.	**Parameters for DMHP, DHQH (other than/ non-DMHP), Medical college hospitals, and PHCs**	**Responsible officials/department**	**Timeline**
8.1	Strategy to reduce alcohol use disorder and complementing it by setting up de-addiction centers in all districts	*NHM, TASMAC, RKSK*	3 years
8.2	Ensuring provision of Disability benefits / concessions and rights of persons with mental illnesses	*DMHP*	As soon as possible
8.3	Suicide: Establishing more helplines and offering emergency interventions	*104 team, NHM*	1 year

8.4	Ensure there is a functional ward for every 30 km distance to improve accessibility to patients	*NHM, DMS*	2 years

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