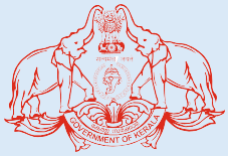

Department of Health & Family Welfare
Government of Kerala

MENTAL HEALTH PROGRAM

TECHNICAL DOCUMENT

KERALA.HEALTH

Acknowledgement

The world has dealt with pandemic of COVID. People, health systems and health functionaries are yet to realize the silent pandemic of mental health.

This document gives relevant information regarding mental health programs in Kerala.

Dr Kiran, the state nodal officer and the district teams have been taking untiring efforts to provide much needed support to patients.

Whether it is pandemic or disasters, the psycho-social support has become an integral part of the package of services provided to the impacted population. The earlier approach where patients used to come to receive treatment has evolved to where health care functionaries provide services proactively not only for physical health but mental health as well.

The district mental health program is now well established and supported by Local Self Governments. I am confident, as we go forward the program will further get strengthened and effectively tackle the mental health issues.

I once again appreciate the work done by Dr Kiran and his team and wish them all the success in future endeavours.

Dr Rajan Khobragade IAS
Addl Chief Secretary
Health & Family Welfare Department
Govt of Kerala

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Chapter 1: Introduction and State Context

Evolution of Mental Health Care can be best described through 5 '**C**'s, namely Confinement, Caring, Curing, Chemicals, & Community. In early and medieval periods, mental patients were mostly **C**onfined or chained, as their behaviors were believed to be due to evil spirits, witchcraft or black magic. But in 18th century, these symptoms and behaviors were started to be considered as part of a disease, and thus the concept that these people need to be **C**ared for, emerged. In late 19th century attempts were made to **C**ure these symptoms, and many psychological methods were developed. But still crude methods including torturing were in vogue in different parts of the world. Using **C**hemicals to cure mental illness found success with the discovery of Chlorpromazine in 1956. Thus began the era of psychopharmacology which drastically reduced the morbidity associated with the illness. But still the benefits were narrowed to a selected few for whom these treatments were accessible and affordable. Thus came the 5th revolution in mental health namely **C**ommunity Psychiatry in 1960s.

Mental Health care started in Kerala in 1870 with establishment of Mental Health Centre Thiruvananthapuram, currently having a bed strength of 531, followed by establishment of Mental Health Centre, Kozhikode in 1872 having a bed strength of 474 and Mental Health Centre, Thrissur established in 1889 having a bed strength of 361. Later on Psychiatry units were started in General Hospitals, District Hospitals and Medical Colleges. As per the latest data there are 181 beds for Psychiatry including de-addiction in GH/DH/TQH.

WHO strongly recommended the delivery of mental health services through primary health care systems as a policy for developing countries, as most developing countries including India did not have adequate number of institutions to care for the mentally ill.

There are several reasons given by World Health Organization (WHO) for integrating mental health into primary care. The burden of mental disorders being huge, it produce significant economic and social hardships that affect society as a whole. As many people suffer from both physical and mental disorders, integrated primary care services help ensure that people are treated in a holistic manner. There is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Primary care for mental health helps close this gap. People can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities. Moreover, mental health services delivered in primary care minimize stigma and discrimination and can also remove the risk of human rights violations that can occur in psychiatric hospitals. Primary care for mental health is affordable and cost effective, as costs in seeking specialist care in distant locations are avoided. In addition to these, primary care for mental health generates good health outcomes especially when linked to a network of services in the community.

Over the last few decades, community psychiatry in India has made substantial advances. **National Mental Health Programme (NMHP)** was established in 1982.

Attempts to develop models of psychiatric services in the PHC setting were made nearly simultaneously at PGI, Chandigarh in 1975 and NIMHANS, Bangalore in 1976. Aims of NMHP include prevention and treatment of mental and neurological disorders and their associated disabilities, use of mental health technology to improve general health

services and application of mental health principles in total national development to improve quality of life.

Strategies adopted to achieve these objectives are integration of mental health with primary health care, provision of tertiary care institutions for treatment of mental disorders and eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority (CMHA), and State Mental Health Authority (SMHA).

District Mental Health Programme (DMHP)

DMHP was started as a component of NMHP to provide sustainable mental health services to the community and to integrate these services with general health services. It helps for early detection of the patients within the community itself and to reduce the stigma attached towards mental illness through change of attitude and public education. Patients and their relatives do not have to travel long distances to go to hospitals or nursing homes in their cities. This also helps to take pressure off the mental hospitals and medical colleges. In addition to these, DMHP also helps to treat and rehabilitate mental patients discharged from the mental hospital within the community. To achieve these objectives the strategies adopted include Capacity building of medical, paramedical personnel and Health workers in mental health skills, Community Mental Health care through existing infrastructure of the health services, IEC activities and Community oriented Rehabilitation Services.

State Overview and Key Initiatives

As part of National Mental Health Programme, first DMHP was started in Kerala in Thiruvananthapuram in 1999. Thrissur district followed by starting DMHP in 2000. Subsequently DMHP was started in Idukki, Wayanad and Kannur districts. Owing to

the success of these districts in Mental Health service delivery with minimum Human Resource, DMHPs where started using state plan funds in Kollam and Alappuzha districts in 2012-13. Mental Health Programme was started and functioning streamlined in all 14 districts in 2017 under State Plan Funds.

Currently DMHPs conduct 306 monthly clinics in the state (mostly Block level), providing mental health services to around half a lakh population. Mental Health Programme aims for Mental Health Services through Primary Care and achieves this through Information Education and Communication (IEC) activities for general public to create awareness, reduce stigma and capacity building for Doctors, Nurses, Pharmacists and Health Workers for Integration of mental health into primary care.

Sustainable Developmental Goals (SDGs)

With the above mentioned issues and concerns in Mental Health, Sustainable Developmental Goals (SDGs) were formulated in 2016-17 for Mental Health in the state as part of Ardram Mission. Seven SDGs were set for mental health mainly

1. Early detection of emotional and behavioural problems in children
2. To reduce high suicide rate
3. To reduce morbidity due to depression
4. To reduce treatment gap
5. To reduce treatment dropouts
6. Integration of mental health in primary care
7. Rehabilitation of mentally ill

Strategies and interventions were devised to achieve the above set goals. Different Targeted Interventions were implemented (Table 1) through Mental Health Programme, incorporating the strategies thus formulated.

Table 1. SDGs and Targeted Interventions

Sl No	**SDGs -Mental Health**	Strategy/Intervention
1	Early detection of emotional and behavioural problems in children	School mental health 'Sampoorna Manasikarogyam'
2	To reduce high suicide rate	'Aswasam' & 'Ammamanass', Jeevaraksha 'Sampoorna Manasikarogyam'
3	To reduce morbidity due to depression	
4	To reduce treatment gap	'Sampoorna Manasikarogyam' (SMA)
5	To reduce treatment dropouts	
6	Integration of mental health in primary care	
7	Rehabilitation of mentally ill	'Sampoorna Manasikarogyam' 'Home Again' through collaboration with NGO Banyan.

Funds from GOI through NMHP are utilised for the Kerala specific Targeted Interventions –Sampoorna Manasikarogyam, Aswasam, JeevaRaksha, Amma Manass, Tribal & Coastal Mental Health and Day Care centres of Mental Health Programme.

DMHPs conduct 306 monthly clinics in the state (mostly at CHC/TH level). Around **50,000** patients are receiving treatment monthly from DMHPs. Mental Health

Programme aims for Mental Health Services through Primary Care and achieves this through Information Education and Communication (IEC) activities for general public to create awareness and reduce stigma, Training for Doctors, Nurses, Pharmacists and Health Workers for Integration of mental health into primary care, Targeted interventions-(Substance abuse prevention, suicide prevention, geriatric mental health, stress management) and Community based Rehabilitation.

'Sampoorna Manasikarogyam' -For finding the undetected mental health case burden, reduction of treatment drop outs and Integration of Mental Health into Primary Care by involving community level workers (ASHAs) in detection, management and follow up of cases and Integration of newly detected cases to Family health care system.

Till date it has been implemented in 698 FHCs, 19,161 ASHAs were trained as part of the programme and 45,058 New cases were detected. A total of 83,722 cases were given treatment as part of the programme and integrated into Comprehensive Primary Care by which they will continue to get treatment & psychotropic medicines from their nearest Family Health Center.

'Thalir' - School Mental Health Programme started in 2012-13 academic year in Thiruvananthapuram district has been extended to whole state. Its implemented in collaboration with School Health and Adolescent Health of NHM. Training is given to school teachers for early detection of emotional and behavioral problems, substance abuse, and suicidal behaviors in school children and prompt referral to nearby DMHP clinics. Till date 73,375 persons (teachers, counsellors &parents) have been imparted such training through 1062 batches.

'**ASWASAM'-Depression management** in Primary Care was implemented for achieving the SDGs of reducing Suicide rate and Morbidity due to depression. Health Workers

and Staff Nurses are trained in Screening Depression among general public using PHQ9 questionnaire, while Doctors are trained in diagnosis and management of Depression at Primary care. Staff nurses of the FHCs are trained in Psychological First Aid and Psycho Social Intervention. Referral Protocol for cases to be seen by DMHP is include in the programme.

3,21,292 persons have been screened till date, of which 34,326 were positive for depression. Pharmacotherapy started for 18,207 and Psychosocial intervention for 28,264. 8518 cases were referred to DMHP till date.

'AMMA MANASS' -Maternal & Infant Mental Health Services -Screening for Stress, Depressive Disorder, Anxiety Disorders and Other Mental Health Issues are done during antenatal (1st, 2nd & 3rd trimester) and post-delivery period (6th wk, 14th wk & 9th month). Training is given for JPHNs, Staff Nurses, Primary Care Doctors, Gynaecologists & Paediatricians.

Till date 7,060 Block level staff and 16,355 ASHAs were trained as part of implementing Amma Manass. Review training has been conducted for 279 batches and 15,984 beneficiaries

'Jeeva Raksha'-Suicide Prevention- Community gate keepers (Elected representatives, doctors, health workers, police personnel, teachers, religious leaders) are given training on suicide prevention especially on warning signs of suicide and psychological first aid. Till Date 29,302 personnel have been trained in 527 batches.

'Tribal Mental Health' - Medical camps and field activities focusing on Substance abuse prevention, Adolescent Mental Health and Treatment Gap & Drop Outs. This includes creating awareness in the tribal community about physical, psychological and social ill effects of substance abuse and treatments available, formation of support groups for

deaddiction treatment and follow ups, providing Life skill training for adolescents and formation of adolescent support groups, ensuring early detection and treatment of depression and other mental illnesses, providing continuity of care and helping the community take responsibility for its mentally ill patients. Till date the program has been implemented in 381 tribal areas in 13 districts.

'Stress Management Programme' at Workplace- For creating awareness about the symptoms of stress and need of stress management and putting in place a system for regular Screening at workplace, following which interventions are given for those in need, thereby improving interpersonal relationships and productivity. Till date 33,348 personnel have been trained in stress management through 669 batches.

'Coastal Mental Health' - To create awareness in the coastal community about physical, psychological and social ill effects and treatments available for substance abuse, which includes formation of support groups for deaddiction treatment, providing Life skill training for adolescents and formation of adolescent support groups and providing community based Counselling services. Till date the program has been implemented in 73 coastal areas in 9 districts.

Palliative Mental Health

Many of the palliative care patients require mental health support for symptoms like insomnia, depression, anxiety, psychosis, delirium etc. Most of the care givers also need psychological support. Also mentally ill patients who are bed ridden may not have access to treatment by mental health team at CHCs.

In order to close these gaps, the Mental Health Programme is linked with Palliative Care Programme at CHC level.For this, trainings are imparted to all palliative care nurses at panchayat level and secondary chronic care nurses and doctors at CHC level

Urban Mental Health

As DMHP monthly clinics are mostly restricted to rural/semi urban areas, Urban PHC Health staff (doctors, staff nurses and health workers) are being equipped in Mental Health service delivery. Mental Health Training are imparted to Urban PHC Staff for the same. Also awareness on mental health, stigma reduction and services available are created in the urban population.

Tele MANAS

Tele MANAS service launched in October 2022 provides 24x7 mental health services which includes tele-counselling and tele- consultation through the toll-free number 14416. It also includes provisions for direct services in all districts through DMHPs. The service addresses emotional problems, behavioral issues, suicidal tendencies, de-addiction treatment, and various mental health concerns.

Counsellors are given regular weekly training with case presentations and have to successfully complete the Certificate Course for Tele Manas Counsellors by NIMHANS. Currently the service is given 24x7 through Psychiatrist, Clinical psychologist, Psychiatric Social Worker and counsellors. **61,939** calls have been handled till date. Video consultation started in 2025 July. 319 Video Consultations completed.

'Santhwanam' Community based Rehabilitation – Day Care Centres

Rehabilitation and mainstreaming of patients with severe psychiatric illness are key issues while focusing quality health care to all. There are many patients under treatment for mental illness who do not have active illness and are in remission. These patients need not be in hospital but should be cared for at home so that they can slowly be brought to the mainstream. But very often, after being discharged, these patients

end up being a burden on their families. Unemployment and rejection could drive them to alcohol or drugs; they could miss medication and finally end up in hospital again. Occupational therapy helps them to build their self-esteem, confidence and also help them to come into the main stream of life like any other individual.

Santhwanam Mental Health Rehabilitation Project is a Day Care Centre for mentally ill patients in remission. It is a joint venture of Block Panchayat (Pothencode), Grama Panchayat (Mangalapuram) and Mental Health Programme for mentally ill persons. Based on its success, Day Care Centres with Occupational therapy units were started in all 14 districts of the State at Panchayat level. Currently 31 community based Day Care Centres are functioning in the State under District Mental Health Programme, in collaboration with Local Self Governments. Rs 6 lakhs are provided to each of these 31 centres from NMHP through Planning & M&E head.Rs 10 lakhs is provided to each centre from State Plan Funds. Patients are brought to the centre from their homes by 10.00 am dropped back by 3.30 pm in the vehicle hired for the purpose. These patients are given breakfast in the morning and tea, snacks in the evening and lunch by noon. They are given occupational therapy (medicine cover making, lotion and soap making, horticulture etc.) and the income generated through this is given to them as remuneration. They are examined monthly and treatment compliance is ensured by the DMHP team. Recreational activities like craft making, indoor games are also conducted daily for creating a friendly environment for the inmates. This rehabilitation centre provides a supportive environment for individuals to manage their mental health conditions. It facilitates rehabilitation of the patients who are under treatment but in remission, helping them to acquire skills to care for themselves. The project impart basic skills, so that the dignity and self-worth of the individual can be sustained through receiving remuneration for the skilled work done. The families of these persons also

benefit with reduce stress and burden as their loved ones receive professional care and support.

Activities of DMHP (Fig 1)

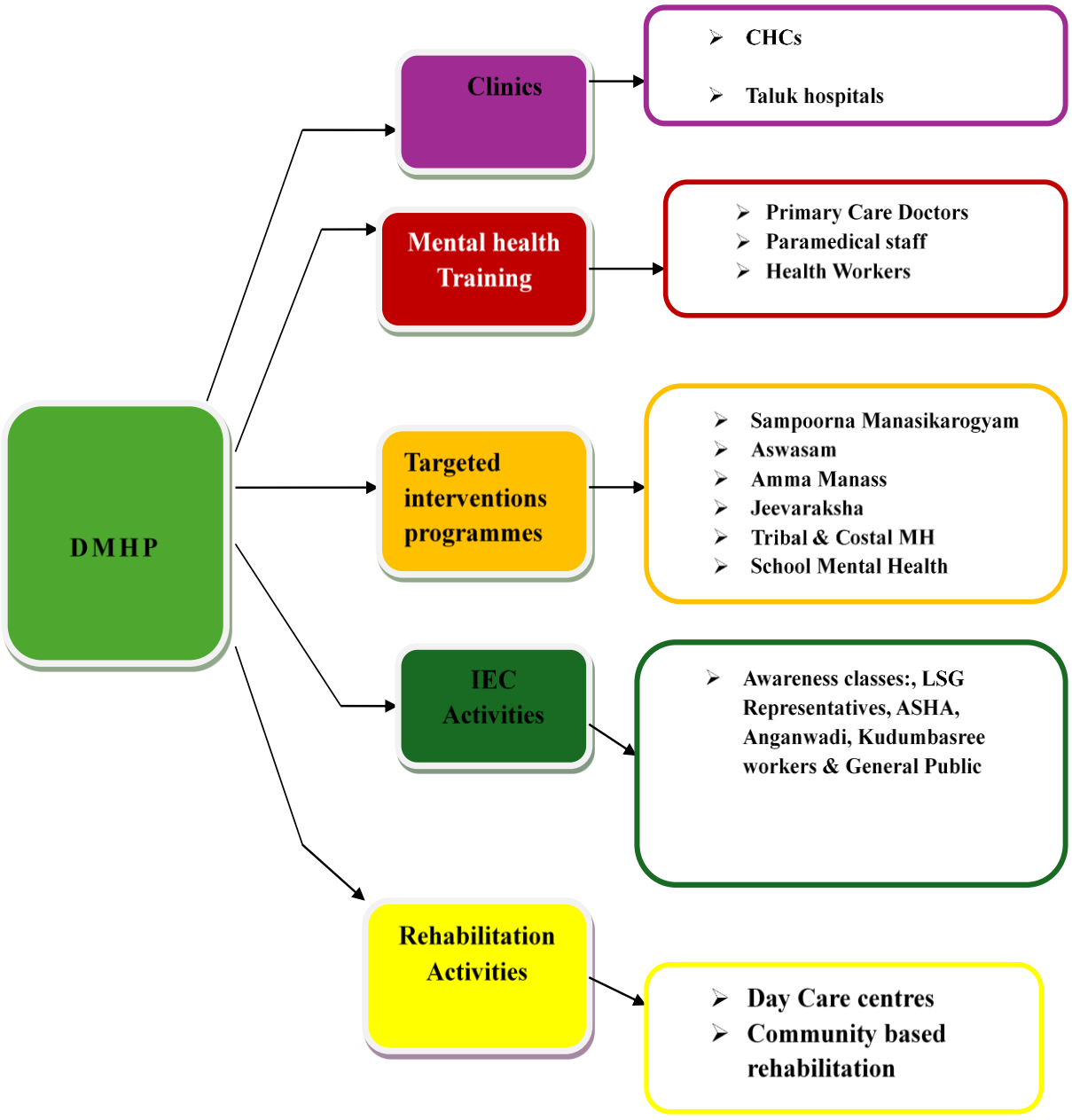


Fig. 1. Activities of District Mental Health Programme

Mental Health Burden

Mental health is the foundation for well-being and effective functioning for an individual and for a community. Psychiatric disorders cause heavy burden on the society world over. According to Global Burden of Disease Report mental health problems are among the first twenty leading causes of disease burden which includes depressive disorder, alcohol use disorders and self-inflicted injuries.

There has been no comprehensive epidemiological data regarding prevalence of mental disorders for India. The available data so far came from the individual studies done by different researchers across the country with varying methodologies. Prevalence rates of psychiatric disorders in these studies varied from 9/1000 to 370/1000. In this background National Mental Health Survey- India was conducted in 2015-16 which estimated the prevalence of mental disorders, disability due to mental disorders, service utilization patterns of those affected with mental illnesses, burden of care and also the services and programmes and other resources for mental health care and services. The study was done in 12 states across the country for getting data at the national level and Kerala was included representing Southern India. NMHS was undertaken in Kerala by IMHANS Kozhikode under guidance of NIMHANS Bangalore.

Key findings of NMHS -1- (Kerala):

Current overall prevalence of any mental disorders is 11.36%. This includes schizophrenia and other psychotic disorders, depressive disorders, bipolar affective disorder, neurotic and stress related disorders and alcohol and other substance use.

Neurotic and stress related disorders and depression of all severity without psychotic symptoms and alcohol and other substance use disorders were categorized as common

mental disorders. Prevalence of common mental morbidity was 11.0%: depressive disorder 2.49%; neurotic and stress related disorders: 5.43%; and mental and behavioral problems due to psychoactive substance use 10.12%. Common mental disorders were more common in men than in women. However, there were variation with respect to individual disorders with substance use being more common amongst males and depression being more common amongst females.

Schizophrenia and other psychotic disorders with bipolar affective disorder and severe depression with psychotic symptoms were clubbed together as severe mental disorders. Prevalence of Severe mental disorders were 0.44%: schizophrenia and other psychotic disorders: 0.19%; bipolar disorder: 0.17%; severe depression with psychotic symptoms: 0.08%. Severe mental disorders were also more common in men than in women.

Neurotic and stress related disorders include phobic anxiety disorders (3.19%) other anxiety disorders (1.62%), panic disorder (0.89%), panic disorder with limited symptoms (0.45%), generalized anxiety disorders (0.28%), obsessive compulsive disorder (2.48%), and PTSD and adjustment disorder (0.36%).

Substance use disorders include: alcohol use disorders (4.82%), tobacco use disorders (7.22%) and other substance use disorders (0.08%). All substance use disorders are more common in men when compared to women.

In this study the occurrence of generalized tonic clonic seizure and has estimated a prevalence of 0.38% and was more in males and those aged between 50-59 years.

As per NCRB, the rate of suicides in 2014 was 23.9 per 1,00,000 population. Those who are at a high risk of suicidality was estimated to be 2.23%. Both suicide risk and rate of completed suicide are higher amongst males compared to females.

With respect to Mental Health Systems Assessment, Kerala is found to have a better developed public health system and mental health services.

There were a total of 626 mental health professionals within the state (psychiatrists: 400, clinical psychologists : 211, and psychiatric social workers: 15). Thus, for every 1,00,000 population, there would be 1.2 psychiatrists, 0.63 clinical psychologists and 0.04 psychiatric social workers.

There are 3 mental hospitals,7 medical college psychiatry departments and 18 general hospital psychiatry units in government sector. Beds available for inpatients admission in government sector is 1962 (5.87 beds for 1,00,000 population). In addition there are several psychiatry hospitals, clinics and psychiatry units in private hospitals.

The District Mental Health Program is being run in all districts. There are 22 mobile mental health units, 43 day care centres, 66 de-addiction units, 10 vocational training centres, 6 sheltered workshops and 146 long stay homes.

While IEC activities were limited in their scope as also mental health research. A key issue was with respect to budgetary allocation for mental health care which was found to be wanting in terms of quantum and also use of even available meagre funds. The Mental Health System Assessment also observed challenges in inter-sectoral collaboration and underscored the need for training both health and health-related sector for better mental health care.

In conclusion, NMHS-Kerala 2016 has shown that, high suicide risk, common mental disorders and substance related disorders are found to constitute most important threats to mental health of the population of Kerala and should become the priority in mental health care plans. It is notable that in spite of advances made on many aspects Kerala still don't have a mental health action plan. The number of professionals need

to increase and training for general doctors and paramedical staff and public awareness programs need to be stepped up.

The Government of India has launched the National Mental Health Survey – 2 (NMHS–2) in 2024. The survey is being conducted across India by NIMHANS, Bengaluru, and the Government T.D. Medical College, Alappuzha, is the participating institution for Kerala. The Government of Kerala has sanctioned the project and an advisory board has been constituted. The said Government Orders have also sanctioned the recruitment of field staff for the survey. The recruitment process and the requisite six-week training in survey methodology and the use of structured questionnaires have been completed. Based on a multi-stage sampling design considering the rural–urban distribution, tribal population, and poverty index, a representative sample of Kerala has been selected. The survey will cover both rural and urban populations across five districts -Alappuzha, Kottayam, Wayanad, Palakkad, and Pathanamthitta and four major urban agglomerations- Thiruvananthapuram, Thrissur, Ernakulam, and Kozhikode. The tablet based survey is designed to include a total sample of 5,313 adults and 2,125 adolescents across 212 clusters (25 participants per cluster)

Problems faced in Mental Health Care

1. Lack of Awareness

    i. **Regarding symptoms**-physical symptoms of depression and anxiety disorders like somatic pain, aches, insomnia and even panic attacks are usually considered as that of physical illnesses (even after physical examination and investigation results are negative and assurance from physician) and repeatedly seek physical treatment or take analgesics and other medications by self.

ii. **Regarding treatment**. Many people are still ignorant regarding psychiatric treatments available, mental health professionals, and where to approach. So they may prefer religious forms of treatment which are easily available. Also, misconceptions regarding psychiatric treatments especially pharmacotherapy keeps patients away from seeking proper treatment.

These are being addressed through increasing awareness regarding mental illnesses and treatments. Conducting regular IEC Programmes in community will help in achieving this aim.

2. Resources

i. Resources are limited. Number of mental health professionals especially in community mental health are few compared to the growing population and demand.
ii. Available resources are concentrated in Mental Health Centres and Medical colleges, leaving psychiatric care scarcely accessible to majority
iii. Lack of mental health skills in primary health care professionals and workers
iv. Quacks thriving in many rural areas due to lack of qualified mental health professionals.

3. Stigma

There is stigma associated with mental illness, because of which people try to ignore the symptoms, or keep it to themselves. They may opt for religious forms of treatment or black magic for cure.

Stigma can be reduced by increasing awareness through IEC programmes. Integration with Primary Care will also help in the process.

4. Follow ups

i. Cost of treatment, especially when multiple drugs are needed.

ii. Long duration of treatment needed as in schizophrenia

iii. It may be difficult to bring the patients for long distances in public transport system, especially if the patient is symptomatic.

Can be addressed to a certain extent through Primary Care integration of Mental Health.

1. Other patient related factors

i. **Poor drug compliance**:- mostly patients relate the treatment with that for acute physical illnesses and discontinue medicines as soon as symptomatic improvement occur.

ii. **Expressed emotions**;- hostility, over-involvement, and critical comments towards the patient from care givers and family members often increase relapse rates.

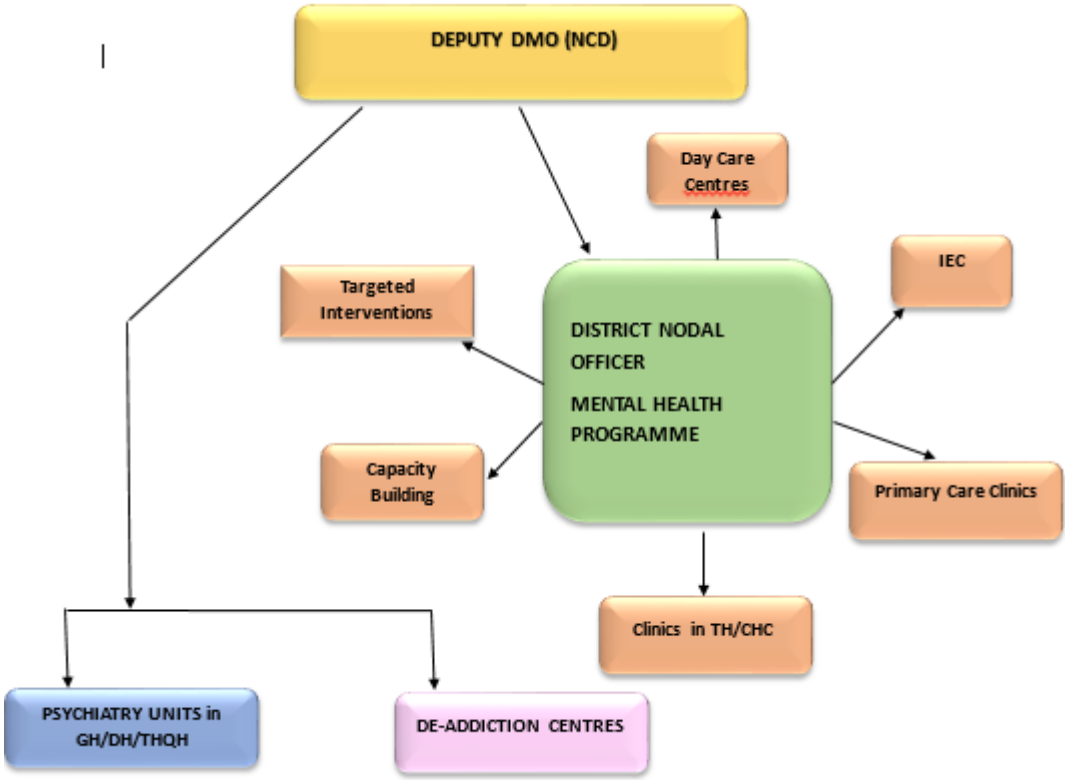
Repeated and regular psycho-education for patients, caregivers and other family members should be given to ensure compliance to treatment and address expressed emotions.

5. Attitude of General public

Even though health is defined as physical, mental and social wellbeing, majority considers physical wellbeing as the only criteria for health. People tend to seek treatment for even minor physical ailments while a severe mental stress or illness is kept to themselves without seeking any help, even though the stress created by the latter is far greater. This attitude of general public may be due to a combination of factors like stigma, lack of awareness, and lack of easy accessibility to treatments. But this forms the leading limitation in the concept of psychological wellbeing to all, as we assume that five by sixth of mild mental disorders still remain untreated in the community

Chapter 2 : Organizational Structure

Deputy DMO (NCD) is in charge of Mental Health in each district, which includes Psychiatry units of GH/DH/THQH, De-addiction Centres and Mental Health Programme, while the overall coordination of Mental Health activities in each district is done by the District Nodal Officer, Mental Health Programme.



District Mental Health Programme

Mental Health Programme in each district is headed by the District Nodal Officer who will be a qualified Psychiatrist.

Role of District Nodal Officer

DNO coordinates the mental health activities in the districts, which includes :-

- Community Mental Health clinics at Block level

- Capacity building of primary care doctors, Nursing officers, pharmacists and health workers for conducting primary care clinics, case detection and default tracking.
- IEC activities for reduction of stigma and increasing awareness among the general public.
- Targeted interventions namely Sampoorna Manasikarogyam, Aswasam, Amma Manass, Jeevaraksha and School Mental Health.
- Day care centres for mentally ill patient in remission.
- Documentation and reporting
- Liaison with DMO office, DPM office and other departments including LSGD, WCD and SJD

District Nodal Officer reports to concerned District Medical Officer and State Nodal Officer DHS.

State Mental Health Unit

ADHS (Medical) is in charge of Mental Health in the State, while the activities are co-ordinated by State Nodal Officer (SNO) Mental Health.

Role of State Nodal Officer

- District Mental Health Programme (DMHP) activities in the districts including monthly clinics, capacity building and IEC.
- Supervision of Targeted intervention activities in the districts namely Sampoorna Manasikarogyam, Aswasam, Amma Manass, Jeevaraksha and School Mental Health.
- Functioning of 31 Day Care Centres in the State.
- State level TOTs

- Preparations and regular updating of modules for training and IECs in districts.
- Functioning of De-addiction services under HSD.
- Co-ordination with Vimukthi project of Excise dept for smooth functioning of the 14 de-addiction centres.
- Functioning of Psychiatry units of THQH/DH/GH.
- Functioning of the three Mental Health Centres at Thiruvananthapuram, Thrissur and Kozhikode.
- Supervision of Community Rehabilitation done in collaboration with NGOs.
- Co-ordination with SHSRC for Research and Evaluation of the programmes under Mental Health.

Kerala State Mental Health Authority

In exercise of the powers conferred by provision to section 4 of the Mental Health Act, 1987 (14 of 1987), the Kerala State Mental Health Authority was constituted by the Government of Kerala on November 1, 1993, as per notification No(P) 122 / 93 Health and Family Welfare Department dated 1/11/1993.

Later, the Mental Health Act of 1987 was repealed by the Mental Healthcare Act of 2017, which came into force on 29.05.2018. In exercise of the powers conferred by sections 45 and 46 of the Mental Health Care Act, 2017 (Central Act No.10 of 2017), the Government of Kerala have constituted the State Mental Health Authority.

The main functions of the Authority are supervision of all Mental Health Establishments in the State, receive complaints about deficiencies in service provision, develop quality and service provision norms for different types of Mental Health

Establishments in the State, and register all Mental Health Establishments and Mental Health Professionals in the State according to the provisions of the Act. The minimum standards stipulated as per Section 65(6) for the various categories of Mental Health Establishments have been developed and forwarded to the Government, which is under consideration of the Government and the Authority.

KSMHA Members (ex-officio)

1. The Additional Chief Secretary, Health & Family Welfare Department - Chairperson

2. Joint Secretary, Health & Family Welfare Department, in charge of mental health.

3. Director Health Services.

4. Joint Secretary, Social Justice Department.

5. Joint Secretary, Home Department.

6. Joint Secretary, Law Department.

7. Joint Secretary, Finance Department

Mental Health Review Boards

As per section 73 of the Mental Health Care Act 2017, the Authority have established five Mental Health Review Boards (MHRB), with an objective of protecting the rights of person with mental illness in connection with their treatment, at Thiruvananthapuram, Thrissur, Kottayam and Kozhikode and Kannur in the State having jurisdiction of 2 to 3 districts(Table 2.1). The functioning of the MHRB, except in Kannur have commenced on 01.04.2024. The infrastructure facilities for MHRB, Kannur is being developed and will start functioning soon.

Table 2.1 MHRBs and Areas of Jurisdiction

Name of Mental Health Review Board	Area of jurisdiction
The Mental Health Review Board, Tvpm State Nutrition Office, District Medical Office campus, Thiruvananthapuram.	Thiruvananthapuram, Kollam Alappuzha
The Mental Health Review Board,Kottayam Government Medical College, Kottayam	Kottayam, Pathanamthitta Idukki
The Mental Health Review Board, Thrissur Government Mental Health Centre,Thrissur	Thrissur, Ernakulam, Palakkad
The Mental Health Review Board, Kozhikode Government Mental Health Centre, Kozhikode	Kozhikode, Malappuram Wayanad
The Mental Health Review Board, Kannur Revenue Tower, Mattannur, Kannur.	Kannur Kasargod

De-addiction services and centers

Under Health services department De-addiction services are available in the following institutions (Table No.2.2). In addition to these, Health Service Department and Excise Department have jointly started 'Vimukthi' De-addiction centres in 14 districts (one per district). While the infrastructure is provided by HSD in GH/DH/TQH, posts/services of Psychiatrists, Psychiatric Social Workers, Clinical Psychologists, Nurses, Attenders

and Security Staff are made available in these centres through funding by Excise Department

Table 2. 2 De-addiction services and centers

Sl.No	Institutions	Sl.No	Vimukthi Centre
1.	GH Ernakulam	1.	GH Neyyattinkara, Thiruvananthapuram
2.	DH Kollam	2.	TH Nedungolam, Kollam,
3.	DH Kozhencherry	3.	THQH Ranni, Pathanamthitta
4.	DH Kannur	4.	DH Mavelikara, Alappuzha
5.	DH Palakkad	5.	GH Pala, Kottayam
6.	THQH Kottarakara	6.	DH Painavu Idukki
7.	THQH karunagappalli	7.	GH Muvattupuzha, Ernakulam
8.	MHC Thiruvananthapuram	8.	THQH Chalakudy, Thrissur
9.	MHC Thrissur	9.	Tribal Specialty Hospital, Kottathara
10.	MHC Kozhikode	10.	DH Nilambur, Malappuram
11.	GH Thiruvananthapuram	11.	GH Kozhikode (Beach Hospital)
12.	GH Kottayam	12.	DH Mananthavady, Wayanad
13.	THQH Punalur	13.	TH Payyanur, Kannur
14.	THQH Thirurangadi	14.	THQH Nileshwaram, Kasargod
15.	THQH Ottapalam		

In addition to these, de-addiction services are present in all institutions where Psychiatrist is available.

Services provided at Deaddiction centres includes

1. Assessment of the drug/ alcohol abuse problems

2. Detoxification therapy

3. Pharmacotherapy

4. Counselling (individual and family)

5. Group therapy

6. Treatment of comorbid medical and psychiatric illnesses

7. Rehabilitation

8. Follow up care

9. Outpatient services

Community level De-addiction services are provided by Mental Health Programme through 300 monthly clinics at Block/CHC level. Community De-addiction training given to Medical Officers in all districts whereby majority of the patients with mild substance use can be treated in PHCs/CHCs.

Under 'Sampoorna Manasikarogyam' project of Mental Health Programme implemented at Grama Panchayat level, cases of substance abuse (along with other mental health issues) are detected and brought to treatment at PHC/FHC by ASHAs and AWs. They are given de-addiction treatment and followed up regularly at PHC itself. Material on substance abuse prevention are included in all IEC activities of Mental Health Programme.

Chapter 3 : Operational Strategies and Service Delivery

Service Delivery Mechanism under Mental Health Programme in Health Service Department including Awareness creation, Screening, Diagnosis, Treatment, Follow ups, Default tracking and Community level Rehabilitation are organised under four levels of care(Table 3).

Table 3. Levels of service delivery

	Field	**Sub centre**	**FHC**	**CHC**
Outreach Clinics				1.Monthly MH clinics 2. Block Conference Review
Sampoorna Manasika Arogyam (SMA)	1. House Visits, Awareness & Screening by ASHA. 2. Awareness by MLSPs, HWs, AWWs 3. Palliative care visits for bedridden/difficult to bring patients	Default tracking by Health Workers, MLSPs	1.Monthly clinics by MO 2. Drug dispensing 3. Psycho Social Intervention	Review of follow up patients once in 4 months/relapse by DMHP
Aswasam	High risk case listing & Screening	Screening	1. Screening by Nursing Officers 2. Diagnosis 3. Psychosocial intervention 4. Pharmacotherapy	Referral consultation in DMHP as per protocol
Amma Manass	Awareness by ASHA	Screening by JPHN	1.Screening 2. Psycho social Intervention	Referral consultation in DMHP as per protocol
Jeevaraksha	Awareness by HW, Screening	Screening	Psycho social Intervention	Block level Training

Community Level Interventions

Screening for Mental Health issues in the community is done through three community level interventions namely Sampoorna Manasikarogyam, Aswasam and Ammamanass. Mental Health issues are also screened as part of Shaili – II Survey.

1. 'Sampoorna Manasikarogyam'

For finding the undetected mental health case burden, reduction of treatment drop outs and Integration of Mental Health into Primary Care by involving community level workers (ASHAs) in detection, management and follow up of cases and Integration of newly detected cases to Family health care system.

The delivery of mental health services through primary health care system as a policy for developing countries was recommended by WHO, as the burden of mental disorders is 10-12% and treatment gap is 80% for mental disorders. Needed an implementation model to detect the case burden in the community, to enable access to mental health care system and to close the treatment gap.

'Sampoorna Manasikarogyam' was implemented with the objectives of ;

- Finding the **undetected case burden** in the community through interventions at Grama Panchayat level.
- **Integration** of newly detected cases to **Family health care system.**
- Ensuring regular follow ups and thus **reducing Treatment Drop Outs**
- **Substance abuse prevention** and management
- Addressing **Adolescent mental health issues**
- Increasing the **Awareness** on mental health issues and treatment, in the community.

- **Community based Rehabilitation** of mentally ill in remission.

The PROTOCOL is as follows.

1. The administrative- financial charge for implementing the programme is done by Family Health Centre (FHC) Medical Officer i/c. Training, IEC, Camps and overall supervision is done by DMHP.

2. Training of grass root level workers-ASHAs on Mental health awareness creation, Stigma Reduction & Screening with Case detection Forms (3 Hours). Sensitization of Elected representatives of Gramapanchayath, Arogyasena workers and Health Workers (JPHN, JHI) on mental health is also conducted along with this. The date for the first camp is fixed on the training day itself.

3. At least one ASHA is trained in each ward.

4. House Visit–

•The number of houses visited by each ASHA is fixed during the training programme itself.

•Only trained ASHAs conduct house visits.

•Maximum 10 days are allotted for house visits.

•Check list are provided for ASHAs to ensure that all houses in the panchayat have been visited.

•ASHAs visit Every Household in the panchayat, give brief mental health awareness class with leaflets & Screens for any mental health issues with structured DMHP case detection questionnaire. Information on camp date is given

•ASHAs screen people with mental health issues using the questionnaire provided.

•All households in the panchayat are given mental health awareness leaflets.

5. Mental Health Awareness Programmes are conducted in Schools, Govt Institutions, ICDS and Kudumbasree units in the Panchayath during the screening period.

6. Case detection forms are evaluated by DMHP team. Families with detected cases are reminded to attend camp at FHC by ASHA workers.

7. Mental health camp in concerned FHC involving DMHP team & FHC Staff.

8. Two review camps are conducted in following two successive months to cover the entire cases detected by repeated intimation by ASHA, and follow ups of newly diagnosed cases

9. Stable cases are transferred to FHC Medical Officer who conducts weekly/monthly (depending upon the number of patients) Mental Health Clinics in the FHC.

10. Medical Officer, Pharmacist, Staff nurses and Health workers are trained by DMHP and they support the management, drug dispensing and records keeping in the FHC.

11. Follow up plans are done for rehabilitation of needed patients in the community, involving Health workers & LSG Elected Representatives.

12. Evaluation of data and analysis.

2. ASWASAM

In view of the high prevalence of depressive disorder in the community, a programme for Depression management in Primary Care was started on April 7 World Health Day in 170 Family Health Centres across the state.

Health Workers are trained to screen for depression using **PHQ 9 questionnaire**. High risk cases for depression are specifically targeted and enlisted in each panchayat. High risk cases include

- Patients under Palliative care.
- Care givers.
- Those with substance abuse and their family members.
- History of suicide attempts.
- Family members of those committed suicide
- NCD patients.

Those who are found positive (score of 10 or above) are referred to the FHC Medical Officer. In addition to this, general patients attending the FHC, if suspected to have depression are referred by MO to Staff Nurse for screening by PHQ 9 questionnaire. If found positive they are referred back to Medical Officer for further management. In both streams of referral (one from community and other from hospital) FHC doctor applies ICD 10 criteria of Depressive Disorder for diagnosis and categorizes into Mild, Moderate, Severe types.

Mild cases are referred to Staff Nurses for Psycho Social Intervention and are followed up. Those cases not showing improvement or worsening are referred to DMHP clinic for further counselling.

Moderate cases are also referred to Staff Nurses for Psycho Social Intervention and are followed up. Those cases not showing improvement or worsening are started on Pharmacotherapy by the FHC Medical Officer.

Severe cases are started on Pharmacotherapy by FHC Medical Officer on first visit itself.

Referral protocol to DMHP

1. Mild depressive disorder not improving with psycho social intervention at FHC

2. Moderate & severe depressive disorder not improving with Pharmacotherapy by 3 weeks.

3. Doubt in diagnosis.

4. Comorbid mental illnesses.

5. Comorbid substance abuse.

6. Suicide tendency.

7. Children & pregnant women,

8. Recurrent depressive disorder & depressive cycle of BPAD.

'Aswasam' training is given by DMHP at FHCs. Doctors, Staff Nurses, Pharmacists & Health Workers are given training. Aswasam reports are incorporated into DMHP monthly reports and send to DMO and District Nodal Officer, Mental Health Programme.

3. AMMA MANASS

Maternal & Infant Mental Health service is implemented in Kerala by the name 'AMMA MANASS' to reduce the suicide rate, incidence of Depression, Anxiety, Post-Partum Psychosis and infanticide during Perinatal period. Amma Manass is implemented jointly by Mental Health Programme and RCH division. It has the following components:-

i. Counselling for Eligible Couples

Eligible couples are counselled by JPHN/ASHA for creating Mental Health Awareness & Positive Mental Health. H/o any mental illness, epilepsy and treatment are elicited and promptly referred to DMHP for expert advice.

ii. Mental Health Screening in Antenatal Period

Screening is done by JPHN during the first, second & third trimester during the antenatal period.

iii. Mental Health Screening in Post Delivery Period

Screening is done by JPHN during the Sixth week, Fourteenth week & Ninth month post delivery period.

iv. Treatment

Those in need are referred to PHC/FHC Medical Officer where confirmation is done and referred to DMHP clinic in CHC.

v. Training

Training is conducted for all Doctors, PHNs, JPHNs & Staff Nurses, as per training module which includes:-

- Need for maternal & infant mental health
- Stress & mental health issues during antenatal period, post-delivery period and its management
- Screening checklist.
- Treatment & referral protocol, reporting.

- Psychological first aid & psycho social intervention.

Training is also given to Gynaecologists & Paediatricians on the above modules.

Awareness is given to ASHAs & ICDS Personnel using separate modules

vi. Documentation & Reporting

Registers are kept in PHCs regarding the screening, treatment started & referrals.

Monthly evaluations are done at Block, District and State level

Mental Health Services available by Levels of care

Mental Health Service delivery in the State is done through three Mental Health Centres, 14 Medical College Psychiatry Departments, Psychiatry units of General Hospitals/District Hospitals/Taluk Hospitals, District Mental Health Programme and Primary Care follow up Clinics in FHCs (Fig 3.1).

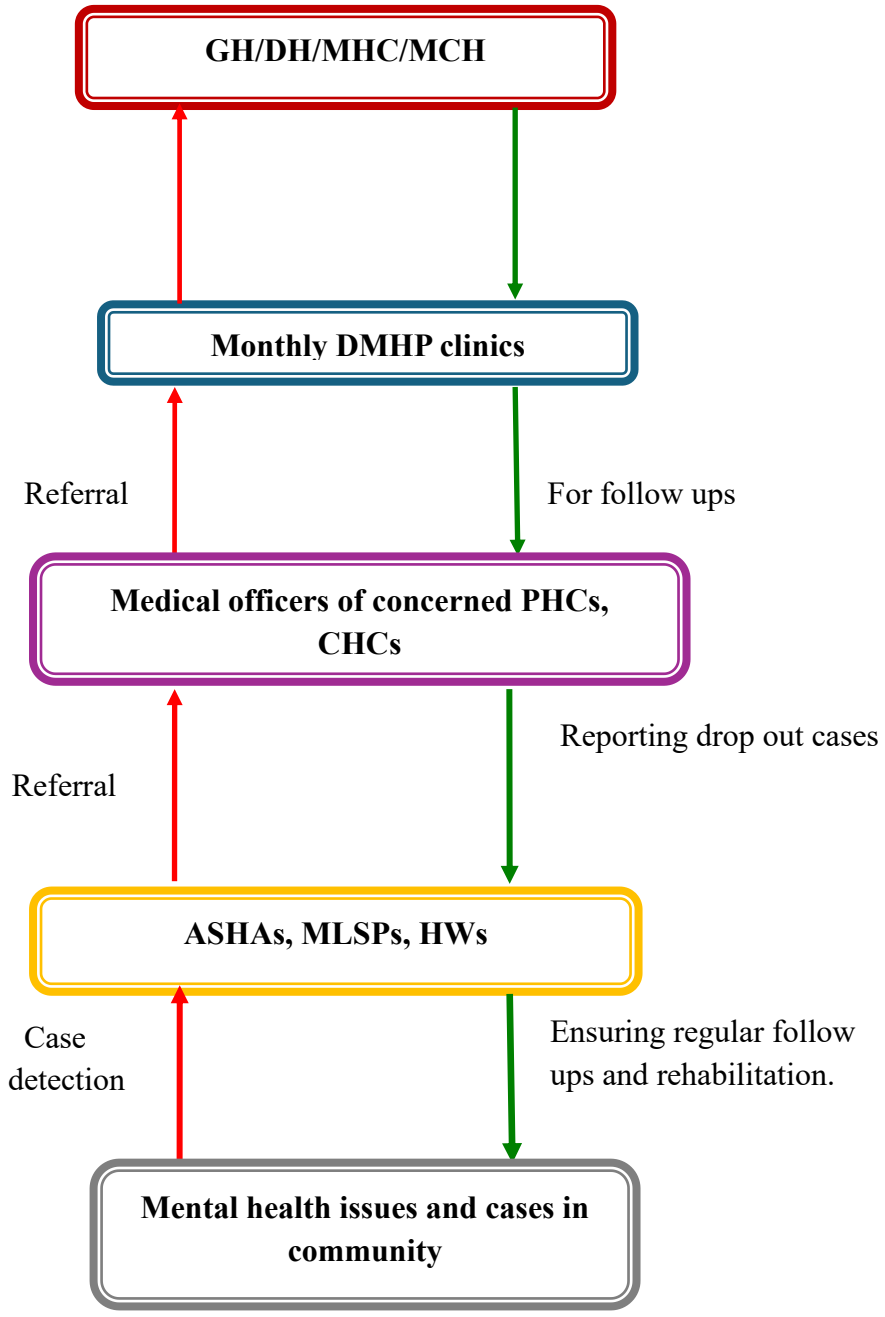


Fig 3.1 Functional level of Mental Health Care in the State

Tele Mental Health

Service Delivery Framework

The general guiding principles governing the service delivery process for Tele MANAS are that:

a) Majority of users (about 80%) will have mental health concerns/mental distress and not mental illnesses and

b) Most of these concerns can be effectively handled by trained non-specialists.

Consequently, a tier-based system was established, and counselling services provided to those with mental health problems and to their family members and caregivers. Based on the level of care necessitated, these services were dispensed by trained HR.

Two-Tier System

The Tele MANAS Cell operate as functional unit of Tele MANAS in the State. Tele MANAS is organized as a two-tier system. Tier 1 comprise the State Tele MANAS cell, which includes trained counsellors and mental health specialists. Tier 2 comprise specialists at District Mental Health Programme (DMHP). Figure 3.2 depicts the two-tier service delivery framework of Tele MANAS.

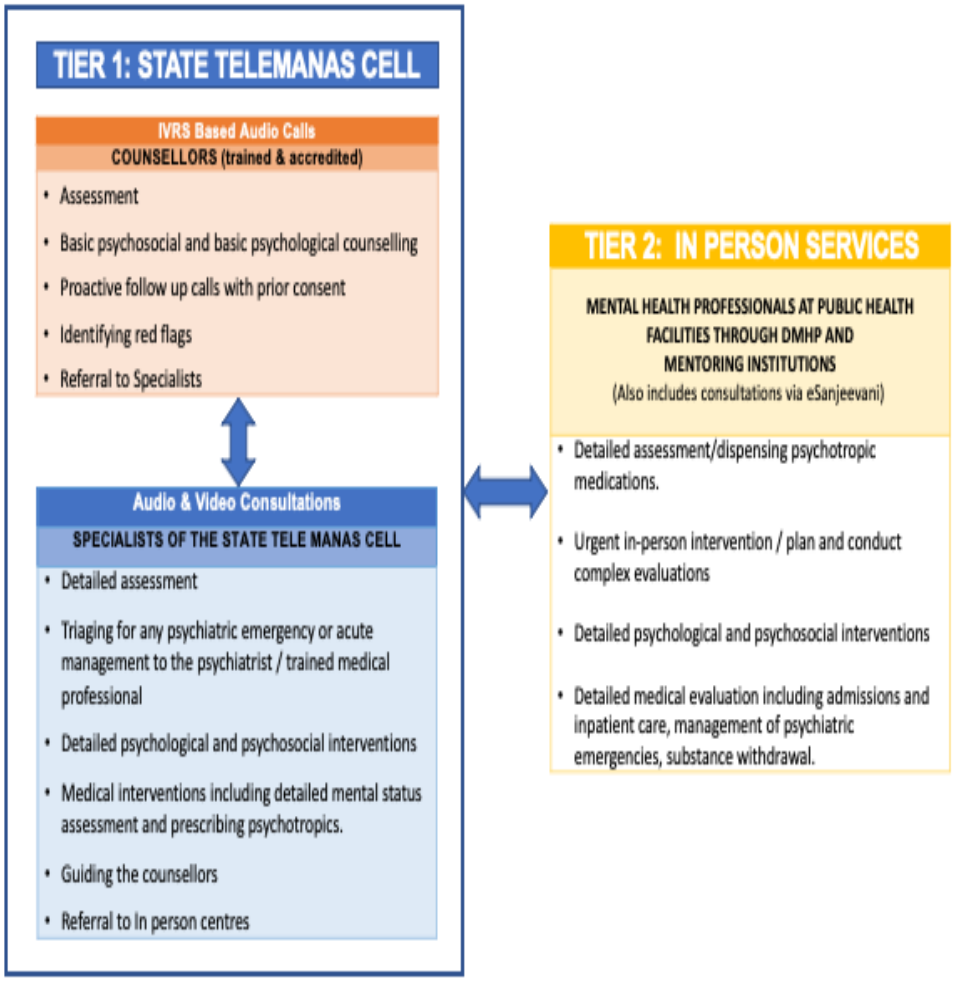


Figure 3.2 Service Delivery Framework for Tele MANAS

A calling mechanism (Figure 3.2) is established in Tele MANAS cell to provide services to population. A brief overview of this arrangement is outlined below:

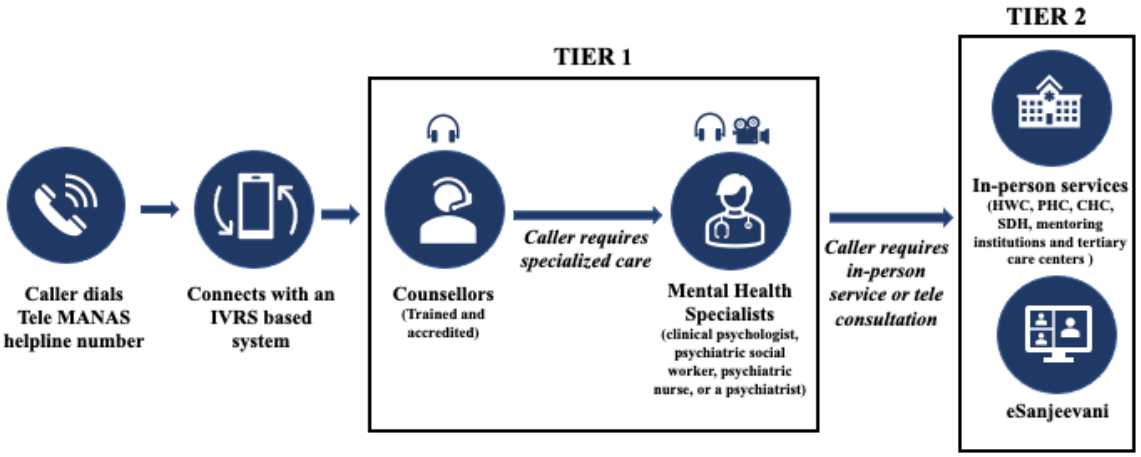


Figure 3.3 Tele MANAS: Calling Mechanism

Beneficiaries will be able to access the Tele MANAS helpline by dialing 14416. This call will be an IVRS based audio calling only, with a timely auto-call back approach. Through the automated call back service, the caller will first be attended to by a trained counsellor. Approximately 15- 30 mins is spent by each counsellor on each call depending on the case.

Based on the level of care required, the counsellor either provide the care needed within their capabilities or refer the caller for specialist care. The counsellor attending the call is trained to triage the calls as well.

If the caller requires specialized care, the call is escalated to the next level that will be handled by a mental health specialist (Psychiatrist, clinical psychologist, psychiatric social worker). Service of Psychiatrist will contain both audio as well as video-based options. At this stage, a decision will also be made about requirement of need for referral to an in-person service.

In case the caller requires urgent in-person intervention/complex evaluations and management, they are referred to the nearest in-person service of DMHP for physical

consultation and/or an audio-visual consultation with a Psychiatrist is arranged in Tele MANAS.

Whether a medical prescription is required or not, attempts to maintain continuity of care (including same care provider and forward and backward linkages) is made. DMHP team mental health specialists will complement the Tele MANAS services from their headquarters itself. Tele MANAS is integrated with DMHP services to supplement and complement them. **In fact Tele MANAS is the 'digital arm' of the DMHP.**

Chapter 4 : Human Resources (HR) and Training

The District Mental Health Programme unit is headed by District Nodal Officer and consist of Psychiatrists, Clinical Psychologist, Psychiatric Social Worker, Counsellors, Social Workers and Nursing Officers (Fig 4.1).

The clinical team of DMHP headed by a Psychiatrist and comprise of Psychiatric Social Worker, Clinical Psychologist and Nursing Officer conducts monthly clinics at block level in each district. The Psychiatrist assess the patients, makes diagnosis and treatment plan. The patient may be referred to Clinical Psychologist for psychological tests or specific psychotherapies; to Psychiatric Social Worker for psycho-education, specific therapies or rehabilitation; to Nursing Officer/Institutional Pharmacist for dispensing psychotropic medicines.

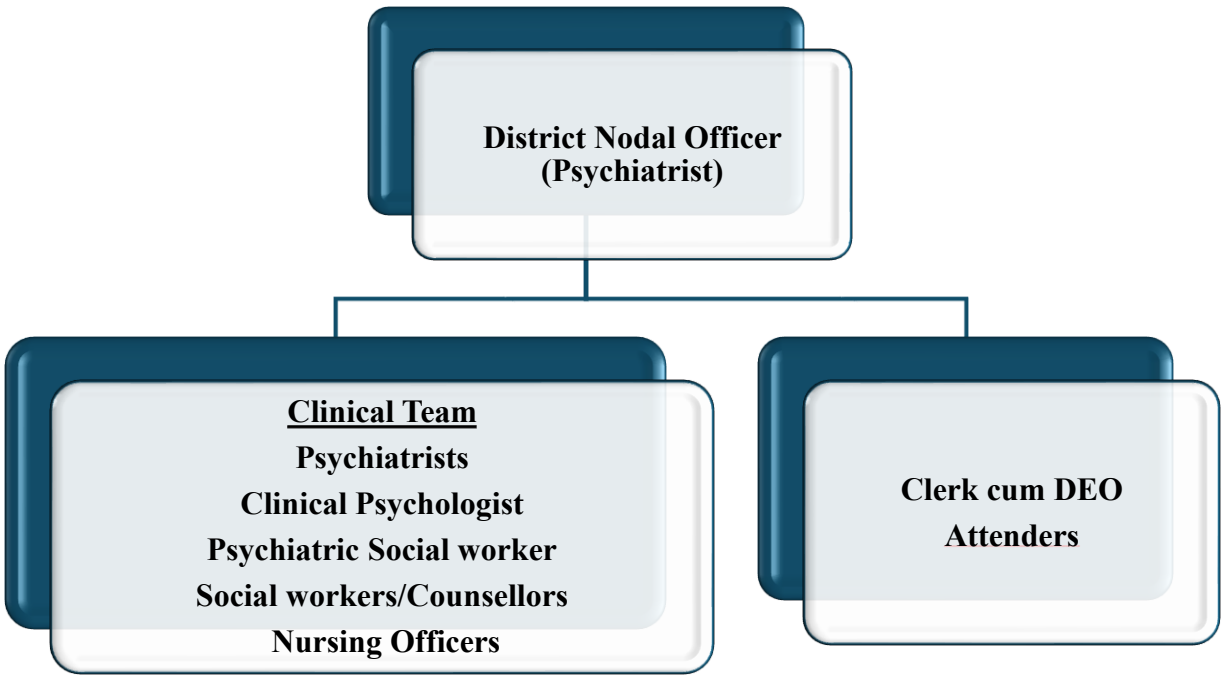


Fig 4.1 DMHP Staff pattern

Key Roles and Responsibilities of DMHP staff at Service Delivery Points (Fig. 4.2)

Role of Psychiatrist in DMHP Clinics

- Participate with the team in clinics, camps, training, and awareness programs.
- Examine patients coming to the clinic, determine treatment, and provide the necessary information to the clinical psychologist, psychiatric social worker, and rehabilitation project officer.
- Reporting of Case dropouts and default tracking with CHC Medical Officer and Health Supervisor.
- Assist the Nodal Officer in analysing the data.

Role of Clinical Psychologist in DMHP Clinics

- Provide psychological treatments and tests prescribed by the psychiatrist to patients attending DMHP clinics.
- Counselling /psychotherapy sessions.

Role of Psychiatric Social Worker in DMHP Clinics

- Provide psychosocial treatments and psychotherapy prescribed by a psychiatrist to patients coming to DMHP clinics.
- Coordination with departments of Local Self-Government, Social Justice, WCD.

Role of Nursing Officer in DMHP Clinics

- Provide psychosocial treatments and psychotherapy prescribed by a psychiatrist to patients coming to DMHP clinics.
- Coordination with departments of Local Self-Government, Social Justice, Women and Child Welfare Team.

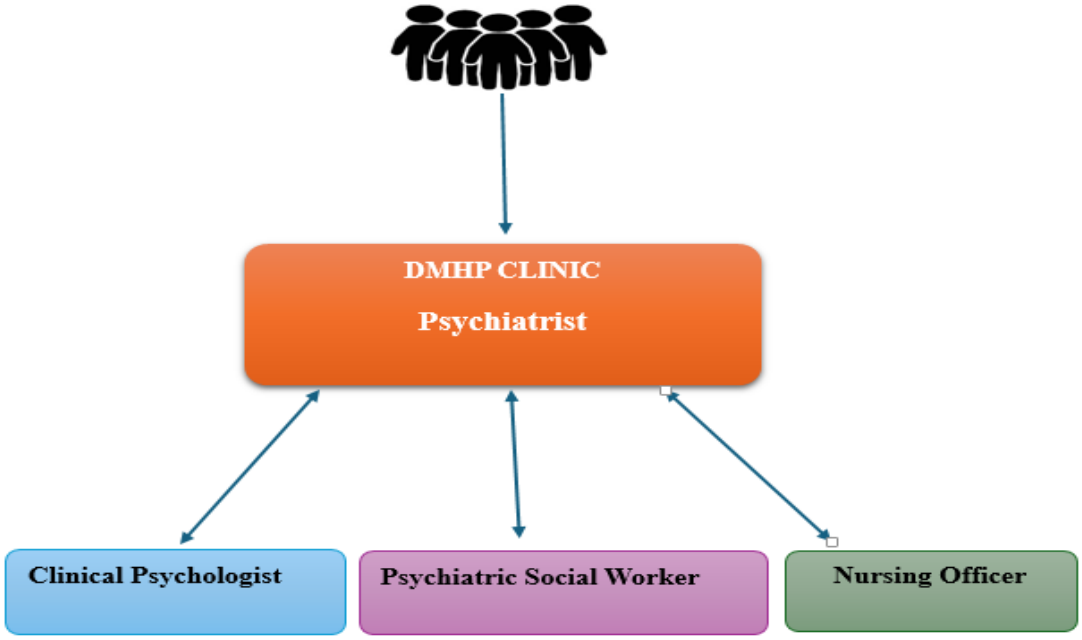


Fig 4.2 DMHP Clinical service

Integration into Primary care

Initially Mental Health Programme was being run as a vertical programme with DMHP team conducting clinics and treating new and all follow up cases in Block level clinics. There has been a steady increase in the number of patients to about 100-200 patients per clinic. This began affecting the quality of care given. Moreover, the other components of DMHP namely IEC activities, training programmes, rehabilitation work etc. were also affected. Hence emphasis was given on the need for integrating mental health with primary care. This was first done in Thiruvananthapuram district and later on extended to other districts through Sampoorna Manasikarogyam project. In Block level DMHP clinics, the new cases after seen by the Psychiatrist gets diagnosed, started on treatment and becomes stable are transferred to their nearest Family Health Centre for follow up treatment by FHC Medical Officer. This makes

sure that patients have to travel least distance to get mental health care, so it becomes most accessible and affordable to them (Fig. 4.3).

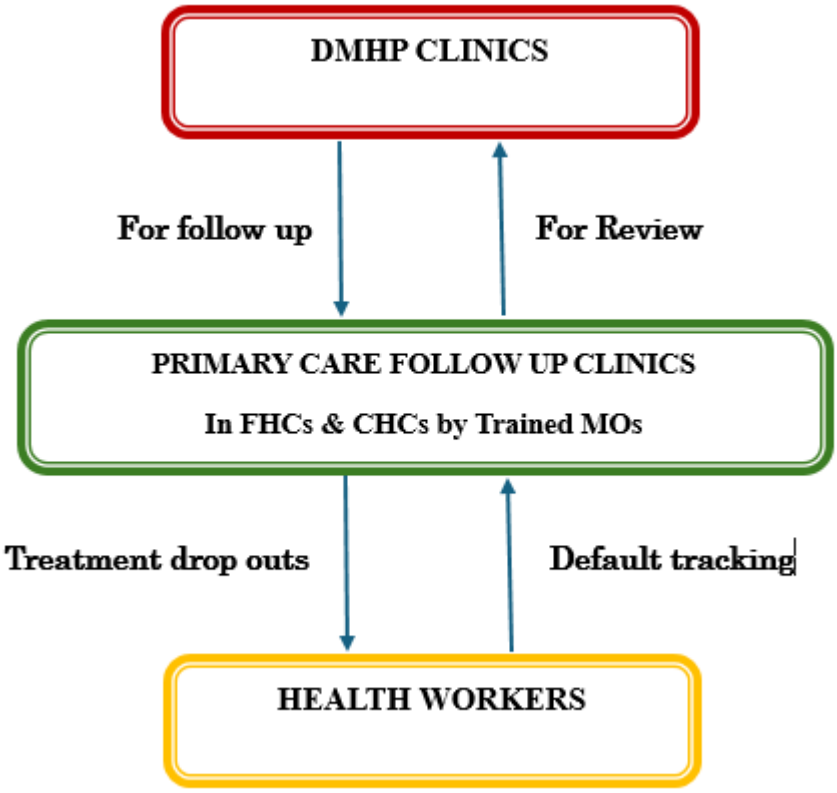


Fig 4.3 Primary care integration

Year	Clinic Data	Number
2021-22	Clinics	3220
	New Cases	11,161
	Total Cases	2,90,657
	Counselling	7171
	Psycho education	8630
2022-23	Clinics	3634
	New Cases	14615
	Total Cases	368348
	Counselling	9357

	Psycho education	11646
2023-24	Clinics	3718
	New Cases	18661
	Total Cases	4,17,257
	Counselling	15008
	Psycho education	21484
2024-25	Clinics	3709
	New Cases	16705
	Total Cases	4,65,187
	Counselling	12205
	Psycho education	22743
2025-26	Clinics	3733
	New Cases	18171
	Total Cases	4,96,516
	Counselling	10199
	Psycho education	26142

Training programs and plans for various cadres (Fig 4.4)

1. Primary care doctors (Two days training for conducting Sampoorna Manasikarogyam follow up clinics, Aswasam and Amma Manass)

2. Nursing Officers (One day training – Aswasam, Amma Manass & Jeevaraksha)

3. Pharmacists – (One day training - Sampoorna Manasikarogyam follow up clinics, Aswasam clinics)

4. MLSPs – (One day training – Case detection and follow up as part of Sampoorna Manasikarogyam, Aswasam, Amma Manass & Jeevaraksha)

5. ASHAs – (Half day training - Case detection and follow up as part of Sampoorna Manasikarogyam & Amma Manass).

6. School teachers and Counsellors – (One day training for early detection, management and referral of behavioural and emotional issues of school children as part of School mental health programme).

Training for Trainers are given for District teams as per Training modules prepared separately for Sampoorna Manasikarogyam, Aswasam, Ammamanas, Jeevaraksha, School Mental health, Palliative care mental health & Substance Abuse Prevention.

Fig 4.4 Training for various cadres

Year	CAPACITY BUILDING	No. of Trainings
2023-24	Mental Health Trainings for MOs, HWs, MLSPs, Pharmacists, Nursing Officers	377
	Sampoorna Manasikarogyam Training	134
	Jeevaraksha Training	105
	Stress Management Training	132
	School Mental Health Training	290
	Amma Manass Training	20
	Tribal Mental Health Training	97
	Coastal Mental Health Training	12
	Aswasam Training	176
2024-25	Mental Health Trainings for MOs, HWs, MLSPs, Pharmacists, Nursing Officers	195
	Sampoorna Manasikarogyam Training	111
	Jeevaraksha Training	124
	Stress Management Training	129
	School Mental Health Training	221
	Amma Manass Training	31
	Tribal Mental Health Training	65
	Coastal Mental Health Training	5
	Aswasam Training	76
	Mental Health Trainings for MOs, HWs, MLSPs, Pharmacists, Nursing Officers	178
	Sampoorna Manasikarogyam Training	130
	Jeevaraksha Training	111

2025-26		
	Stress Management Training	130
	School Mental Health Training	233
	Amma Manass Training	26
	Tribal Mental Health Training	88
	Coastal Mental Health Training	41
	Aswasam Training	96

Capacity Building - Photo Gallery


Samsung Theresa's F42


TRAINING

Chapter 5 : Communication and Advocacy

Kerala follows a decentralized, community-based and integrated approach to mental health under the District Mental Health Programme (DMHP). Information, Education, and Communication (IEC) in the state follows a comprehensive strategy to promote positive behavioral change, awareness, and social development. Mental Health IEC themes in the state include :

i. Reduction of Stigma associated with mental illness.
ii. Common signs and symptoms, in particular the somatic symptoms.
iii. Treatments available and removing misconceptions regarding it.
iv. Substance abuse Prevention
v. Early detection of behavioural and emotional issues in school children.
vi. Awareness regarding Aswasam, Ammamanas, Tele-MANAS initiatives.

IEC activities in Mental Health include:

i. Posters and leaflets
ii. Street play
iii. Booklets for distribution to households
iv. Mass media : Broadcasting of short films on local TV channels, Dissemination of messages through radio health, FM channels, community radio, Advertisement and articles on mental health in local newspapers, magazines, etc
v. Outdoor media: Hoardings, Bus and train panels, Exhibitions, Wall paintings.
vi. Awareness classes to general public, Kudumbasree units, Residence associations, Workplaces.
vii. Interpersonal communication : Meetings with the family members of the patients

Key Communication Objectives

a. Awareness to reduce stigma and myths about mental illness and promote understanding of mental disorders and treatment availability

b. Behaviour Change Communication (BCC) to promote healthy coping mechanisms, stress management, emotional resilience, address harmful behaviours, substance abuse and suicide risk

c. Demand Generation to increase utilization of Government mental health services, Tele MANAS service and Help-seeking behavior

Advocacy Strategies includes

a. Policy Advocacy regarding implementation of Mental Healthcare Act, ensuring mental health is included in public health policies and budgets and promotion of rights-based mental healthcare

b. Program Advocacy for strengthening Community Mental Health services, rehabilitation services, de-addiction services and targeted interventions.

c. Media Advocacy includes use of television, radio, newspapers, campaigns during Observance of World Mental Health Day, Suicide Prevention Day, Substance abuse Prevention Day and use of storytelling and real-life experiences to reduce stigma

Communication Channels includes Mass Media (TV and radio campaigns, Public service advertisements, Print media awareness articles), Social Media (Government campaigns via Facebook, Instagram, YouTube, Use of digital storytelling, short videos, reels, Targeting youth and urban population) and Interpersonal Communication (through ASHAs, AWWs, MLSPs and HWs)

Social Mobilization Efforts (Patient Support Groups) through formation of Self-help groups, Caregiver support groups and Community participation encouraged through NGOs, Kudumbasree, Mahila samakhya society etc., focusing on Rehabilitation, Reintegration into society and Reducing social isolation

Setting-Based Approach

Mental Health in Schools

School Mental Health Project aims at the holistic development of mental health of school children. Through awareness classes, distribution of booklets, posters, leaflets, counselling sessions and other psychiatric services, DMHP makes sure that the aim is being achieved. 'School Mental Health' awareness focuses on 5 aspects of school mental health namely

a) Behavioural and emotional problems
b) Substance abuse
c) Suicide prevention
d) Stress management
e) Life skill education

This helps in early identification of children having behavioural and emotional issues who are referred to the nearest DMHP clinics.

Workplace Stress management programmes

For creating awareness about the symptoms of stress and need of stress management and putting in place a system for regular Screening at workplace, following which interventions are given for those in need, thereby improving interpersonal relationships and productivity

Mental Health Intervention in Prisons

Includes Mental health screening of inmates, Counselling and psychiatric services and De-addiction and rehabilitation programs

Kerala's communication and advocacy strategy in mental health is comprehensive, community-oriented, and integrated with primary healthcare. The state emphasizes:

- Awareness and stigma reduction
- Community participation
- Accessibility through digital and decentralized services

This model has made Kerala a leading example in public mental health communication in India.

Chapter 6 : Monitoring, Supervision, and Evaluation (M&E)

M&E Framework

Kerala follows a structured M&E framework under the Mental Health Programme integrated with the broader public health system. It is based on National Mental Health Programme (NMHP) guidelines and integrated with primary healthcare monitoring systems. It mainly focus on Service delivery tracking, Quality of care, and Outcome measurement.

Multi-level monitoring is done at State level (Directorate of Health Services), District level (DMHP), Facility level (PHC/CHC/FHC), emphasising on Routine data collection, Periodic evaluation and Feedback-driven improvements

Process Indicators of Mental Health Programme

I. FHC/PHC

- Number of mental health clinics conducted per month
- Number of new cases referred to DMHP
- Default tracking done for drop-outs
- Number of suicides per month in the Panchayat

II. CHC

- Number of new cases in DMHP clinic
- Number of drop-outs brought back to treatment by Health Workers
- Number of suicides per month in the block
- Number of screened positives as part of Amma Manass

III. Taluk Hospitals

- Number of New OP cases per month
- IP per month
- Number of disability certificates issued

IV. District/General Hospital

- Number of new OP cases per month
- IP per month
- Number of De-addiction cases treated
- Number of disability certificates issued

Mental Health Programme activities are evaluated in

1. Block conferences, which include:
    - Aswasam screening
    - Aswasam High-risk case list preparation
    - Ammamanas screening
    - Ammamans case referrals
    - Dropout case reporting
    - Default tracking
1. DMO Conference, which include:
    - Mental Health Programme Clinics
    - Key deliverables - No. of new cases & Total cases
    - Sampoorna Manasikarogyam Followups in FHCs
    - Aswasam, Ammamanas screening and referrals

- Psychiatry units in THQH/DH/GH – New cases & IP
- De-addiction centers – New cases & IP

2. SMO Conference, which include:
    - Mental Health Programme – KD - New cases, Total cases
    - Sampoorna Manasikarogyam Followups in FHCs
    - Aswasam, Ammamanas screening and referrals
    - Mental Health Centers
    - Psychiatry units in THQH/DH/GH – New cases & IP
    - De-addiction centers – New cases & IP

Detailed Programme evaluation done monthly by State Nodal Officer with District Nodal Officers and MHP Consultants. Mental Health review comprising of Mental Health Programme, Mental Health Centers, Psychiatry Units of THQH/DH/GH, De-addiction centers to be done quarterly by Additional Director (Medical), DD (Medical), State Nodal Officer (Mental Health), Deputy DMOs (NCD), District Nodal Officers, and Superintendent of the three mental Health Centers.

Evaluation of the programme and Targeted Interventions like Aswasam, Sampoorna Manasikarogyam, Ammamanas done in collaboration with State Health System Research Centre (SHSRC).

Data Flow Mechanism and Reporting (Fig 6.1)

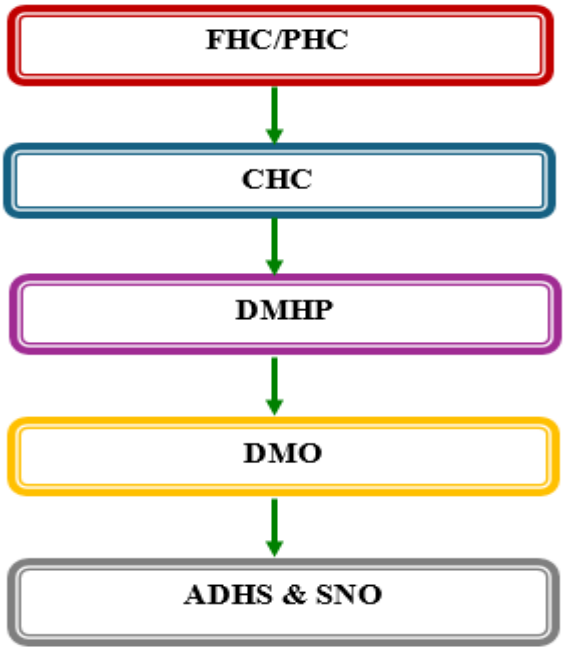


Fig 6.1

Monthly reports from FHCs & PHCs are sent to CHCs where it is consolidated and sent to DMHP. The data from all Blocks are consolidated and analysed in DMHP. The corrective measures to be done is reported in DMO Conference.

Monthly reports comprising Mental Health Programme clinic details (New cases, Followups, Total cases, Counselling/therapies, psycho educations), Aswasam, Ammamanas and Sampoorna Mansikarogyam from district is sent from DMHP to DMO and State Nodal Officer.

Reporting formats for different levels are attached as Annexures

Digital tools

Digital Platform – SHAILI

The Annual Health Screening programme utilizes the SHAILI mobile application, developed by Kerala eHealth, for digital data collection.

Key advantages of the SHAILI system include:

- Real-time monitoring of survey activities
- Digital line listing of screened individuals
- Reduction in manual reporting errors
- Creation of a statewide NCD registry
- Improved transparency and accountability

The platform also enables follow-up tracking of individuals identified as high-risk.

The second round of the Annual Health Screening program incorporated Mental Health issues for screening which improved the comprehensiveness of community health assessment.

Chapter 7: Finances and Programme Implementation Plan

Fund for Mental Health Programme is sourced from Plan Funds and NMHP through NHM. There is an increase in plan outlay in all the three components over the years.

Mental Health Programme for all Districts have been included in state plan funds from 2017-18 financial year. Allocation comes under two schemes namely District Mental Health Programme (DMHP - 2210-01-110-40-PLAN) and Comprehensive Mental Health Programme (CMHP - 2210-01-110-68-34OC). Funds under DMHP scheme (Table 7.1) are utilised for running of 306 Block level monthly clinics of Mental Health Programme, while the funds under CMHP scheme (Table 7.2) are utilised primarily for running 31 Community based Day Care Centers under Mental Health Programme. Human resource for Mental Health Programme is catered through these two schemes. NMHP funds (Table 7.3) through NHM are utilised for implementing State specific Targeted Interventions namely Sampoorna Manasikarogyam, Aswasam, Ammamanass, Jeevaraksha, Workplace Stress management program, School Mental Health, IECs, Capacity building and purchase of Psychotropic Medicines

Table 7.1 DMHP Funds

Year	Approved	Allocation	Expenditure	Expenditure percentage
2021-22	40000000.00	36530613.00	33834142.00	92.61
2022-23	50000000.00	32912257.00	31949369.00	97.07
2023-24	50000000.00	35878654.00	34846368.00	97.12
2024-25	60000000.00	38702376.00	38442439.00	99.32
2025-26	60000000.00	35711041.00	35168717.00	98.48

Table 7.2 CMHP Funds

Year	Approved	Allocation	Expenditure	Expenditure percentage
2021-22	50000000.00	35836474.00	33164653.00	92.54
2022-23	60000000.00	36358611.00	35594997.00	97.89
2023-24	60000000.00	38527129.00	36828240.00	95.59
2024-25	70000000.00	39970905.00	39488254.00	98.79
2025-26	70000000.00	43954087.00	42278434.00	96.18

Table 7.3 NMHP Funds

Financial year	Approved	Allocation	Expenditure	Percentage
2021 - 22	692.90	NA	451.73	65
2022 - 23	872.65	NA	431.81	49
2023 - 24	847.40	NA	349.52	41
2024 - 25	684.40	NA	277.41	41
2025 - 26	778.31	NA	265.93	34

The allocation of funds for Mental Health through NMHP were uncertain and on the lower side during the last few years. This has affected the implementation of Targeted Interventions at Community level and hence lower district wise utilization.

Chapter 8 : Linkages and Convergence

Since 2018, The Department of Health and Family Welfare, Government of Kerala has been working in partnership with the Banyan, to support long-stay residents of state-run Mental Health Centres (MHCs) in transitioning back to community living. The collaboration spans three MHCs located in Thiruvananthapuram, Thrissur, and Kozhikode.

With the Memorandum of Understanding renewed in December 2023 for a further three-year period, the partnership continues to prioritise discharge planning and rehabilitation through pathways such as family reunification, the Home Again program, and linkages to other suitable care facilities. The Banyan's multidisciplinary team works closely with MHC psychiatrists and case managers to identify individuals ready for discharge, conduct home and community assessments, and prepare families to support reintegration. In cases where family reunification is not feasible, alternative community-based living options, including the Home Again model, are facilitated. Structured aftercare and follow-up support remain central to the intervention, helping ensure continuity of care and reducing risks of relapse, re-institutionalization, or homelessness.

As of October 2025, the Home Again program operates a total of 22 assisted living homes across Kerala. Of these, 14 homes are directly managed by The Banyan, while 8 are run in partnership with community-based organisations, including Mariyasadanam Charitable Trust and Mehac Foundation. These homes currently support 105 persons with mental health needs, including two individuals living independently with minimal support.

Table 8.1

		2018 - November 2023	2023 December - 2024 December	Q1 (Jan 25 – Mar 25)	Q2 (April25 - June25)	Q3 (July25- Sept 25)	Q4 (Oct 25- Dec 25	Up to Dec 2025De
Thrissur MHC	Family	32	3	4	1	1	1	42
	Home Again	40	6	1	0	0	1	48
	Institutions	29	0	0	0	3	0	32
Trivandrum MHC	Family	71	6	3	7	0	3	90
	Home Again	33	6	3	1	1	1	45
	Institutions	32	0	4	7	5	0	48
Kozhikod	Family	56	1	5	2	2	2	68
	Home	70	5	2	1	0	0	78

e MHC	Agai n							
	Institutio ns	38	8	0	4	0	2	52
Total		**401**	**35**	**22**	**23**	**12**	**10**	**503**

Mental Health Programme - collaboration with other departments

Table 8.2

Sl. No.	Programme	Department
1.	Sampoorna Manasikarogyam	LSGs
2.	Ammamanass	WCD
3.	Aswasam	Ayush
4.	Community Rehabilitation	SJD, LSGs
5.	School Mental Health	Gen. Education Dept & WCD
6.	Tribal Mental Health	ST Development Dept & Forest Dept
7.	Coastal Mental Health	Fisheries Dept
8.	De-addiction	Excise Dept & SJD
9.	'Ottaykkalla Oppamund' Psycho-social Support	KSDMA

Mental Health programme – linkage with the other Health Programmes

Table 8.3

Sl. No.	Programme	Department
1.	Ammamanass	RCH
2.	Aswasam	NCD, NTCP
3.	Sampoorna Manasikarogyam	Palliative care
4.	Community based De- addiction	NTCP
5.	School Mental Health	RKSK, RBSK

'Ottaykkalla Oppamund'- Psycho-social Support in Disaster Management

Mental Health Intervention in Disaster Management were done by Mental Health Programme during

1. OCKHI 2017
2. NIPPAH 2018
3. FLOODS 2018
4. LANDSLIDES 2019
5. COVID- 19
6. WAYANAD LANDSLIDE 2024

I. OCKHI 2017

During the OCKHI Cyclonic Storm, Psycho Social Intervention started on 2nd December. Mental Health Disaster Management team was constituted under District Mental Health Programme (DMHP) Tvpm comprising of School Counsellors of ICDS, School Health Nurses of RBSK (NHM) & DISHA Counsellors.

- 20 Teams were constituted, each comprising of a School Counsellor and a Nurse. (Teams were numbered A1-A10 & B1-B10)
- 5 Teams were coordinated by a Counsellor.
- Teams conducted Home Visits with JHI, JPHN, ASHA & AWW. (Also Elected Representative of the area wherever possible)
- Target Population were

  1. Survivors (Rescued),
  2. Family Members of Missing
  3. Persons Family Members of the Dead

- Pro Forma for Assessment was prepared which included Social, Physical and Psychological Need Assessment and 523 families were evaluated.
- Based on the Data obtained, Evaluation and Interventions were jointly done by Health, Revenue, Social Justice, Fisheries, LSG and Education Depts.
- Short term Interventions included- Food, Clothing, Injuries.
- Long term Interventions were Housing, Education, Jobs (including for spouses of dead and missing), Management of Liabilities, Mental Health interventions.

(II) NIPPAH OUTBREAK MAY 2018

Psycho Social Support team was constituted under District Mental Health Programme (DMHP) Kozhikode.

- Telephonic Psychological Support Service was started on 30th May.
- 147 calls were received and Psycho Social Support given.

(III) Floods August 2018

In the context of flood and landslides that occurred in the state on August, Govt of Kerala constituted Mental Health Disaster Management team, under District Mental Health Programme (DMHP) in each district on 18th August 2018, and directed to coordinate all mental health services in the disaster affected areas under these teams. The above mentioned District teams were later expanded to form a 'Core team' and multiple 'Intervention teams' in each district. The core team in each district was entrusted with the coordination of mental health activities, consolidation of data and timely submission of reports. The intervention teams were assigned the responsibility of visiting the relief camps & identifying and managing people who are in need of mental health services. These intervention teams provided the service to all the affected people. Special attention was given to the problems of children and elderly.

Later, as people started moving back to their homes from the relief camps, the intervention teams started home visits for providing mental health services.

In the second phase of mental health intervention, it was decided to broaden the services and make it a permanent system for which ASHAs were included for grass root level work and were given training in all the affected panchayths from 28th August. The

training modules, reporting format, awareness leaflets were prepared and handed over to all districts. Along with this, trainings were also given to the health staff (doctors, nurses, health workers), revenue officials, LSGD employees and elected representatives who are in regular contact with the affected people for equipping them to interact and console the people.

384 training programmes were conducted in the most affected 10 districts through which 17,643 ASHAs and volunteer counselors got trained. They visited 717 camps and conducted 1,30,999 house visits, thereby provided Psycho Social Intervention to 2,12,797 persons in need . In addition 1543 persons who needed further intervention were given mental health treatment by Mental Health teams thereby ensuring mental health service to all the survivors.

As mental health issues may arise few weeks to months after the disaster and as the symptoms of anxiety , depression etc may present long term, a comprehensive long term intervention by the name '**PARIRAKSHA'** was implemented under the supervision of DMHPs.

It strengthened the existing primary care settings to detect and manage disaster related Psycho Social issues in the affected panchayats and included Psycho Social counselors in the severely affected panchayats, working full time for counseling and Psycho Social Interventions. Training and equipping ASHAs for regular house visits, screening and detection of psycho social problems. It had mental health team in each district under DMHP, exclusively for the affected panchayats.

(IV) Landslides 2019

In the wake of Landslides that occurred in Kavalappara and Puthumala in August 2019, Mental Health Disaster Management teams were constituted under DMHP Malappuram and Wayanad for Psycho Social Interventions. Counsellors working under PARIRAKSHA (for 2018 Floods) came in handy for the purpose. The teams under DMHP conducted 743 camp visits and 1191 house visits by which group therapies were given to 42,493 persons and individual psycho social interventions to 10,698 persons. In addition to this 415 people were given pharmacotherapy.

(V) Covid 19

During the corona virus outbreak in Kerala, as the number of people in Quarantine/Isolation began to increase, it was decided to provide psychological support to the persons in Quarantine/Isolation and their family members.

Activities

1. Psycho Social Intervention teams were constituted in all districts, under DMHPs.
2. A Total of 1236-member team (Psychiatrists, Psychiatric Social Workers, Clinical Psychologists, Social Workers, Psychiatric Nurses, Counsellors) were working in the entire state under DMHPs.
3. A psycho social helpline was arranged in each district
4. All persons in Quarantine/Isolation were called, given reassurance and District Helpline Number were provided to call back in case of any psychological need.
5. Stigma related issues were mostly due to spread of fake information, social isolation and social media harassment. Measures were taken to create awareness in those areas

and in case of social media harassment, information was sent to media cell of control room.

6. Follow up Psycho Social support were given. Those with psychosocial issues were called on once in 3 days, those with severe issues were called every day.

7. A 6 Minute Video on Relaxation Technique was prepared by Mental Health Programme and sent to the persons in need.

8. An awareness leaflet on communication skills was prepared and given to staff of isolation wards. The same was also provided to the training team to be included in the training module of isolation ward staff.

9. Psychological Support was also being provided to Health Personnel working in Corona Control activities.

10. 'Ottaykkalla Oppamundu' was extended to school children to address the psycho social issues faced by them.

11. A total of 1,40,90,284 Psycho Social Support and Counselling Calls have been given to all such categories

VI) Wayanad Landslides

The District Mental Health Programme team visited the first relief camp at Meppadi GHSS on the day the landslide occurred. A psychosocial support task force was created including psychiatrists and qualified counsellors from district mental health programme and National health mission, ICDS and later counsellors from police department, kudumbashree, social justice department and volunteers from Wayanad and other districts of Kerala were integrated into the task force. These team members after being given training for psychosocial interventions for disaster management, were posted to all the relief camps. The main purpose was to provide reassurance and support

to all the inhabitants of the camp and to identify people under distress. The counsellors were present round the clock in all the camps and if any person needed higher level intervention specialist services were made available. A twenty four hour mobile psychiatry unit was started to ensure speciality services in the camps and also to provide house visits if needed. Tele consultation facilities using two toll free numbers and Telemanas toll free number provided twenty four hour on call psychiatric counselling services.

High risk population ie children less than 18 years, elderly more than 60 years, pregnant and lactating women, people with history of mental illness, people with psycho active substance use, migrant workers were identified and special attention were given to them. Follow up screening and support was ensured by making the same set of counsellors being available to interact with the same people which helped in establishing good rapport and observing day to day changes. Daily data reporting was done to the concerned higher authorities, which helped in proper evaluation and monitoring the progress of the ground level activities. Physical, social and biological needs of the people residing in the relief camps were assessed and based on which a list was prepared and were put on repeated follow ups.

IEC/ training has been given to ASHAs of Vythiri block for screening all the residents. Field monitoring of the people impacted by the landslide started from the very next day after the relief camps closed. People who were shifted to temporary shelters were visited by our counsellors after the relief camps were closed. Based on the data from the district administration and the camps[need assessment] 1146 people were given repeated counselling which included weekly, bi weekly, monthly follow up visits.

Counselling were also given to people who were indirectly involved in the landslide like NDRF Team, Police & Fire force, Aapda Mitra volunteers, Harithakarma sena, jeep drivers and Kudumbasree workers.

As mental health issues may arise few weeks to months after the disaster and as the symptoms of anxiety, depression etc may present later, a long term comprehensive Psycho Social Intervention project was implemented for one year till July 2025.

Annexures

1. Sampoorna Manasikarogyam Screening Checklist

<u>സമ്പൂർണ്ണ മാനസികാരോഗ്യ ചോദ്യാവലി</u>

ജില്ലാ മാനസികാരോഗ്യ പരിപാടി (DMHP)

പേര്	വയസ്സ്		ആൺ/പെൺ
വിലാസം	വിദ്യാഭ്യാസം		
ലിസ്റ്റിലെ ക്രമ നമ്പർ	ചെക്ക്		

1.	കുടുംബത്തിലാർക്കെങ്കിലും തുടർച്ചയായി 2 ആഴ്ചക്കാലം സങ്കടം, ഉറക്കക്കുറവ്, എന്നിവ ഉണ്ടാവുകയോ, ആത്മഹത്യ ചെയ്യുന്നതിനെപ്പറ്റി ചിന്തിക്കുകയോ / പറയുകയോ, ശ്രമം നടത്തുകയോ ചെയ്തിട്ടുണ്ടോ?	
2	കുടുംബത്തിലാർക്കെങ്കിലും, മറ്റുള്ളവർക്ക് ബുദ്ധിമുട്ടുണ്ടാക്കുന്ന രീതിയിൽ അമിത സന്തോഷം, അമിതദേഷ്യം, അമിത ഭക്തി എന്നിവ ഉണ്ടായിട്ടുണ്ടോ?	
3.	കുടുംബത്തിലാർക്കെങ്കിലും കഴിഞ്ഞ 6 മാസക്കാലമായി നെഞ്ചിടിപ്പ്, വെപ്രാളം, തളർച്ച, ശരീരം വിയർക്കൽ , ഭയം, അസ്വസ്ഥത, ഉൽക്കണ്ഠ എന്നിവ തോന്നാറുണ്ടോ?	
4	കുടുംബത്തിലാർക്കെങ്കിലും ആവർത്തിച്ചു വരുന്നതും അനാവശ്യവുമായ ഒരേ തരത്തിലുള്ള ചിന്തകൾ മനസ്സിൽ നിയന്ത്രണാതീതമായി കടന്നുവരികയോ അതനുസരിച്ച് പ്രവർത്തിച്ചില്ലെങ്കിൽ ഉത്കണ്ഠ കൂടും എന്നുള്ളത് കൊണ്ട് ആവർത്തിച്ചു ചെയ്യാറുണ്ടോ?	
5.	കുടുംബത്തിലാരെങ്കിലും മദ്യം / മറ്റു ലഹരി വസ്തുകൾ ഉപയോഗിക്കാറുണ്ടോ? തുടർന്നും കഴിക്കണം എന്ന അതിയായ താൽപര്യവും നിർത്താൻ ബുദ്ധിമുട്ടും അനുഭവപ്പെടുന്നുണ്ടോ?	
6.	കുടുംബത്തിലുള്ള ആർക്കെങ്കിലും അകാരണമായ സംശയം / സംശയങ്ങൾ, ഭയം എന്നിവയുണ്ടോ?	
7.	കുടുംബത്തിലുള്ള ആർക്കെങ്കിലും ഒറ്റയ്ക്ക് ഇരുന്നുള്ള ചിരി, സംസാരം, പിറുപിറുപ്പ് തുടങ്ങിയവ ഉള്ളതായി ശ്രദ്ധയിൽപ്പെട്ടിട്ടുണ്ടോ ?	
8.	കുടുംബത്തിലുള്ള ആർക്കെങ്കിലും കാരണമില്ലാതെ ദീർഘകാലം നീണ്ടു നിൽക്കുന്ന ശാരീരിക രോഗലക്ഷണങ്ങളുണ്ടോ? ചികിത്സകൾ മാറി മാറി പരീക്ഷിച്ചിട്ടും കുറയാതെ ബുദ്ധിമുട്ടിക്കുന്നുണ്ടോ? (ശാരീരിക വേദന, പെരുപ്പ്)	

9.	കുടുംബത്തിലാർക്കെങ്കിലും, പ്രത്യേകിച്ചു പ്രായമായവർക്ക് മറവി കൊണ്ട് ഉണ്ടാകുന്ന ബുദ്ധിമുട്ടുകൾ, പെരുമാറ്റ പ്രശ്നങ്ങൾ, ഇറങ്ങിപ്പോക്ക്, സംശയങ്ങൾ എന്നിവ തോന്നാറുണ്ടോ?	
10.	കുടുംബത്തിലാർക്കെങ്കിലും നിസ്സാരകാര്യങ്ങൾക്കും ആത്മഹത്യ ഭീഷണി, ആത്മഹത്യ പ്രവണത, സ്വയം ഉപദ്രവിക്കൽ, എന്നിവ ഉണ്ടോ?	
11.	കുടുംബത്തിലാർക്കെങ്കിലും അപസ്മാര രോഗമുണ്ടോ ?	
12.	കുട്ടികളുടെ പ്രശ്നങ്ങൾ	
	♦ പഠനത്തിൽ പിന്നോട്ടു പോവുക / താല്പര്യം ഇല്ലായ്മ	
	♦ ഹൈപ്പെർ ആക്ടിവിറ്റി / ശ്രദ്ധക്കുറവ്	
	♦ അക്രമ വാസന /മോഷണം / കള്ളം പറയുക / ലഹരിവസ്തുക്കളുടെ ഉപയോഗം /ഒറ്റ (തറുതല)പറച്ചിൽ	
	♦ പ്രായത്തിനനുസരിച്ച് ആശയ വിനിമയം ഇല്ലായ്മ/ വൈകാരിക അടുപ്പം ഇല്ലായ്മ/ശരിയായ മാനസിക വളർച്ച ഇല്ലായ്മ	
13.	ശ്രദ്ധയിൽപ്പെട്ട മറ്റേതെങ്കിലും മാനസിക രോഗ ലക്ഷണങ്ങൾ ഉണ്ടോ? ഉണ്ടെങ്കിൽ ഏതൊക്കെ ?	

ആശയുടെ പേര്	
വാർഡ് നമ്പർ	

2. Aswasam PHQ-9

PHQ-9
രോഗിയുടെ ആരോഗ്യത്തെ സംബന്ധിച്ച ചോദ്യാവലി

പേര് വയസ്സ് തീയതി

കഴിഞ്ഞ രണ്ടാഴ്ചയായി താഴെപ്പറയുന്ന പ്രശ്നങ്ങൾ താങ്കളെ എത്രമാത്രം അലട്ടുന്നുണ്ട്? താങ്കളുടെ ഉത്തരത്തിനു നേരെ ശരിയിടുക(√).

	ഒട്ടുമില്ല	പല ദിവസങ്ങളിൽ	പകുതിയിലധികം ദിവസങ്ങളിൽ	മിക്കവാറും എല്ലാദിവസവും
1 കാര്യങ്ങൾ ചെയ്യുന്നതിന് താത്പര്യക്കുറവ് അല്ലെങ്കിൽ സന്തോഷക്കുറവ്	0	1	2	3
2. സങ്കടം/വിഷമം/നിരാശ തോന്നുന്നുണ്ട്	0	1	2	3
3. ഉറക്കംവരാനുള്ള ബുദ്ധിമുട്ട്/ ഇടയ്ക്ക് ഉണർന്നു പോയാൽ വീണ്ടും ഉറക്കം കിട്ടാനുള്ള ബുദ്ധിമുട്ട്/ അമിത ഉറക്കം	0	1	2	3
4. ക്ഷീണം തോന്നുക അല്ലെങ്കിൽ ഉന്മേഷം ഇല്ല എന്ന് തോന്നുക	0	1	2	3
5. വിശപ്പ് കുറവ് അല്ലെങ്കിൽ അമിത വിശപ്പ്	0	1	2	3
6. സ്വയം മതിപ്പില്ലായ്മ തോന്നുക, അല്ലെങ്കിൽ താങ്കളൊരു പരാജയമാണ് എന്ന് തോന്നുക അല്ലെങ്കിൽ താങ്കളുടെയോ കുടുംബത്തിന്റെയോ വില കെടുത്തി എന്ന് തോന്നുക	0	1	2	3
7. പത്രം വായന, ടി വി . കാണൽ തുടങ്ങിയ കാര്യങ്ങളിൽ ഏകാഗ്രത/ ശ്രദ്ധ പുലർത്താൻ കഴിയുന്നില്ല	0	1	2	3
8. കാര്യങ്ങൾ ചെയ്യുന്നതും സംസാരിക്കുന്നതും മറ്റുള്ളവർ ശ്രദ്ധിക്കുന്ന രീതിയിൽ,പതുക്കെയാവുക അല്ലെങ്കിൽ നേരെ മറിച്ചു സാധാരണയിൽ കൂടുതൽ അസ്വസ്ഥമായി/ ഇരിക്കപ്പൊറുതിയില്ലാതെ അങ്ങോട്ടുമിങ്ങോട്ടും നടക്കുക	0	1	2	3
9. ഇതിലും ഭേദം മരിക്കുന്നതായിരുന്നു അല്ലെങ്കിൽ ഏതെങ്കിലും രീതിയിൽ സ്വയംപീഡിപ്പിക്കണം എന്ന ചിന്ത	0	1	2	3
കോളങ്ങൾ തമ്മിൽ കൂട്ടുക				

ഈ ചോദ്യാവലിയിലുള്ള പ്രശ്നങ്ങൾ പരിശോധിച്ചതിൽ നിന്ന് ആ പ്രശ്നങ്ങൾ താങ്കൾക്കു ജോലി ചെയ്യുന്നതിനോ വീട്ടുകാര്യങ്ങൾ നോക്കുന്നതിനോ മറ്റുള്ളവരുമായി ഇടപെടുന്നതിലോ എന്തുമാത്രം ബുദ്ധിമുട്ടുണ്ടാക്കുന്നുണ്ട്.

ഒട്ടും ബുദ്ധിമുട്ടില്ല ☐ കുറച്ചു ബുദ്ധിമുട്ടുണ്ട് ☐ വളരെ ബുദ്ധിമുട്ടുണ്ട് ☐

അങ്ങേയറ്റം ബുദ്ധിമുട്ടുണ്ട് ☐

3. Ammamanass Screening Checklist

'അമ്മ മനസ്സ്'

മാതൃ-ശിശു മാനസികാരോഗ്യ പദ്ധതി

മാനസികാരോഗ്യ ചോദ്യാവലി

ക്രമ നം	ചോദ്യം	1 (1st Trimester)	2 (2nd Trimester)	3 (3rd Trimester)	4 (6th week immunization)	5 (14th week immunization)	6 (9th month immunization)
1	മാനസിക സമ്മർദ്ദം ടെൻഷൻ/						
2	ഉറക്കക്കുറവ്,വിഷാദം , കരച്ചിൽ എല്ലാത്തിലും , താൽപര്യക്കുറവ്						
3	ആത്മഹത്യാ ചിന്തകൾ / പ്രവണത സ്വയം , ഉപദ്രവിക്കൽ						
4	നെഞ്ചിടിപ്പ് ,വെപ്രാളം , , ശരീരം വിയർക്കൽ ഉത്കണ്ഠ						
5	മുൻപ് എപ്പോഴെങ്കിലും മാനസിക പ്രശ്നങ്ങളോ , അപസ്മാരമോ . ഉണ്ടായിട്ടുണ്ടോ						
കൂടെയുള്ളവരോട് ചോദിച്ച് അറിയേണ്ടവ							
6	അമിതമായ ദേഷ്യം , അമിതമായ സംസാരം						
7	അകാരണമായ സംശയങ്ങൾ ഭയം ,						
8	ഒറ്റയ്ക്കിരുന്നുള്ള ചിരി , . പിറുപിറുപ്പ് ,സംസാരം						
9	കുഞ്ഞിനെ പരിചരിക്കാൻ ഉള്ള താൽപ്പര്യക്കുറവ് , അപാകത						
10	ശ്രദ്ധയിൽപെട്ട മറ്റേതെങ്കിലും മാനസിക പ്രശ്നങ്ങൾ						
സ്ക്രീൻ ചെയ്യുന്ന നഴ്സിന്റെ പേരും ഒപ്പും							

4. Stress Management Questionnaire

മാനസികസമ്മർദം അളക്കാനുള്ള ചോദ്യാവലി

പേര് ..... വയസ്സ് ..... പു/സ്ത്രീ: ..... ഫോൺനമ്പർ :.....

പൂരിപ്പിക്കാനുള്ള നിർദ്ദേശങ്ങൾ

1. *കഴിഞ്ഞ ഒരുമാസത്തിനുള്ളിൽ നിങ്ങളുടെ മനസ്സിലുണ്ടായ ചിന്തകളേയും സംഘർഷങ്ങളേയും കുറിച്ചുള്ള 10 ചോദ്യങ്ങളാണിത്*
2. *എല്ലാ ചോദ്യങ്ങൾക്കും ഏറ്റവും യോജിച്ച ഉത്തരത്തിനുനേരെ ✓ എന്ന് രേഖപ്പെടുത്തുക.*

	ചോദ്യങ്ങൾ	ഒരിക്കലുമില്ല	അപൂർവ്വമായി	ചിലപ്പോഴൊക്കെ	മിക്കപ്പോഴും	എപ്പോഴും
1	അപ്രതീക്ഷിതമായി സംഭവിക്കുന്ന കാര്യങ്ങളെക്കുറിച്ചോർത്ത് നിങ്ങൾ വിഷമിക്കാറുണ്ടോ ?					
2	ജീവിതത്തിൽ പ്രധാനപ്പെട്ട കാര്യങ്ങൾ നിയന്ത്രിക്കാൻ കഴിയുന്നില്ല എന്ന് തോന്നാറുണ്ടോ?					
3	മാനസികസംഘർഷവും പിരിമുറുക്കവും അനുഭവപ്പെടാറുണ്ടോ ?					
4	വ്യക്തിപരമായ പ്രശ്നങ്ങളെ ആത്മവിശ്വാസത്തോടെ നേരിടാൻ കഴിയുമെന്ന് നിങ്ങൾക്ക് തോന്നാറുണ്ടോ?					
5	കാര്യങ്ങളെല്ലാം നിങ്ങൾ വിചാരിക്കുന്ന രീതിയിൽ നടക്കുന്നുവെന്ന് തോന്നാറുണ്ടോ?					
6	നിങ്ങൾ ചെയ്യേണ്ട കാര്യങ്ങളുടെ സമ്മർദം അതിജീവിക്കാൻ കഴിയില്ലെന്ന് തോന്നാറുണ്ടോ ?					
7	കാര്യങ്ങളെല്ലാം നിങ്ങളുടെ നിയന്ത്രണതിലാണെന്ന് തോന്നാറുണ്ടോ?					
8	പ്രകോപനങ്ങളെ നിയന്ത്രിക്കുവാൻ കഴിയാറുണ്ടോ?					
9	നിങ്ങളുടെ നിയന്ത്രണത്തിലല്ലാത്ത കാര്യങ്ങളാൽ കോപിക്കാറുണ്ടോ ?					
10	പ്രയാസങ്ങൾ കുന്നുകൂടുന്നു ,അവയെ മറികടക്കാൻ സാധിക്കില്ല എന്ന് തോന്നാറുണ്ടോ?					

സംസ്ഥാന ആരോഗ്യവകുപ്പ് ദേശീയ ആരോഗ്യ ദൗത്യം

For the use of investigator only

Question	1	2	3	4	5	6	7	8	9	10
Score										

Total Perceived Stress Scale Score

6. Monthly Reporting Formats

District Mental Health Programme, Consolidated Report of the activities of the District Mental Health Programme for …….					
I .	**Clinical and Diagnostic Data**				**Remarks, if any**
	Number of :				
1	Clinics conducted by DMHP				
2	Camps (Specify)				
3	House Visits, if any (Specify)				
4	New cases Registered				
5	Follow ups				
6	Total (new + follow ups)				
7	Cases referred				
8	Psycho education given				
9	Counselling/Psychotherapy sessions				
10	Cases rehabilitated				
11	**Diagnosis Data (New Cases DMHP)**	**Male**	**Female**	**Total**	
	Dementia				
	Substance Use Disorders				
	Schizophrenia and Psychotic Disorders				
	Bipolar Mood Disorder				
	Depressive Disorder				
	Anxiety disorder				
	Somatoform Disorder				
	Intellectual Disability				
	ADHD				
	Autism Spectrum Disorder				
	Other Childhood Behavioural disorders				
	Epilepsy				
	Delibrate Self Harm (Suicide attempt)				
	Relationship issues				
	Personality Disorder				
	Others				
	TOTAL	**0**	**0**	**0**	
II	**Training programs (Date, Venue, Participants, Resourse person)**				
III	**IECs (Date, Venue, Participants, Resourse person)**				

IV	**School Mental Health**				
V	**Other Targeted Interventions**				
VI	**Day care Centers**				
	Number of patients in each center				
	Occupational Therapies / Vocational Activites done				
VII	**Primary Care (Sampoorna Manasikarogyam)**				
	Number of :				
	FHCs/PHCs/CHCs conducting mental health clinics				
	Cases seen in FHC/PHC/CHC clinics				
	New cases reported by Health workers/MLSP/ASHAs				
	Drop outs reported to health worker from FHCs/PHCs				
	Drop outs brought back to treatment				
	IECs conducted by Health Workers				
VIII	**Aswasam**				
	Number of :				
	FHCs conducting Clinics				
	Cases screened				
	Screened positives				
	Number of cases Diagnosed by MO	**Male**	**Female**	**Total**	
	Mild				
	Moderate				
	Severe				
	Cases started on pharmacotherapy in the FHC				
	Cases started on psycho social intervention in the FHC				
	Cases refered to DMHP				
IX	**Amma Manass**				
	Number of :				
	Antenatal Screened				
	Screened Positives				
	Postnatal Screened				
	Screened Positives				
	Cases referred to DMHP				
	Cases started on treatment by DMHP				

7. EDL Mental Health

Essential Drug List – Mental Health		
SL No	Drug Name	Strength
1	Alprazolam Tab Ip	0.25 mg
2	Amitriptyline Tab Ip	25 mg
3	Carbamazepine Tab Ip	200 mg
4	Carbidopa + Levodopa Tab Ip	25 mg+ 100 mg
5	Chlorpromazine Tab Ip	50 mg
6	Clobazam Tab Ip	10 mg
7	Clomipramine Cap Ip	25 mg
8	Clomipramine Tab	75 mg
9	Clonazepam Tab Ip	0.5 mg
10	Clozapine Tab Ip	25 mg
11	Clozapine Tab Ip	100 mg
12	Diazepam Tab Ip	5 mg
13	Escitalopram Tab Ip	10 mg
14	Fluoxetine Cap Ip	20 mg
15	Fluphenazine Decanoate Inj Ip	25 mg
16	Haloperidol Inj Ip	5 mg/ml
17	Haloperidol Tab Ip	5 mg
18	Haloperidol Tab Ip	1.5mg
19	Levetiracetam Tab Ip	500 mg
20	Lithium Carbonate Tab Ip	300 mg
21	Lorazepam Inj Ip	2 mg/ml
22	Lorazepam Tab Ip	2 mg
23	Olanzapine Tab Ip	10 mg
24	Olanzapine Tab Ip	5 mg
25	Oxcarbazepine Tab Ip	150 mg
26	Phenobarbitone Tab Ip	30 mg
27	Phenobarbitone Tab Ip	60 mg
28	Phenytoin Sodium Tab Ip	100 mg
29	Quetiapine Tab Ip	25 mg
30	Quetiapine Tab Ip	100 mg
31	Risperidone Tab Ip	1 mg
32	Risperidone Tab Ip	2 mg
33	Sertraline Tab Ip	50 mg

34	Sodium Valproate Gastro Resistant Tab Ip	200 mg
35	Sodium Valproate Gastro Resistant Tab Ip	500 mg
36	Sodium Valproate Oral Solution Ip	200 mg/5 ml
37	Trihexyphenidyl Tab Ip	2 mg
38	Zolpidem Tab Ip	10 mg
39	Amisulpride Tab Ip	100 mg
40	Donepezil Tab Ip	10 mg
41	Oxcarbazepine Tab Ip	300 mg
42	Aripiprazole Tab Ip	10 mg
43	Atomoxetine Tab	25 mg
44	Atomoxetine Tab	10 mg
45	Fluvoxamine Tab Ip	100 mg
46	Levetiracetam Oral Solution Ip	100 mg/ml
47	Topiramate Tab Ip	50 mg
48	Venlafaxine Prolonged Release Cap Ip	75 mg

PHOTO GALLERY


LOGISTICS MANAGEMENT
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Muthoot Finance
WORLD MENTAL HEALTH DAY
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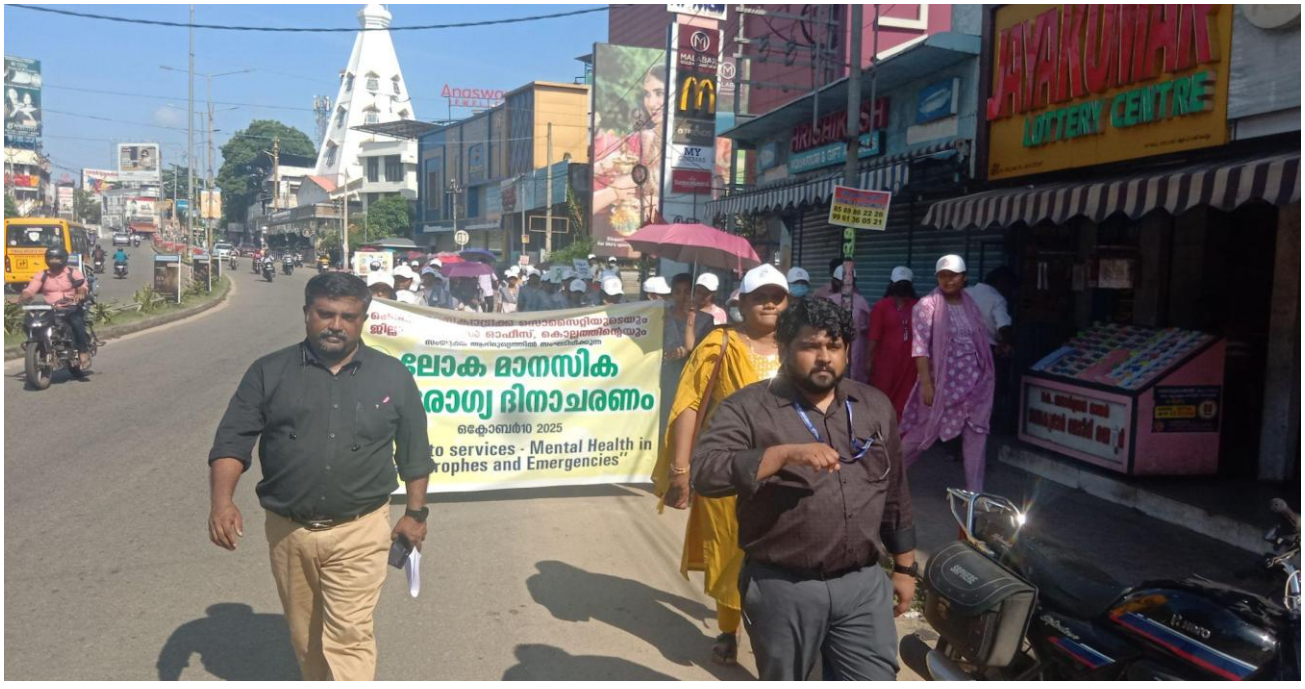
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LOTTERY CENTRE
ലോക മാനസിക
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2025 ഒക്ടോബർ 10


ജീവരക്ഷ


Fear/Stress Pathway AMYGDALA centred circuit
" ACTIVATED "


District Level Public Function
& Awareness Class
10 September 2025, 10 AM
WORLD
SUICIDE
PREVENTION


ജീവരക്ഷ


സമ്പൂർണ്ണ
മാനസ
രോഗ്യം
മെഡിക
ക്യാമ്പ്


What is Mental Well-being?
Common Challenges for Engineering Students


ജില്ലാ ആശുപത്രി


ജില്ലാതല പരിപാടി


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ജില്ലാ മാനസികാരോഗ്യ പദ്ധതി
മലപ്പുറം
പകൽവീട്
നിലമ്പൂർ
APRIL 7
WORLD HEALTH DAY 2026