NATIONAL TELE MENTAL HEALTH PROGRAMME OF INDIA

Tele Mental Health Assistance and Networking Across States (Tele MANAS)

COURSE CONTENT FOR TELE MANAS COUNSELLORS

Edition-1





मन एव मनुषयाणां कारणं बनधमोकषयोः। बनधाय वषियासकतं मुकतयै नरिवषियं समृतम ॥

As is the mind, so is the man; attachment or liberation are in our own mind. A mind that is unduly attached to objects is under servitude and that devoid of desire for objects is considered free

Shloka
- from the Upanishads

Course Content for Tele MANAS Counsellors

Course Content for Tele MANAS Counsellors

ISBN Number:978-93-91300-09-8
NIMHANS Publication Number: 239

Copyright © 2022
National Institute of Mental Health &
Neurosciences (NIMHANS), Bengaluru, 560029
Proofreading by Mr. S Viswanath
Designing and Printing: Futura Digital Colorpress

This book is not for sale

डॉ. मनसुख मांडविया
DR. MANSUKH MANDAVIYA

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक मंत्री
भारत सरकार
Minister for Health & Family Welfare
and Chemicals & Fertilizers
Government of India



MESSAGE

Mental health often does not take precedence in an individuals' life. COVID 19 pandemic which began in early 2020 has demonstrated the importance of Mental Health and the negative impact which mental health issues can have on the overall health and wellbeing of individuals of all ages, across the socio-economic class. Government has continuously strived to give impetus to the mental healthcare through the National Mental Health Program (NMHP) and District Mental Health Program (DMHP), despite which we continue to see that the treatment gap is more than 80 % as demonstrated in the National Mental Health Survey of India.

In the recent years, with efforts from all stakeholders, mental health is given impetus in the form of the progressive and comprehensive National Mental Health Policy, and the Rights based Mental Healthcare Act, 2017. The Ayushman Bharat Mission Aims at providing affordable and quality healthcare services to all through various schemes and infrastructure development. Technology deployment is one of the key features of the Ayushman Bharat Mission.

In this context, the National Tele Mental Health Program (Tele MANAS) will provide free and round the clock mental health services with counsellors and mental health experts. This ambitious initiative also wants to build a very broad and deep network of all the mental health facilities across the nation, to serve the patient better and within a meaningful timeframe. Tele MANAS is supported by counsellors who will be the first line of call of people requiring services. These manuals are designed for providing standardized training for counsellors who will work with mental health experts and have topics covering a range of issues.

I congratulate the entire Tele MANAS team – who have worked towards getting these guidebooks ready and those who will implement the program in the field – and wish them the best.

(Dr. Mansukh Mandaviya)

कार्यालय: 348, ए-स्कंध, निर्माण भवन, नई दिल्ली - 110011 • **Office:** 348, A-Wing, Nirman Bhawan, New Delhi - 110011
Tele.: (O): +91-11-23061661, 23063513 • **Telefax** : 23062358

डॉ. भारती प्रविण पवार
Dr. Bharati Pravin Pawar

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA



MESSAGE

"आरोग्यं परमं भाग्यं स्वास्थ्यं सर्वार्थसाधनम्" - means being healthy is the ultimate fortune and all other tasks are accomplished by health. This is true, not only for us as individuals but also for us collectively as a nation.

The provision of healthcare can never be completed without including mental health. In today's world and with the current challenges we face, mental disorders are a major cause of health burden. As our Prime Minister said that skill, education and empathy are essential qualities doctors must possess for treating patients with mental ailments, concerted efforts have been made to shed light to the need for mental healthcare and improve the availability of resources in the form of mental health infrastructure and manpower.

As we all know, the mental health burden increased several fold after the COVID-19 pandemic. This brought forth the need to develop a robust mental healthcare system with the use of digital technology that makes mental healthcare accessible, affordable and immediate in providing relief to distressed individuals of all ages and from all walks of life leading to the inception of the National Tele Mental Health Programme of India. It will strengthen and boost the existing mental health infrastructure of our nation in a way that was not feasible before, through the use of technology.

Tele MANAS aims to be a 24 x7 mental healthcare service that aims to reach out to every Indian in need of mental healthcare, even in the remotest regions of our country. This service will be supported by Tele MANAS counsellors at the first tier. These training manuals have been developed to ensure standard training material for these counsellors and trainers of the counsellors to ensure uniforms and quality services across the country.

The Government of India, under the visionary leadership of Hon'ble Prime Minister Shri Narendra Modi ji, is committed to meet the health needs of the people of India and I wish all the stakeholders involved in Tele MANAS all the very best and hope that everyone can come together and join forces to make this national endeavour a true success.

BPw.

(Dr. Bharati Pravin Pawar)

Office: 250, 'A' Wing, Nirman Bhavan, New Delhi-110011, Tel. : 011-23061016, 23061551, Telefax : 011-23062828
E-mail : mos-mohfw@gov.in

राजेश भूषण, आईएएस
सचिव

RAJESH BHUSHAN, IAS
SECRETARY

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare



MESSAGE

Mental health is integral to overall health of any individual. The Govt. of India has taken several initiatives in making mental healthcare accessible to all in the country, including announcing the National Mental Health Policy (2014), the rights' based Mental Healthcare Act (2017), expansion of National Mental Health Program (NMHP) and District Mental Health Program (DMHP). Mental health is also included in the 12 packages of comprehensive primary health care packages under AYUSHMAN BHARAT Health and Wellness Centre scheme. Digital academies have also been established in central mental health institutes to enhance reach and human resources.

In the aftermath of COVID 19 pandemic and given the magnitude of problem, we need a contemporary, innovative, and effective strategy that will reach majority of Indian population in a timely manner to address and alleviate their psychological distress, to identify common mental health problems, to swiftly identify severe mental illness and suicidality and to provide timely professional help.

National Tele Mental Health Program was announced in the above context. A two-tier model is being set up for providing easy access to quality mental health care over digital platforms. Telephone call will first be received by a trained counsellor who will be providing service. If the distress warrants specialized help/healthcare, the call will be escalated to a Mental Health Professional (MHP) such as clinical psychologist, psychiatric social worker, psychiatric nurse, or a psychiatrist. A robust system has been built for training and mentoring of Tele MANAS counsellors.

These manuals are a critical part of the training scheme and it is hoped that they will serve the purpose. I wish National Tele Mental Health Program a grand success.

Date : 23rd November, 2022
Place : New Delhi

(**Rajesh Bhushan**)

Room No. 156, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele : (O) 011-23061863, 23063221, Fax : 011-23061252, E-mail : secyhfw@nic.in

रोली सिंह, भा.प्र.से.
Roli Singh, I.A.S.
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Additional Secretary & Mission Director (NHM)

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011



MESSAGE

India stands at the brink of a revolutionary era with regard to mental health. We all underwent some form of distress during the pandemic and that is when one truly appreciated the need for mental well-being and how important our mental health was for our overall health.

One of the important points highlighted by the pandemic was the need to digitally connect healthcare professionals with individuals in need. It has been shown that digital technology has proved to be of immense use to the health experts. During the pandemic Tele- Medicine and Tele-Consultation brought relief to over 2.5 crore individuals throughout the nation.

Several initiatives from the Government of India have led to the revamping of healthcare services over the past few years and made healthcare reach the common man in ways that were never possible before. India has now set a global standard demonstrating strength, capability and reliability in the field of healthcare and pharma during a challenging period like COVID-19.

We certainly need more mental health human resources in our nation. The current mental health needs of the Indian population of 1.4 billion are being catered to by only around a few thousand psychiatrists. The existing mental health infrastructure is burdened and will benefit from novel initiatives such as the National Tele Mental Health Programme to address the demand of our nation. The pandemic taught us that the practice of tele-medicine provided a welcome relief to healthcare providers and patients alike. This was especially true in rural areas where mental health specialists may not be easily available and where a perceptible need for an initiative such as Tele MANAS was felt.

With trained Tele MANAS counsellors acting as gate-keepers and connecting the individuals in distress with specialists and facilitating referrals to higher centres of care, this service would help in providing a continuum of care to individuals in distress. The manuals developed as part of the training curriculum for the Tele MANAS Counsellors will help guide them in dispensing their duties and making this program a success. I congratulate and send my best wishes to the Tele MANAS Team that has worked tirelessly towards this endeavour.

Roli Singh

(Roli Singh)

Tele : 011-2306 3693, Telefax : 011-2306 3687, E-mail : asmd-mohfw@nic.in

विशाल चौहान, भा.प्र.से.
संयुक्त सचिव
VISHAL CHAUHAN, IAS
Joint Secretary

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI - 110011
Tele: 011-23063585 / 23061740
e-mail: js.policy-mohfw@gov.in



Message

The Government of India has always strived to provide for the healthcare needs of the nation. It has been recognized that developing the health sector is crucial for the overall progress of the nation and a worthy investment to make.

Mental illness has been acknowledged as a major cause of disability. In addition to the usual challenges faced by sick individuals, those suffering from mental illness and their families have the added burden of facing stigma. We live in a country where mental illness is attributed to a multitude of socio-cultural causes and the individuals or their families are often shunned from society as a result of this stigma. We see that many individuals refrain from seeking help, often suffering for years before being brought to a mental health professional. It was necessary to develop means to provide for the distressed individuals where they can access mental health services from the comfort of their own homes.

The sheer number of individuals in need for mental healthcare and the limited mental health resources led to the inception of Tele MANAS, envisioned as a robust mental healthcare system that uses digital technology in making mental healthcare accessible, affordable and immediate in providing relief to distressed individuals across the nation.

The National Tele Mental Health Programme of India (Tele MANAS) will provide a crucial link between distressed individuals and mental health professionals. 51 State-wise Tele MANAS cells spread across the country with trained counsellors and a team of specialists that will further network with mental hospitals and locally available mental health resources, this national program aims to provide all individuals with optimum level of mental healthcare.

We hope that Tele MANAS will help bridge the treatment gap providing essential mental health interventions to those in need just a call. These manuals are being released as part of training for the counsellors and facilitators who are integral to the impact of Tele MANAS. I wish all those involved in the formulation of the manuals the very best.

(VISHAL CHAUHAN)

डॉ. विनोद कुमार पॉल
सदस्य
Dr. Vinod K. Paul
MEMBER

सत्यमेव जयते

भारत सरकार
नीति आयोग, संसद मार्ग
नई दिल्ली–110 001
Government of India
NATIONAL INSTITUTION FOR TRANSFORMING INDIA
NITI Aayog, Parliament Street
New Delhi-110 001
Tele. : 23096809 Fax : 23096810
E-mail : vinodk.paul@gov.in

November 22, 2022

Foreword

The National Tele Mental Health Programme of India was announced in the Union Budget by the Government of India in February 2022. This occurred in the background of the issues brought forth during the COVID-19 pandemic. The National Tele Mental Health Programme aims "to better the access to quality mental health care services". The Ministry of Health and Family Welfare, Govt. of India was tasked with the overall implementation of the programme. The National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru in collaboration with the International Institute of Information Technology-Bengaluru (IIIT-B) and National Health Systems Resource Centre (NHSRC) were identified as apex centres to collaborate and partner with all States and Union Territories to set up Tele MANAS Cells to function as a 24×7 digital mental health service facility.

The vision of the program is to link Tele MANAS with existing in-person mental health services (particularly the ones related to District Mental Health Program) to provide a comprehensive continuum of care. Networking was completed by including Centers of Excellence (COE)/Medical Colleges /Tertiary Care Centres spread across the length and breadth of the country.

This manual comprises of course content for Tele MANAS counsellors (TMC) who will be the frontline gatekeepers of the Tele MANAS initiative. The manual has been devised in a manner which is easily understandable. Available literature has been reviewed and concepts incorporated. Language used is very simple and lucid. It starts with a brief introduction to Tele MANAS and briefs about basic components of a call. Next, a module on basic communication and counselling skills finds a place. Ethical and legal aspects of tele counselling have been dealt with to provide some dos and don'ts for counsellors. Mental Health First Aid forms the crux of tele counselling and has been illustrated in the next module. Separate modules on 'challenging situations in counselling' and 'challenging calls' by clients who may have suicidal ideations or are very aggressive/disorganized have been included to help counsellors take best possible decisions (including referral to in person services). Stress management and managing people who are worried/anxious/nervous and having sleep disturbances has also been addressed. Domestic Violence has risen during Covid-19 pandemic and a module addressing gender-based violence has been included. The

स्वच्छ भारत
एक कदम स्वच्छता की ओर

manual aims to guide the Tele MANAS Counsellor in directly handling the distress of individuals reaching out to Tele-MANAS and facilitating appropriate referrals to specialists in State Tele MANAS Cells and other in-person services when necessary.

Taking note of the need for a quick reference guide for TMCs, the authors have come up with a **Point-of-Care Guide** that can be easily referred to while on the job. This guide consists of various possible clinical scenarios/encounters and provides flow-charts to guide a TMC to take quick actions in a professional manner.

Finally, a **Facilitators' Manual** has also been developed for the trainers' reference. This would ensure uniformity in training across the country. This is designed keeping andragogical principles in mind. Various training methodologies are explained and guides the trainer to incorporate them. This is also important keeping in mind the possible high turnover rate of the TMCs as well as the trainers.

It would be prudent to note that scenarios/clinical encounters would change as the initiative progresses. The coordinators and leaders for the program should take note of this and be ready to incorporate and revise these manuals based on the new learnings.

I wish Tele MANAS a grand success and hope that it will play an important role in not only reducing the treatment gap for psychiatric disorders in the country, but also will be a constant source of help for those in mental distress.



(Vinod Paul)

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
INSTITUTE OF NATIONAL IMPORTANCE
P.B. 2900, Bengaluru - 560 029 (India)

Dr. Pratima Murthy
MBBS, DPM, MD, FRCP (Glasgow)
Director and Senior Professor of Psychiatry

Off : 91-80-26564140, 26561811
26565822, 26995001 / 2
Res : 91-80-22239127
Fax : 91-80-26564830 / 26562121
Email : pratimamurthy@gmail.com
pmurthy@nimhans.ac.in

Preface

It is often reiterated that there is no health without mental health and the Covid-19 pandemic has strongly reinforced this adage. The National Mental Health Survey 2016 found that while one in ten persons has a diagnosable mental disorder, only about 20-25% of this group has access to mental health care. For every person with a diagnosable mental disorder there are several more with psychological distress. The Government of India has undertaken several initiatives to address the wide treatment gap, including the formulation of the National Mental Health Policy (2014), enactment of the patient rights-centric Mental Healthcare Act (2017), support of 25 Centres of Excellence, enhancement of seats in specialized professional courses in mental health and expansion and strengthening of the District Mental Health Program (DMHP).

The COVID-19 pandemic also highlighted the importance of using technology to bridge the resource gaps in mental health care and presented an opportunity to strengthen digital mental health platforms for ease of access to mental health care. Against this background, the MOHFW has initiated the National Tele Mental Health Programme (Tele MANAS). This novel strategy is envisioned to provide immediate care to distressed individuals through a network of Tele MANAS cells in all States/UTs. These cells in Tier 1 will be operated by trained counsellors under supervision of mental health professionals. The counsellors will provide psychosocial support to callers and also identify persons who need urgent referral to mental health care services, including the DMHPs, which will function as the Tier 2 facilities. Thus, Tele MANAS will function as the digital arm of the DMHP and provide a comprehensive continuum of care. Such large-scale networking and links between digital and in-person mental health services aims to bridge the existing gaps in mental healthcare.

This effort of the MOHFW is anchored by NIMHANS, in technical partnership with the International Institute of Information Technology, Bengaluru (IIITB) and the National Health Systems Resource Centre (NHSRC). NIMHANS, the Central Institute of Psychiatry (CIP), Ranchi, the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health

Contd...2

(LGBRIMH), Tezpur, Post Graduate Institute of Medical Education and Research (PGIMER) and Institute of Human Behaviour and Allied Sciences (IHBAS), will function as Regional Coordinating Centres, and along with Mentoring Institutions for each State/ UT, provide support to Tele MANAS.

The support from the Niti Ayog is gratefully acknowledged.

Since its launch on the World Mental Health Day (10th October 2022), Tele MANAS has received over 7400 calls from distressed individuals. Over 1000 counsellors have been trained and cells have been established in about 25 locations across 23 states.

These training manuals will train the counsellor in Tele-MANAS to address the various concerns of callers to the Tele MANAS.

Dr. Pratima Murthy
Director, NIMHANS

Acknowledgements

We thank the following individuals who have contributed to the three manuals by way of reviewing, suggesting changes and edits and approving the content.

National Technical Advisory Group (NTAG) for the National Tele Mental Health Programme (Tele-MANAS):

- Ms Roli Singh (current Chairperson; N-TAG), Addl. Secretary and Mission Director (AS & MD), NHM, MOHFW, Govt. of India.
- Shri Vikas Sheel (former Chairperson), former Addl. Secretary and Mission Director (AS & MD), NHM, MOHFW, Govt. of India.
- Shri. Vishal Chauhan, Joint Secretary (Policy), MOHFW, Govt. of India.
- Dr Pratima Murthy, Director and Senior Professor of Psychiatry, NIMHANS, Bengaluru, Member Secretary, NTAG; Tele-MANAS
- Dr B N Gangadhar - Chairman, Medical Assessment and Rating Board, National Medical Council, Govt. of India.
- Maj Gen (Dr., Prof) Atul Kotwal, Executive Director, National Health Systems Resources Centre (NHSRC), MOHFW, Govt. of India and Govt. of India Member,
- Dr Praveen Gedam – Mission Director, ABDM and Additional CEO, National Health Authority, MOHFW, Govt. of India
- Shri Magesh Ethirajan, Director General, C-DAC, Pune.
- Prof T K Srikanth - Director, Professor and Faculty in-charge, Computing and Core Member of E-Health Research Centre (EHRC), IIIT-Bengaluru.
- Dr Prabha S Chandra - Dean, Behavioural Sciences and Senior Professor of Psychiatry, NIMHANS, Bengaluru.
- Shri Anil Kumar T K, IAS, Addl. Chief Secretary, Department of Health and Family Welfare Services, Govt. of Karnataka.
- Thiru T S Jawahar, IAS, Addl. Chief Secretary, Health and Family Welfare Department, Govt. of Tamil Nadu.

Technical Advisory Sub-Committee on IT Architecture for the National Tele Mental Health Programme (Tele-MANAS):

- Prof T K Srikanth (Chairperson), Director, Professor and Faculty in-charge, Computing and Core Member of E-Health Research Centre (EHRC), IIIT- Bengaluru.
- Dr Suresh Bada Math (Member Secretary), Professor of Psychiatry, Officer in charge, NIMHANS Digital Academy and Head, Forensic Psychiatry Unit, NIMHANS, Bengaluru
- Shri Sunil Bhushan, Deputy Director General, National Informatics Centre (NIC), New Delhi.
- Dr Kalai Selvan K, Centre Head, Centre for Development of Advanced Computing (C-DAC), Thiruvananthapuram.
- Dr (Flt. Lt.) M A Balasubramanya, Advisor, Community Processes-Comprehensive Primary Healthcare - NHSRC, MOHFW, Govt. of India.
- Ms Noorin Bux, Deputy Secretary, MOHFW, Govt. of India.
- Dr Prameela Baral, State Nodal Officer, Mental Health, Odisha.
- Dr Manish Srivastava, Chief Technology Officer, eGov Foundation, Bengaluru.
- Dr Seema Mehrotra, Professor and Head, Dept. of Clinical Psychology, NIMHANS, Bengaluru
- Dr Vijender Singh, Prof and Head, Dept. of Psychiatry, AIIMS, Bhopal.
- Representative from ABDM/ e-Sanjeevani.
- Prof S Sadagopan, Former Director, IIIT-Bengaluru.
- Prof Prasanta Kumar Pradhan, President, Telemedicine Society of India, Lucknow.
- Shri Girish Krishnamurthy, Managing Director and Chief Executive Officer, Tata Medical and Diagnostics, Mumbai.
- Dr V Rajesh Kumar, Senior Group Manager, Infosys Data Protection Office, Bengaluru.

- Ms Sunita Nadhamuni - Head, Digital Life Care, Dell Technologies.
- Dr Prabhat Kumar Chand – Professor of Psychiatry and Officer in charge, Centre for Addiction Medicine, NIMHANS, Bengaluru.
- Smt Aparna U, Mission Director (NHM), Uttar Pradesh.
- Ms Ayushi Sudan, Mission Director (NHM), Jammu & Kashmir.

Technical Advisory Sub-Committee on Health Systems for the National Tele Mental Health Program (Tele MANAS):

- Maj Gen (Dr., Prof) Atul Kotwal (Chairperson), Executive Director, National Health Systems Resources Centre, MOHFW, Govt. of India
- Dr Girish N Rao (Member Secretary), Professor of Epidemiology, Centre for Public Health, Dept. of Epidemiology, NIMHANS, Bengaluru.
- Dr Atreyi Ganguli, WHO India Office, New Delhi.
- Dr Ajay Chauhan - State Nodal Officer, Mental Health, State Health Society, Health and Family Welfare Dept., Govt. of Gujarat.
- Dr Rinku Sharma, Joint Director, Directorate General of Health Services (DGHS), MOHFW, Govt. of India.
- Dr S K Deuri, Director, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur (Assam).
- Dr Anant Bhan, Sangath, Bhopal.
- Dr Jahanara M Gajendragad – Professor and Head, Dept. of Psychiatric Social Work, IHBAS, Delhi.
- Dr Athokpam Ranita Devi, State Nodal officer, State Mental Health Programme, Manipur.
- Shri Amrit Kumar Bakhshy, Chairperson of Advisory Board, Let's walk Together (Ability over Disability), Pune.
- Dr Sahajanand Prasad Singh, President, Indian Medical Association.
- Dr Sekar Kasi, Former Registrar & Former Professor, Dept. of Psychiatric Social Work, NIMHANS, Bengaluru.
- Dr N Manjunatha, Addl. Professor of Psychiatry and Consultant, Community Psychiatry Unit & Tele Medicine Centre, NIMHANS, Bengaluru.
- Ms Shalini Pandit, Mission Director, National Health Mission (NHM), Dept. of Health and Family Welfare, Govt. of Odisha.
- Dr Abhinav Trikha, Mission Director, National Health Mission (NHM), Punjab.

Technical Advisory Sub-Committee on Mental Health Service Delivery for the National Tele Mental Health Program (Tele MANAS):

- Dr Prabha S Chandra, Dean, Behavioural Sciences, Senior Professor of Psychiatry, NIMHANS, Bengaluru (current Chairperson).
- Dr Sanjeev Jain – Former Dean of Behavioural Sciences Division and Senior Professor of Psychiatry, NIMHANS, Bengaluru (former Chairperson).
- Dr R Thara - Former director, SCARF, Chennai.
- Dr Himanshu Bhushan (Advisor PHA) - Nominee from NHSRC, MOHFW, Govt. of India.
- Dr Rajesh Sagar - Professor of Psychiatry, Dept. of Psychiatry, AIIMS, New Delhi.
- Dr N Raju - President, Indian Psychiatric Society.
- Dr Naveen Kumar C (Member Secretary) - Professor of Psychiatry and Head, Community Psychiatry, Dept. of Psychiatry, NIMHANS, Bengaluru.
- Dr Kishore Kumar - Professor of Ayurveda, Dept of Integrative Medicine, NIMHANS.
- Dr Gowri Nambiar Sengupta, ADG, Public Health, NMHP, NPHCE, NPPC, Dte Gen Health Services, MOHFW, Govt. of India.
- Dr Satish Rasaily – In-charge Drug Deaddiction Centre, Singtam, Sikkim.
- Dr Dherandra Kumar, President, National Professional Association of Clinical Psychologists, India.
- Dr T Dileep Kumar, President, Indian Nursing Council.
- Mr Divyaraj - IIIT Bengaluru.
- Dr Ratan Khelkar, Mission Director (NHM), Kerala.

- Ms Remya Mohan, Mission Director (NHM), Gujarat.

Heads of the Departments of the Behavioural Sciences Division, NIMHANS, Bengaluru:

- Dr Y C Janardhan Reddy – Professor and Head, Department of Psychiatry, NIMHANS, Bengaluru.
- Dr Seema Mehrotra – Professor and Head, Department of Clinical Psychology, NIMHANS, Bengaluru.
- Dr Dhanasekara Pandian – Professor & Head, Department of Psychiatric Social Work, NIMHANS, Bengaluru.
- Dr Sailaxmi Gandhi – Professor & Head of Department, Department of Nursing, NIMHANS, Bengaluru.
- Dr K John Vijay Sagar – Professor & Head, Child and Adolescent Psychiatry, NIMHANS, Bengaluru.
- Dr K S Meena – Additional Professor & Head, Mental Health Education, NIMHANS, Bengaluru.
- Dr Vivek Benegal, Professor of Psychiatry and I/C Head, Department of Psychosocial Support in Disaster Management, NIMHANS, Bengaluru

NIMHANS Core Committee for Tele MANAS

- Dr Pratima Murthy, Director and Senior Professor of Psychiatry, NIMHANS, Bengaluru, Member Secretary, NTAG; Tele-MANAS
- Dr Girish N Rao, Professor of Epidemiology, Centre for Public Health, Dept. of Epidemiology, NIMHANS, Bengaluru.
- Dr Suresh Bada Math, Professor of Psychiatry, Officer in charge, NIMHANS Digital Academy and Head, Forensic Psychiatry Unit, NIMHANS, Bengaluru
- Dr Prabhat Kumar Chand – Professor of Psychiatry and Officer in charge (former), Centre for Addiction Medicine, NIMHANS, Bengaluru.
- Dr Naveen Kumar C - Professor of Psychiatry and Head, Community Psychiatry, Dept. of Psychiatry, NIMHANS, Bengaluru.
- Prof T K Srikanth, Director, Professor and Faculty in-charge, Computing and Core Member of E-Health Research Centre (EHRC), IIIT- Bengaluru.
- Mr Divya Raj, Principal Technical Strategist in the E-Health Research Centre (EHRC) & Adjunct faculty, IIIT-Bengaluru
- Dr Sekar Kasi, Former Professor, Dept. of Psychiatric Social Work, NIMHANS, Bengaluru.
- Dr Rajani Parthasarathy, Deputy Director, Mental health, Dept. of Health and Family Welfare Services, Govt. of Karnataka.

We wholeheartedly thank the representatives and nodal officers of the state governments and the nodal officers from Regional Coordinating Centres and Mentoring Institutes. The details are described at length in Annexure.

We express our special thanks to the officials from the Ministry of Health and Family Welfare including Dr Noorin Bux (Deputy Secretary, MOHFW) and Sri Manish Raj (Under Secretary, MOHFW, Govt. of India).

We wholeheartedly thank NIMHANS Administration including Dr B S Shankara Narayana Rao, Registrar, teams from IIIT B team and NHSRC including Dr Neha Dumka, Lead Consultant, Knowledge Management Division, NHSRC.

We would like to extend our gratitude to the technical and non-technical staff of Telemedicine Centre, NIMHANS, NIMHANS Digital Academy and staff of Library and Information Centre, NIMHANS, Bengaluru.
Last but not the least, we extend our immense gratitude to everyone who has been instrumental in the development of these manuals.

Contributor's List:

NIMHANS, Bengaluru:

Dr. Lakshmi Nirisha P, Dr. Patley Rahul, Dr. Hari Hara Suchandra K, Dr. Swati Ravindran, Dr. Nileswar Das, Dr. Suhas Satish, Dr. Bhaskaran A. S, Dr. Gautam Sudhakar N, Dr. Harshitha H A, Dr. Gajanan Ganapati Sabhahit, Dr. Praveen V Raj, Dr. Sukriti Mukherjee, Dr. Aishwarya John, Dr. Shivam Gakhhar, Dr. Madan R, Dr. Kalyani BG, Dr. Neha B Kulkarni, Dr. Prakyath Hegde, Dr. Ateev Sudhir Chandna, Dr. Arul Kevin Daniel D, Dr. Arpita Krishna, Dr. Tushar Kanta Panda, Dr. Apurva Mittal, Mr.Kiran Kumar CTL, Mrs. Deepa P S, Dr. Anusha M N, Dr. Liya Thomas, Dr. Kishore Kumar Ramakrishna, Dr. Hemant Bhargav, Dr.Nishita J, Dr. Vidhya Sanker, Dr. Kavyashree, Dr. Prabha S Chandra, Dr N Manjunatha, Dr. C Naveen Kumar, Dr. Suresh Bada Math.

IIIT- Bengaluru:

Prof TK Srikanth, Mr Divya Raj, Ms. Archana Karthik

NHSRC:

Dr. Neha Dumka, Dr. Tarannum Ahmed, Dr. Surabhi Sethi

Suggested Citations:

Nirisha, PL., Patley, R., Suchandra, H. H., Ravindran, S., Das, N., Satish, S., Bhaskaran, A. S., Sudhakar, N. G., Harshitha, H.A., Sabhahit, G. G., Raj, P.V., Mukherjee, S., John, A., Gakkhar, S., Madan, R., Kalyani, B.G., Kulkarni, N. B., Hegde, P., Chandna, A. S., David, A.K.D., Krishan, A., Panda, TK., Mittal,A., Kumar, CTL. K., Deepa,P.S., Anusha, M.N., Thomas, L., Ramakrishna, K.K., Bhargav, H., Nishita, J., Sanker, V., Kavyashree., Dumka,N., Ahmed, T., Sethi, S., Srikanth, T.K., Raj, D., Karthik, A., Chandra, P.S., Manjunatha, N., Kumar, C.N., Math, S. B. (2022). Course Content for Tele MANAS Counsellors

Contents

Module No.	Module Name	Page No.
Module 1	Overview of the National Tele-Mental Health Program	1
Module 2	Basic Components of a Call	8
Module 3	Basic Counselling/Communication Skills	10
Module 4	Roles and Responsibilities of a Tele-Counsellor, Self-care tips	14
Module 5	Interventional Framework for Tele-MANAS Counsellors: Manasvita	16
Module 6	Introduction to Mental Health and Mental Health Disorders	20
Module 7	Overview of Mental Disorders	24
Module 8	Stress Management: dealing with common mental health concerns	29
Module 9	Handling distress related to death and grief	35
Module 10	Handling couple and family conflicts	39
Module 11	Handling problems related to Addiction	42
Module 12	Handling women's mental health issues and gender-based violence	50
Module 13	Handling concerns of Vulnerable populations	56
Module 14	Ethical and Legal aspects of Tele-Counselling	70
Module 15	Challenging Situations in counselling	81
Module 16	Handling difficult scenarios: Suicide/Aggression/Risk of harm to others	85
Module 17	Mental Health First Aid	93
Module 18	Mental Health Promotion	98
Module 19	Mental health issues arising in the context of pandemic/disasters	109
Module 20	Manohita (AYUSH)	115
Module 21	Rehabilitation services and Benefit Schemes in mental healthcare	128
Module 22	Technical Components of Tele MANAS: IVRS, Flows, Data Fields	136
	Annexures	

MODULE 1

Overview of National Tele - Mental Health Programme (Tele MANAS), Introduction to Online and Telephone Counselling

Objective of this module

Part 1

- Introduction to the Health Systems of India and Overview of the NMHP
- A brief description of the burden of mental illness in India
- Overview of the National Tele Mental Health Programme - Tele MANAS: Objectives, workforce, and various mental health services under the purview of Tele MANAS

Part 2

- Introduction to Online Counselling
- Introduction to Telephone Counselling

Among the general population, several types of mental health issues can be found ranging from minor to major mental illnesses. In the National Mental Health Survey(NMHS) 2015-2016, it was found that 10.3% of individuals suffer from a mental disorder. One individual out of every 20 people in India suffers from depression. 22% of individuals used some substance of abuse such as tobacco, alcohol and other drugs; of which 20% individuals consumed tobacco and 4.6% individual have alcohol use disorder. These percentages, when translated into numbers in a populated country like India, are quite large. In addition to psychiatric disorders, suicide is also an important mental health concern which cannot be overlooked. In India, more than 1 lakh people end their life by suicide. As per the data on causes of suicide in India in 2020, 33% committed suicide due to family problems, and 18% committed suicide due to an "illness". Most others died due to causes with various social and interpersonal problems. Thus, it is critical to address the mental health issues urgently. Further, many individuals with "minor mental health issues" do not seek help for various reasons, indicating that what be seeing and addressing a small proportion of the burden due to mental health issues.

Access to mental healthcare is a basic human right of every individual. No individual suffering from mental illness should face discrimination. It is important to note that majority of mental health concerns will not require specialised care, and many can be helped by other trained healthcare providers. Mental Health Promotion should be advocated widely and encourage people to seek help when faced with mental health problems. The Coronavirus Disease 2019 (COVID 19) pandemic added to the burden of mental health problems and had detrimental effect on individuals' ability to ask for mental health assistance. During this period, there was an exponential increase in outreach for mental healthcare through Tele-Mental healthcare services.

During the COVID 19 Pandemic, the Government of India launched a National Psychosocial Support Helpline to provide psychosocial support during the pandemic, and over 6 lakh individuals reached out to the helpline across the country. Furthermore, several other initiatives by state governments, government institutions, private bodies, and non-governmental organisations (NGOs) have demonstrated the advantages and feasibility of technology-driven mental healthcare, in other words, Tele-Mental Healthcare services. One such step towards continuing the application of tele-mental healthcare services on a larger scale is the National Tele-Mental Health Programme or **Tele MANAS** (**Tele**-**M**ental **H**ealth **A**ssistance and **N**etworking **A**cross **S**tates). We will first have a brief look into the existing Health systems of India.

Introduction to the Health Systems of India

Health services in India are delivered by both public and private sectors. These health care sectors vary by patterns of ownership and different organizations. Allopathic health care systems in India are supplemented by other systems of medicine, such as Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH).

Various curative and preventative treatments are offered in the public healthcare sector. These public funded health-care services in India are governed at the state level by the departments of health and at the national level by the health and other ministries under the Government of India.

The public sector facilities include:

- **Primary level:** Primary Health Centres (PHCs) and Sub Health Centres (SHCs) comprising of 24.7 lakh health care workers.
- **Secondary level:** Sub division and community health centres (CHC) comprising of 18.2lakh healthcare workers.
- **Tertiary level:** District level Hospitals and Medical Institutions comprising up to 6.9 lakhs healthcare workers. Tertiary care is also provided state-level super-specialty hospitals.

Central government under the National Health Mission (NHM) provides partial funding to the state government for the functioning and maintenance of the facilities up to the district hospital level. State health departments fund State government run medical colleges and super-specialty hospitals functioning at the state level. Apart from healthcare facilities operated by the state and national ministries of health, public sector employers divisions of the Ministry of Defence, the Ministry of Railways, the police, and port authorities also offer health services through healthcare facilities run by them. Other organised sector workers can access health services from hospitals and dispensaries under the Employees' State Insurance Corporation (ESIC) hospitals and dispensaries.

National Health Mission (NHM)

The National Health Mission (NHM) laucnched in 2005 with the vision of achieving universal access to equal, affordable, and quality health care services that are sensitive to patient needs and effective in addressing broader social determinants of health. The NHM encompasses two sub-missions, the National Rural Health Mission(NRHM) and the National Urban Health Mission(NUHM). The key priority areas of the NHM have expanded from its original emphasis on reproductive, maternal, new-born, and child health services to now adolescent health services, strengthening the health system, and combating other communicable and non-communicable diseases.

The National Health Systems Resource Centre (NHSRC)

NHSRC was established in the year 2007 by the Government of India, with the aims of:

- Policy development in providing and mobilising technical assistance to the states
- Capacity building for the Ministry of Health and Family Welfare (MoHFW)

National Mental Health Programme (NHMP)

The National Mental Health Programme (NMHP) was launched by Govt. of India in the year 1982 with the objectives of:

1. Ensuring the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;
2. To encourage the application of mental health knowledge in general healthcare and in social development; and
3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

District Mental Health Programme (DMHP_

District Mental Health Programme (DMHP) was launched under NMHP in the year 1996 (in the IXth Five Year Plan). It was designed to increase the scope of NMHP's mental health services through targeted service provisioning, training initiatives, community awareness campaigns, the development of human resources, and facility improvement. It was based on 'Bellary Model' with the following components:

1. Early identification & provision of treatment.
2. Training and strengthening of available human resources: providing general practitioners with brief training in the diagnosis and management of common mental diseases with a minimal amount of medications under the supervision of experts. Other healthcare workers are also being trained to identify the individuals with mental illnesses.
3. Information Education and Communication (IEC): generation of public awareness.
4. Monitoring: record keeping for future monitoring of all the services that were provided.

The NMHP was re-strategized in the year 2003 (in the Xth Five Year Plan) with the following components:

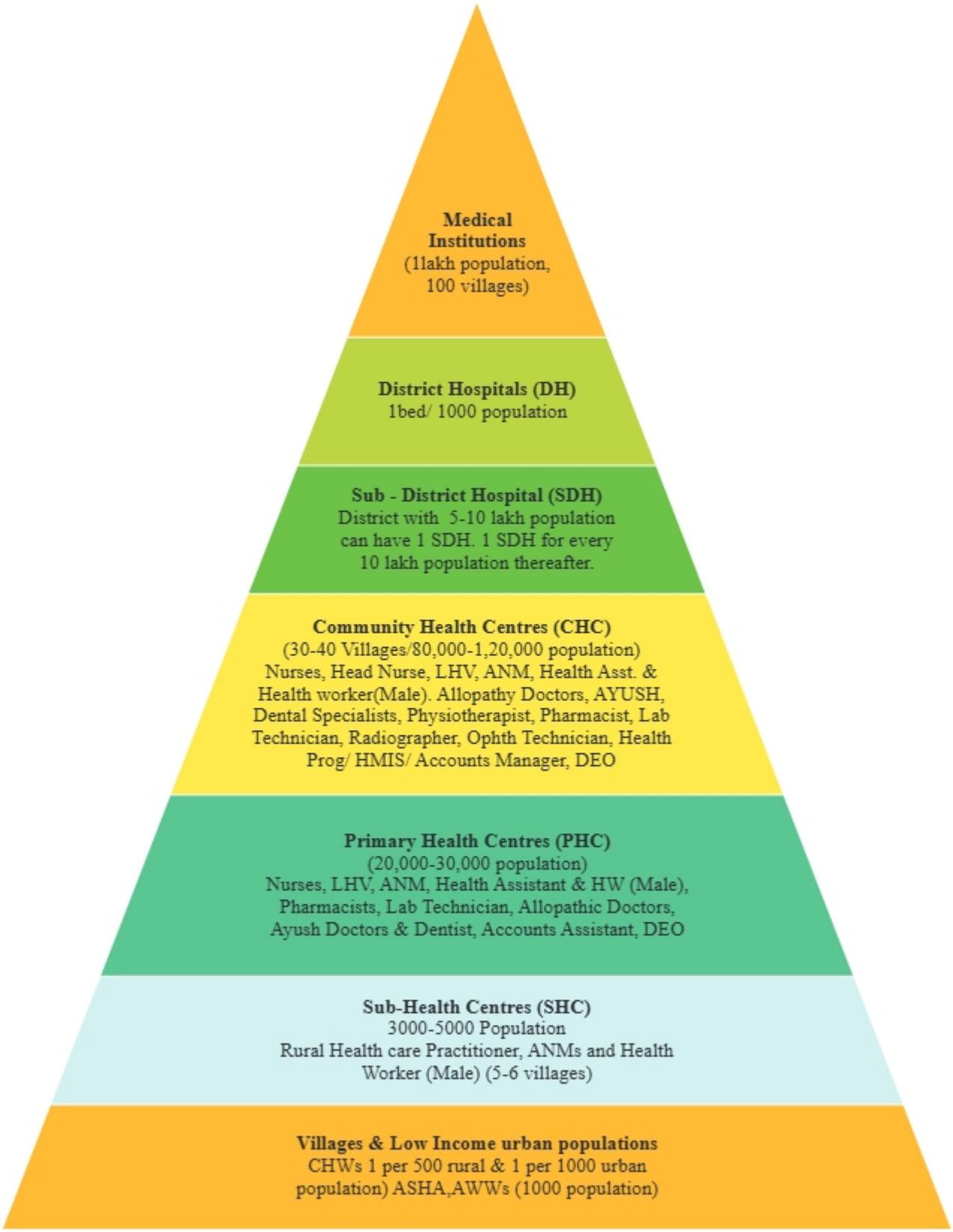
1. Extension of DMHP to 100 districts
2. Upgradation of Psychiatry wings of Government Medical Colleges/ General Hospitals
3. Modernization of State Mental hospitals
4. Promotion of IEC
5. Regular surveillance

Since its inception in 1996, DMHP has evolved greatly over the last 20–25 years under the last four (Xth – XIIIth) 'Five Year Plans'.

Current National Tele-Mental Health Programme (Tele MANAS) has been envisioned as the digital arm of the DMHP as further extension of the mental healthcare service in the country.

Current Health Infrastructure in India

ANM- Auxiliary nurse midwife, LHV- lady health visitor, DEO- data entry operator, ASHA- accredited social



health activist, AWW- Anganwadi workers (adapted from National health Mission, Ministry of Health & Family Welfare, Government of India)

Overview of the National Tele-Mental Health Programme (Tele MANAS)

In the Union Budget (2022-23), the Government of India announced in February 2022 the establishment of 23 Centres of Excellence of the country, with the National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru as the apex nodal centre to roll out **Tele MANAS.**

Objectives of Tele MANAS:

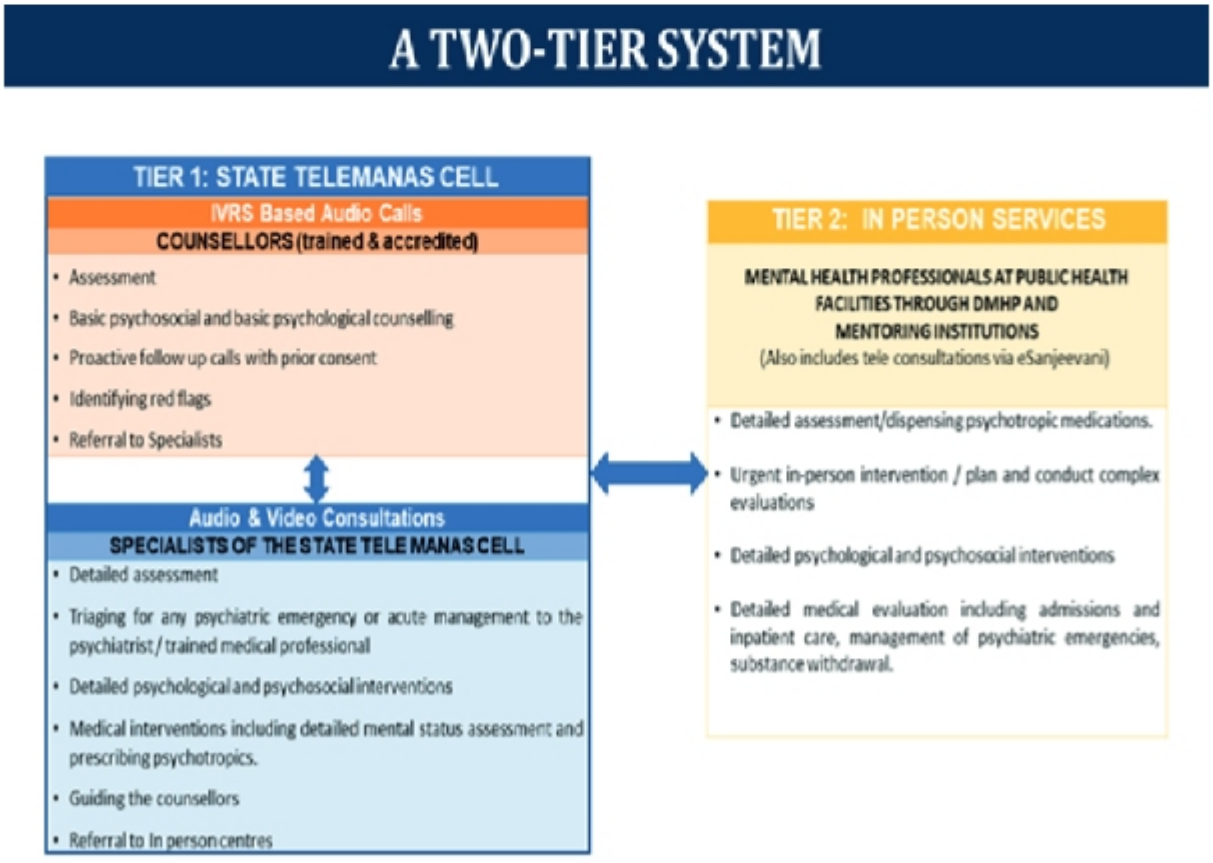
a. To enhance health service capacity in order to deliver accessible and timely mental healthcare through a tele-mental health network support system.
b. To ensure a continuum of services in the community, including tele-mental health counselling.
c. To facilitate timely referral for specialist care and follow-up as appropriate.
d. To enhance mental healthcare capacity and networking at primary healthcare/health and wellness centres/district/state/apex institution levels.

Beneficiaries of Tele MANAS:

Any individual with mental health issues can reach out to Tele MANAS services for help. In addition, grassroot healthcare providers/community health providers, i.e., Accredited Social Health Activists (ASHAs) and community volunteers from the community can reach out to Tele MANAS on behalf of an individual or individuals in that community with mental health issues. Primary healthcare providers such as MBBS primary care doctors (PCD), AYUSH healthcare providers, and nurses may also reach out to Tele MANAS, wherein collaborative care shall be provided to the individual.

The workforce of Tele MANAS:

Workforce/human resources under Tele MANAS is divided into two tiers based on the level of the services provided (counselling, psychiatric consultation along with pharmacotherapy/ psychotherapy) and the expertise of the workforce. The two tiers comprising the allocated human resources with their place of functioning have been described in the flow chart below.



Components of Tele MANAS services:

Tele-Mental health services include providing advice, counselling, connecting with a mental health professional for tele-psychiatry services, and enabling people to seek help when it is not possible for them to come physically to a hospital or a help centre. The Tele MANAS services range from telephonic counselling to facilitating referrals for operational care.

Counselling:

With the background of the Tele MANAS objectives, workforce, and services provided, we shall now discuss Online Counselling and Telephone Counselling that you shall be providing as a Tier 1 First Responder/ Counsellor. Specific details about the characteristics of a counsellor, handling a call, and addressing specific situations shall be discussed in the subsequent modules.

To begin with, here we shall discuss 'online' and 'telephone' counselling. Though face-to-face interaction is better, whenever it is not feasible to have an interaction in-person, online and telephone counselling provides useful alternative modes to seek help. It is crucial to understand that when we talk about counselling, we mean the process of working through emotional issues with a skilled counsellor or therapist.

Counselling gives people the time and space to talk about their problems and explore their tough feelings in a setting that is confidential, dependable, and interruption-free. Counselling alone, is different from psychotherapy by a psychiatrist/clinical psychologist/psychiatric social worker or a psychiatric nurse, which requires special training and expertise and is more structured compared to basic counselling which any individual wishes to help those in distress can carry out.

Online Counselling:

Online Counselling refers to counselling through online modes connected through the Internet which could be in real-time via audio, video, or asynchronous i.e., via text messages, chat, or emails. As Tier 1 workforce you shall be providing counselling through the 24/7 helpline, mode of which could be through audio calls and asynchronous modes such as text messages and chats. Real-time video counselling/consultations will be primarily carried out by specialists at the state Tele MANAS cell and at Tier 2 level in which you may be required to provide basic information and also be an observant for training and skill enhancement.

Telephone Counselling:

Telephone Counselling involves providing psychosocial support or counselling through the telephone. Telephone counselling involves providing addressing the concerns of the caller and counselling individuals seeking help directly or through another individual such as ASHA or a family member via the telephone, which could be a landline or mobile phone **with or without Internet connectivity.** Telephone counselling has a unique advantage that an individual in distress can call and access mental healthcare from a trained healthcare provider anywhere, 24 hours a day. Also, it enables some privacy to individuals who seek help wherein they can seek help when comfortable and has enough space to ensure confidentiality.

Despite access to the telephone being easy, at times when an individual still is unable to seek help, they can reach out to a community health worker (CHW) in their community or the nearest Primary Health Centre (PHC) or the Health and Wellness Centres and seek assistance from there.

Manual Development:

This training manual was developed through these sequential steps. Initially, the draft was prepared by contributors from NIMHANS. It was then presented to the NIMHANS core committee for Tele MANAS, and inputs were incorporated. Further, the Heads of various Departments , i.e Psychiatry, Clinical Psychology, Psychiatric Social Work, Nursing, Child and Adolescent Psychiatry and Mental Health Education were consulted for their inputs. After incorporating their suggestions, the draft was sent to the members of the National Technical Advisory Sub-Committee on Mental Health Service Delivery (for Tele MANAS) and the nodal officers of the Regional Coordinating Centres. A meeting was held on 30th August 2022 to clarify and finalise suggestions from their end. All these were incorporated into this version of the manual.

In the upcoming chapter, topics pertaining to telephone counselling and specific mental health issue/s will be discussed.

References / Further reading:

1. Gururaj G, Varghese M, Benegal V, Rao G N, Pathak K, Singh L K, et al. National mental health survey of India, 2015-16. National Institute of Mental Health and Neuro Sciences, NIMHANS; 2016.
2. Math S B, Manjunatha N, Kumar C N, Basavarajappa C, Gangadhar B N. Telepsychiatry operational guidelines -2020. Bengaluru: NIMHANS; 2020.
3. Ibrahim F A, Pahuja E, Dinakaran D, Manjunatha N, Kumar C N, Math S B. The future of telepsychiatry in India. Indian J Psychol Med 2020 Oct 1; 42 (5_suppl): 112S–17S.
4. T-MANAS to function as 24x7 tele mental health facility in states, UTs. The Indian Express. Feb 04, 2022.

MODULE 2

Basic Components af a Call

Objective of this module

- To know about components of a call
- How to introduce yourselves, do assessment, setting agenda, planning action, intervention, referral and finally closing a call

Individuals with mental health issues or their caregivers may call helpline services for various reasons, including seeking help for a particular mental health issue or obtaining other general information about a service, resources etc. It is thus important for the counsellor as a first-line service provider, to structure the call in such a manner that in the limited amount of time during the call, important information may be communicated mutually, and counselling may be imparted effectively.

Components of a Call:

Components of a call include:

1. Introduction and Intake
2. Assessment
3. Transition to agenda-setting
4. Action planning or intervention
5. Referral to next tier
6. Closing

Introduction and Intake:

Introduction: When an individual reaches out to a helpline it often happens that they do not know what to expect from the call. Thus, introduction will enable to understand what is likely to happen during the call. This helps to set an agenda and expectations during this telephonic conversation, thus developing a buy-in i.e., actively accepting and willing to participate in the intervention discussed. An introduction enables one to form a therapeutic relationship with the caller, which is essential to provide effective intervention in a short span of time. The introduction includes:

- Identify self by name and designation
- Thank the caller for reaching out to the helpline
- Inform the likely duration of the call
- Provide an overview of the issues that are likely to be discussed - which is called "signposting"
- Inform the caller about any confidentiality statements as required by the helpline guidelines or law (sample statements examples: This call is/will being/be recorded for evaluation purposes, by accepting to proceed indicates your consent to seek help/treatment)
- Enquiring the reason for the caller to reach out to the helpline

Intake: Involves understanding the issues of the caller. Intake helps the counsellor to plan further assessments. It allows one to get an impression of the caller, just like an in-person visit.

A primary intake would include:

- Collecting basic socio-demographic details: Name of the caller, age, (if it is a caregiver in addition to the details of the distressed individual, collect sociodemographic details and relationship of the caregiver to the distressed person
- Past treatment details, if any
- Support available
- The reason for which caller has called the helpline

Assessment:

Assessment involves understanding the issue for which the call has been made and to make appropriate clarifications for a better understanding of the issue. Assessments allow us to determine the seriousness of the issue and the nature of intervention that is required. This information will allow the counsellor to set the agenda, formulate a plan of action and inform the same to the caller. It provides context and helps in effective communication with the caller. These questions consist of:

- Caller's response which would be required to fill the helpline database
- Questions to identify signs and symptoms of the issue to make a provisional impression of the mental health issue faced by the caller

Transition to agenda-setting:

- The agenda setting focuses on the intervention to be provided to the caller. It is based on the combination of the information received from the caller, the counsellors' understanding of the nature of the issue, the guidelines and protocols of the helpline provided to the counsellor.

Action planning or intervention

Here, the counsellor educates the caller about the issue faced by them, and the intervention required. It is a collaborative plan with the caller as the expertise of the counsellor which may range from directive advice by the counsellor to referral to MHPs in Tier 2 and Tier 3. The action steps should follow the SMART model i.e., the action plan should be Specific, Meaningful, Attainable, Relevant, and Timely.

Referral to next tier:

In case the counsellor feels that the caller requires more complex or hospital-based interventions, the call can be transferred to the higher tier team i.e., Tier 2 and 3 comprising qualified mental health professionals and experts. Some of the situations can be:

- Severe mental disorder in the patient
- Medication related (psychiatric drugs) effects or adverse events
- Aggression and Suicide risk related issues
- Substance withdrawal

Closing:

Once the counsellor has set the agenda and informed the action plan to the caller, it brings to an end the conversation which is termed as 'closing'

Closing involves

- Counsellor summarising the steps of the intervention
- Informing the caller that they may reach out for support again as and when required
- When a follow-up is required, the counsellor should inform the when and who will likely reach out to the caller again.

References/Further reading:

1. Rosenfield M Counselling by Telephone. In: Feltham C, Hanley T, Winter Annie Luara, editors. The SAGE Handbook of Counselling and Psychotherapy [Internet]. 4th Ed. New Delhi: SAGE; 2017 [cited 2022 Aug 23]. p. 629–34. https://uk.sagepub.com/sites/default/files/counselling_by_telephone.pdf
2. Ormond KE, Haun J, Cook L, Duquette D, Ludowese C, Matthews AL. Recommendations for Telephone Counseling. Journal of Genetic Counseling. 2000 Feb: 9(1):63–71.
3. Dickson JM, Moberly NJ, O'Dea C, Field M. Goal Fluency, Pessimism and Disengagement in Depression. PLOS ONE. 2016 Nov 30; 11(11):e0166259.

MODULE 3

Basics Counselling / Communication Skills

Objective of this module

- What is counselling and what is not?
- Features of good counsellors
- Basics of communication
- Crux of Effective Communication during Counselling

Counselling is a process to solve problems - a professional tool to empower clients to take appropriate decisions for themselves.

Counselling is focused, specific and goal-targeted, interactive, and collaborative, based on the needs of the client.

Counselling 'is' and 'not':

Counselling 'is'	Counselling is 'Not'
A process that helps to solve problems	Buddy talk
A professional tool	Giving advice
A process that leads to better decisions	A random conversation
Focus specific and goal directed	An interrogation
Interactive and collaborative	A confession
Based on the focus of client	Praying

Positive features of counsellor:

1. Good interpersonal skills
2. Sensitive cultural awareness
3. Ability to inspire trust and optimism
4. Willingness to form an alliance
5. Non-judgmental
6. Being objective
7. Confidence and attention to progress
8. Flexibility to adapt the therapy
9. Provide space for intense emotion to be expressed
10. Trust and safety (confidentiality)
11. Provides motivation for change
12. Provide support

Negative features of counsellors: A good counsellor should avoid these pitfalls!

1. Pressuring or yelling at the client
2. Providing one's viewpoint
3. Judging the client or their way of life
4. Imposing one's personal views
5. Avoiding or downplaying the client's current issue
6. Being emotionally over-involved in the client's circumstance
7. Using the terms 'should' and 'must'
8. Avoiding intense feelings
9. Interrupting
10. Assuming accountability for the client's issues and choices

Basics of Interpersonal Communication:

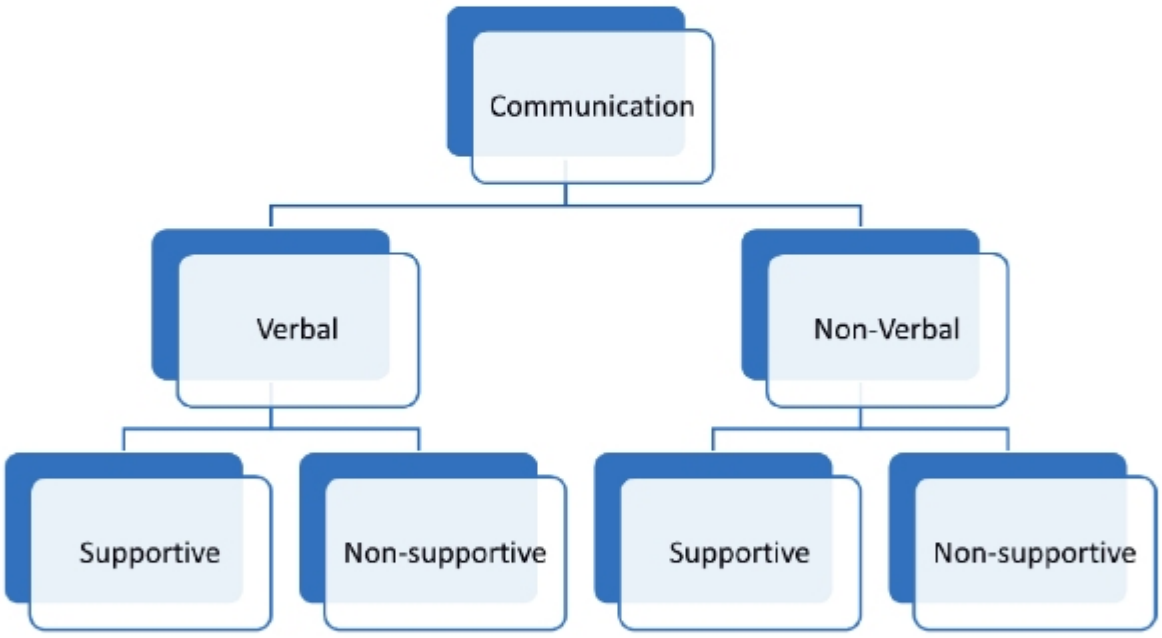
We can define communication as a dynamic process to convey a thought/feeling. The way our communication is received and acknowledged depends on many contextual factors which the receiver is exposed to. 'How to say' and 'what to say' play an important role in communication.

Verbal supportive communication includes: Asking effective questions, paraphrasing (summarising and repeating the client's wording in your own words, so that they feel understood), reflecting feelings (understanding the emotions of the client and stating it back to them)

Verbal non-supportive communication includes: Criticising or blaming, scolding or threatening, trying to state your own values, rejecting whatever the client says, making your own interpretation about the client's statements, prematurely asking questions in a manner which is embarrassing or humiliating to the client, arguing with the client, labelling the client, indirectly encouraging client's dependence on the therapist.

Non-verbal supportive communication includes: Active listening (paying careful attention to verbal and nonverbal cues of the client), maintaining an appropriate distance for suitable conversations, initiating and keeping adequate eye contact, showing interest through an attentive body posture.

Non-verbal non-supportive communication includes: Frequently looking away from the client, maintaining too close/far distance from the client, appearing bored or irritated, yawning, constantly glancing at the watch.



Ways of communication:

- Friendly/Affiliative vs Business-like/dominance
- Client-centered vs Disease–centered.
- Directive vs sharing consulting style

Directive	Sharing
"This is a serious problem; you have come (are calling so) late"	"Why do you think this has happened? What made you consult at this point in time?"
"You are suffering from…."	"It's been sometime that you have this problem! Have you thought what could be the reason?"
"It is essential to take tablets"	"What have you tried to do to help yourself? Would you like a prescription? I recommend meds will help in your case!"
"Come and see me after…"	"When would you like to come and see me again"

Barriers to effective communication:

Communicator	Receiver
Not being willing to state things differently	Personal values
Not being willing to relate differently with others	Faulty prior knowledge about subject
Unwillingness to learn new approaches	Prejudice/misconception over the subject
Lack of self confidence	Unwillingness to understand /accept other's perspective.
Lack of enthusiasm	
Lack of self-awareness.	

Essentials of communication:

Do's	Don'ts
Always plan your future comments in advance.	Never presume that everyone will understand you.
Use understandable language that is straightforward to grasp.	Don't look around while you're listening since it might distract the speaker.
Become more knowledgeable about all the issues you must speak about	Don't cut the speaker off.
Speak loudly and clearly.	Do not assume that you have fully grasped everything.
Verify with the listener twice that you have been understood correctly.	Do not lash out in anger right away and speak something.

In the event of an interruption, always give a brief summary of what was spoken previously.	Avoid using terminology and technical phrases (jargons) that the majority of people may not understand.
Always listen with your complete concentration on the speaker.	Avoid speaking too quickly or slowly
Always take notes during a conversation on key topics.	Avoid speaking in noisy areas since you won't be heard.
Always seek an explanation if you don't understand someone else's perspective.	
To ensure you have understood correctly, have the speaker repeat what they just stated.	

Take Home Message:

- Counselling is a professional tool and is different from Advice or Guidance.
- It is a collaborative process, and the process is to reach a 'near-best' solution.
- The onus of solving the problem-in-hand lies on the client and the counsellor is just a facilitator.
- Communication during counselling is not as similar to a casual conversation and hence, needs insights into what and how you say!

References:

1. MNS care training manual for CHO | National Health Systems Resource Centre [Internet]. [cited 2022 Aug 23]. https://nhsrcindia.org/mns-care-training-manual-cho
2. MNS care training manual for MPW at HWC (Hindi) | National Health Systems Resource Centre [Internet]. [cited 2022 Aug 23]. https://nhsrcindia.org/mns-care-training-manual-mpw-hwc-Hindi
3. Kumar D & Kishore M. (2016). "Living life positively: A facilitators' manual for conducting sensitisation programme in the domains of Life-skills education, stress management and suicide prevention" In collaboration with Director General of Health Services, National Institute of Health and Family Welfare and the country office of the World Health Organisation. 2016.
4. The MANAS Manual for Health Counsellors [Internet]. Mental Health Innovation Network. 2014 [cited 2022 Aug 22]. https://www.mhinnovation.net/resources/manas-manual-health-counsellors
5. Sagar R, Muralidharan K, Aggarwal S, Sahay S, Thomas B, Tabassum H, et al. Guidance Document for the Psychosocial Support for Healthcare Workers during Covid-19pandemic. 2021.

MODULE 4

Roles and Responsibilities of a Counsellor and Counsellor's Well-being

Objective of this module

- To know the roles and responsibilities of the counsellor
- To know regarding counsellor's well being
- To understand burn out

As a counsellor for the Tele MANAS, one may face difficult situations, and challenging or at times disrespectful callers. The counsellor must anticipate such scenarios and be prepared for any troubling situation during their shift.

Roles and responsibilities of a tele-counsellor:

1. To have the knowledge and ability to function within the ethical, legal and professional guidelines while working as a Tier 1 counsellor in Tele MANAS.
2. To be able to adequately respond to a wide variety of mental health concerns that callers may present to Tele MANAS.
3. To be updated with the use of the technology required in the functioning of Tele MANAS.
4. To maintain confidentiality and protect the rights of the individual calling.
5. To be able to discern the cases that need immediate attention and referral to trained mental health professionals available nearby.
6. To be able to facilitate timely check-ups and maintain a record for cases that need periodic follow-ups.
7. To be able to document individual digital case notes appropriately during a call.
8. To maintain the highest level of professionalism possible by avoiding personal comments and basing your interaction on the resources provided during training.
9. To be mindful of maintaining professional boundaries at all times during a conversation with the distressed individual. Thus, the counsellor should not reveal any personal information.
10. To maintain a polite and calm disposition while dealing with difficult scenarios over a call (e.g., prolonged silence/crying while not speaking/ angry callers).
11. To be able to flag inappropriate/prank calls urgently and escalate the matter to the state Tele MANAS Cell (TMC) supervisor/ administrator for further action.

Counsellor well-being and practicing self-care:

It can sometimes be difficult to be the first person handling distressed individuals/caregivers who are in a crisis and expecting a quick resolution for their complaints. Tele-counselling can be even more challenging, given the physical barriers between the distressed individual and the counsellor.

What is Burn-Out?

Burn-out is a term used to describe a manifestation of long-term chronic stress. It presents like a syndrome with a multitude of symptoms such as:

- Emotional fatigue
- Poor view of one's professional competence
- Exhaustion
- Depersonalisation

It is important to recognise signs of burnout as it may affect the quality of service provided, the performance of the tele-counsellor and the health of the counsellor. One must know that help is readily available and that, in case you experience such symptoms, you should inform your supervisors regarding the same.

It is crucial to practice self-care to maintain and enhance the psychological well-being of the counsellor and thus effectively work as a tele-counsellor. Some practical techniques that may help include:

- Structuring your work day in order to allow for screen breaks.
- Taking care of the positioning of devices and furniture as a tele-counsellor in a shift requires prolonged hours of sitting in front of a computer screen.
- Informing your supervisor regarding any difficulties you may face as a tele-counsellor.
- To speak to the Tier 1 mental health professional available at the state TMC, you will be working regarding any psychological issues you may face, including burnout, disturbances in mood, and fatigue.

References:

BACP (2021) Online and phone therapy (OPT) training curriculum. Lutterworth: British Association for Counselling and Psychotherapy (BACP). pp 1-64. https://www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/online-and-phone-therapy/

MODULE 5

Manasvita : The Crisis Interventional Schema for Tele Manas Counsellors

Objectives of this module

- To understand the basic principles of intervention provided by Tele MANAS counsellors.
- To learn the basic skills for applying the above interventions.

The National Tele Mental Health Program (Tele MANAS) goal is to address the lacunae in accessing mental healthcare, making mental health accessible at the click of a button. The Tele-MANAS counsellors (TMC counsellors) will be the first point of contact for these digitalised services. Counselors must prepare for a large number of calls from distressed individuals with a variety of mental health issues. In previously successful tele-mental health initiatives, studies have shown that the initial few minutes of interaction with a distressed caller are crucial in deciding the outcome of the call.

It is therfore important to understand the framework of the intervention that tele-counsellors need to provide as part of Tele MANAS initiative. The outcome of the intervention provided to individuals in distress through Tele MANAS services will depend on various factors such as the nature of the distressing situation, the counsellor's understanding and knowledge of the subject, ethical and legal aspects and the caller's own biases about the service being provided. However, learning the following basic skills may help the counsellor deal with these problems more efficiently and quickly.

The TMC counsellor intervention package is based on components derived from multiple brief psychosocial interventions.

Basic Principles:

1) Maintaining a collaborative approach: The caller and TMC counsellor have to work together in a professional relationship with the aim of solving the concerns and problems.

a) **Professional boundaries**: Relationship between the caller and TMC counsellors should maintain professional boundaries with clarity in the purpose and nature of the interaction. E.g., if the caller reports mental stress in the workplace during a call, the aim of the TMC counsellor would be to ensure that the track of discussion remains focused on concerns in the workplace. Both of them should work on the same objective to reduce workplace stress so that, as an outcome, the caller can handle the stress in the workplace.

b) **Mutual Respect**: TMC counsellors should ensure the dignity and respect of the caller regardless of differences in age, gender, and sociocultural background. Also, show respect for the caller's experiences. E.g. The caller reports having repeated sexual thoughts or feeling fearful in a public space. TMC needs to listen and acknowledge the experience as it is reported by the caller.

c) **Honesty**: TMC counsellors need to be open and prepared to interact with callers by being aware of one's own bodies and minds. TMC counsellors have to express empathy and professional willingness to help the caller without false promises.

d) **Impartiality**: TMC counsellors need to interact without any bias and judgments about the good or bad qualities of the caller. TMC counsellors have to be open, accepting, and appreciate callers for being themselves during the call.

e) **Being empathetic**: TMC counsellors should try to relate, imagine and perceive the concerns of the callers. Expressing empathy can be done by paraphrasing and rephrasing the caller's statements. E.g., if the caller reports of failure in an exam, TMC counsellors can say, "I know it's not easy to face the situation", or "I see that you are going through a difficult time now".

f) Being mindful of the caller's cultural background.

2. Supportive principles:

a) **Listening**: TMC counsellors need to allow callers to talk freely and TMC counsellors should listen attentively without any interruptions. Facilitate callers to share their concerns openly and freely by paying attention to their talks.

b) **Acknowledging**: TMC has to accept the caller's concerns by allowing them to share and respond by expressing empathetic statements. Responding to the caller's concerns with honest and empathetic reactions will make the caller trust TMC. It also helps callers to feel relieved from distressing thoughts and emotions.

c) **Providing information**: TMC needs to guide the caller to access or avail of services with the right information. Providing the right information plays a crucial role to deal with the problems of callers. Information can be about common mental health problems, or disorders, ot the process of availing of mental healthcare services.

3. Behavioural principles:

a) Empowering to solve problems: TMC needs to teach callers to solve problems by themselves and make them learn new skills to deal with various stressful and problems of daily living situations.

b) Readjusting to lifestyles: By adapting to new activities and following them regularly. Regulating emotions by control on anger, sadness, and anxiety.

4) Interactive principles:

a) Improve relationship: understanding problems within relationships (family, friends, and others) and working on solving the relationship problems.

b) Enhance Communication styles: develop better communication styles to maintain healthy relationships.

Problem situations	Callers to whom this may apply
A. **Providing basic information about mental health issue for which the individual has called** Includes resolving myths and misconceptions with facts and knowledge about mental health issues, sharing available information related to mental healthcare services, and social security schemes and benefits.	Applicable to all callers
A. **Healthy ways of handling stress** Includes all principles of interventions . **Lifestyle Changes:** Maintaining a routine of healthy ways of living including yoga & exercise, healthy diet, minimum use of screens, and involvement in social activities . **Educating about mental health problems**: Providing information about the cause and effect of events on mind and body. . **Enable to solve problems**: Helping clients to identify problems, locate the root cause, develop alternative solutions and implement them efficiently. . **Empowering in regulating emotions**: Understanding own emotional reactions	Callers reporting sadness, grief, anxiety, and stress of everyday life
C. Mental Health First Aid . Look - Listen and Link . Listen without judgment . Assessing risk of harm to self (suicide risk) or risk of harm to others . Reassurance & information . Referral to the Tier 1 MHP	A caller who is in severe distress and needs immediate attention
D. Dealing with suicidal behaviour . Listen to the caller with patience and stay calm . Express concern towards the problems of the caller . Reassure and encourage them to express . Paraphrase and summarise the concerns . Refer to the Tier 1 MHP	Callers who have expressed self-harm ideas
E. Sleep hygiene: Basic components of sleep hygiene has been described in the **Module 8: Stress Management Module**	Caller with sleep disturbance
F. Deep Breathing Exercises	A caller who is in

Teach callers to do deep breathing exercises to calm and relax. **Steps:** • Inform about benefits • Take consent before starting • If agreed: Start deep breathing • If disagree: Repeat the benefits and inform services are available at any time • Clarify doubts related to deep breathing • Ask to sit comfortably • Ask to keep right or left palm on stomach or chest • Ask them to focus on inhaling over 3 seconds and exhaling over the next 3 seconds • Tell them to take deep breath and sense the feel of air filling in chest or stomach (e.g., Imagine a balloon they are blowing into) • Ask them to do the same exercise for 5 - 10 times • If the caller is very distressed, encourage them to practice this with you over the call • Take feedback about the exercise • In case the caller is too anxious to be able to follow these step-by-step instructions, reassure them that it is only natural to be unable to do this when one is very anxious to tell them to attempt only exhaling first over 3 seconds before asking them to attempt again once they are feeling a bit better • Ask them to practice everyday **Note:** Deep breathing exercise is not advised for callers who suffer from severe respiratory problems and sadness (cardiac or asthma problems)	severe distress and needs immediate attention

MODULE 6

Introduction to Mental Health and Mental Health Disorders

Objective of this module

- To understand the concepts of mental health
- To understand the bio-psycho-social cause of mental illness
- To know about common misconceptions and myths around mental illnesses

There are many ways in which mental illnesses are classified. It can be based on the presentation of the illness, the symptoms, duration (how long the symptoms are present), the intensity of the symptoms and the dysfunction caused to the person suffering from the illness. The way men and women are affected by mental disorders is different. As a counsellor, one should be able to identify different types of mental health issues in individuals, so that effective interventions can be provided, whenever necessary.

Mental Health and its importance

World Health Organization (WHO) defines Health is "**a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity**". Without mental health there can be no physical health and for individuals to stay healthy, it is a norm that physical and mental wellness go hand in hand.

If an individual can realise their own potential, cope with the daily stressors, work fruitfully and productively and contribute to the community, it is indication of mental well-being of the individual.

Factors effecting mental health are:

- **Resilience**: The ability to effectively deal with stressors of life without getting overwhelmed is very important for one's mental health. Factors helping in developing resilience include life skills like problem solving, distress tolerance and critical thinking.
- **Self-esteem**: The confidence in one's own ability is very important to fulfil the goals and become confident about their value to others. Positive self-esteem helps to develop better mental health.
- **Emotional well-being**: The ability to deal with emotions effectively and not let it affect negatively is crucial.
- **Spiritual well-being**: Possessing a sense of purpose & feeling connected to others is referred to as spiritual well-being.
- **Social connectedness**: Ability to accept other's beliefs and having wider societal perspective leads to positive mental health.

Bio-psycho-social model:

Many people often ask the health providers the reasons for developing mental disorders. Contrary to popular belief, it is very important for them to understand that mental illness is not the result of being possessed by devil, astrological influence, weakness of character, laziness, curses or black magic.

The beginning and progression of mental illnesses are due to wide range of causes and factors. Most mental illnesses are associated with combination of factors such as biological factors (genetic factors, temperament, disability, chronic illness, chemical imbalance in the rain), psychological factors (low self-esteem, coping skills, social skills) adverse childhood events (neglect, violence, abuse, death of a parent) and social factors (migration, family relationships, poverty).

Each of these elements has an impact on a person's mental health, and they frequently work in concert to develop mental diseases. However, not everyone with mental health problems will, develop mental disorders. Some people are more vulnerable due to the above-mentioned factors and when they are exposed to stressful life events, they tend to develop mental illness.

Stressful situations can cause an imbalance in brain chemicals, and when people are also dealing with other risk factors like unemployment, low income, physical illnesses, a difficult childhood, and unhealthy behaviours like excessive alcohol and nicotine use, it can result in mental health issues and mental illnesses/disorders.

Risk Factors for the development of mental health illnesses & factoes protecting against it :

The factors can broadly be dicussed as shown:

At individual level

- Negative attitude towards life stressors
- Poor self esteem
- Excessive use of substances (habit forming)

At family level:

- Interpersonal relationship issues
- Family history of mental illness
- Adverse upbringing in the childhood

At community level:

- Inadequate access to healthcare
- Stigma and discrimination
- Poor socio-economic support

Protective factors include:

At individual level:

- Adequate physical activity
- Positive lifestyle such as yoga, meditation
- Excessive use of substances (habit forming)

At family level:

- Strong family support
- Cohesiveness in the family
- Good family values

At community level:

- Inclusiveness in the community activities
- Independent livelihood
- Adequate financial support

Common myths about mental illnesses:

One of the most important roles of counsellor is to provide appropriate knowledge and to address the misconceptions associated with mental health problems and mental disorders. Some of the common myths and the facts are as follows:

Myths	Facts
Mental illnesses are due to demons and black magic	Mental illnesses are caused by the combination of various factors which include biological, psychological and social factors.
There is no treatment for mental illnesses.	Mental illness can be treated, and it can include both medicine as well as counselling.
Mental illnesses can be cured by marriage.	Mental illnesses cannot be cured by marriage. In fact, interpersonal issues in the marriage are a stressor.
Patients with mental illness can be treated only in hospital.	Most of the patients are treated in the community on the outpatient basis.
Persons with mental illness can never become normal and work normally.	They can become better with proper treatment and can lead a normal and productive life.
Unlike physical illness; mental illness is all in the person's head.	Since both physical and mental illnesses are physiologically grounded, they are similar..
People develop mental illness because they are weak and cannot cope with stress.	Mental illness is largely unrelated to a persons character.. Anyone can develop mental disorder.
Mental patients remain as patients throughout their life and cannot live in the society	With adequate supervision and treatment, an individual with mental illness can lead a normal life in the society.
Mental disorders are not seen in children	All age group individuals are affected by mental illness including children.
Mental illnesses are contagious (Spread to others who interact or come in contact with the effected person).	NO Mental illnesses is not contagious.
Only Cowards commit suicide	Attempting suicide is a sign of severe stress/depression and cowardice.
All psychiatric patients are dangerous and extremely violent	Only few patients with severe psychiatric illness can show violence at times. However, a significant proportion of patients are not aggressive or violent.

References / Further reading:

1. National Institutes of Health (US); Biological Sciences Curriculum Study. NIH Curriculum Supplement Series [Internet]. Bethesda (MD): National Institutes of Health (US); 2007. Information about Mental Illness and the Brain. https://www.ncbi.nlm.nih.gov/books/NBK20369/

2. National Collaborating Centre for Mental Health (UK). Common Mental Health Disorders: Identification and Pathways to Care. Leicester (UK): British Psychological Society (UK); 2011. (NICE Clinical Guidelines, No. 123.) 2, COMMON MENTAL HEALTH DISORDERS. https://www.ncbi.nlm.nih.gov/books/NBK92254/

3. Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. International journal of epidemiology, 43(2), 476–493. https://doi.org/10.1093/ije/dyu038

MODULE 7

Overview of Mental Health Disorders

Objective of this module

- Knowledge about the symptoms of mental illness
- Overview of types of mental disorder
- Overview of common and severe mental disorders

Introduction:

To begin with, symptoms are what the patient or family members complaint that the person is suffering from, while signs are those which are observed and elicited. It's crucial to understand that not all people with mental problems will exhibit elicitable symptoms. Most of the symptoms they exhibit are thought to be typical and may not be cause for concern. Most of the time symptoms are not visible outside. Additionally it is important to note just presence of one symptoms does not indicate that the person has mental illness.

Some of the classical signs that a person is experiencing a mental disorder are listed below. If you observe any of these, you should be able to help the person to talk through the problems they could be having. Through early intervention, you would be able to help and possibly prevent mental illness from becoming more severe.

1. **Symptoms of disturbance in emotions**: Symptoms of emotional disturbance , such as prolonged sadness, elevated or lowered self-esteem, anxiety and worry, mood swings, excessive fear, loss of drive, and lack of motivation.

2. **Physical symptoms or bodily symptoms:** Involve changes in how the body physically functions, such as aches and pains, racing heartbeat, excessive sweating, fatigue, weakness, disturbed sleep, increased or decreased appetite, and loss of body weight.

3. **Symptoms related to thought**: Symptoms that are related to how a person thinks, such as difficulties focusing, remembering, understanding, and judgment (decision-making). Suicide thoughts or a persistent erroneous feeling that someone else is going to harm you.

4. **Symptoms related to behaviour:** Behaviors are what we actually observe other people doing, such as being hostile, talking more or talking less, withdrawing from friends and family, self-harming, such as cutting skin, or attempting suicide or becoming violent towards others.

5. **Symptoms related to perception**: These include the symptoms that a person is experiencing (hearing, smelling or seeing things) that aren't really there- although they seem very real to the person experiencing them. For instance, the person might be hearing voices, seeing images, objects or individuals, or experiencing unreal feelings. Imaginary beings and voices telling the person what to do.

All these symptoms (symptom domain 1-5) of mental illnesses are also common in our daily life experiences and as a reaction to the different life situations (e.g., pounding heart when we are about to face an exam or an interview), except the symptoms related to the perception. This is one of the many important reasons why mental illnesses often goes unnoticed or ignored.

It's critical to understand that there are several symptoms and warning indicators of mental health illnesses, and that everyone may exhibit a different set of symptoms. If the person is in need of counselling, you should be able to engage them in a fruitful conversation and discuss any concerns they may be having. These exchanges can provide insight into whether the person is likely to be dealing with any mental health condition which requires treatment such as medication or psychotherapy or both.

Signs and symptoms of mental illness:

Hallucinations: Experiencing things that are not real.

Hearing voices not heard by others	Seeing things which are not seen by others	Muttering to self
Smiling and talking to oneself	Gesturing as though speaking to someone even when no one is there	

Delusions: False, unshakable belief or beliefs that are not based on the individual's culture or the reality.

Firm belief that they are going to be harmed / targeted / conspired against without understandable reason	Fearfulness that persists despite reasonable reassurance being given	Beliefs that are not explainable by person's socio-cultural background and circumstances

Disturbances in normal emotions and behaviours:

Feeling sad	Feeling anxious	Feeling angry
Feeling frustrated	Feeling excessively happy	

Disturbances in thinking:

Not being able to speak in a coherent/understandable manner	Inability to take the right decisions	Poor concentration

Disturbance in Behaviour

Odd/bizarre behaviour Talking and Smiling to self Becoming violent towards others	Inability to take care of self and daily activities Such as not bathing or changing clothes for several days

Mental Disorders may be broadly divided into sub -groups, these include:

1. **Severe Mental Disorders:** Individuals with Severe Mental Disorders (SMD) present with severe symptoms as described above, the symptoms are casue significant dysfunction. If untreated (i.e SMDs require medication), it leads to disability. Around 1% of the population suffere from SMDs. They are frequently accompanied with odd or outlandish beliefs and externally observable behavioural problems – scientifically termed as psychosis. In common terms, psychosis is also described as 'losing touch with the reality'. These disorders are especially difficult for the common man to understand. For example: hearing voices of God or a deceased family member; or expressing strange or unusual beliefs that people are conspiring against the person to kill him or her.

2. **Common Mental Disorders:** Common mental disorders (CMD) are named that way as they are more prevalent in the community and we all occasionally encounter some of the symptoms of these diseases, such as emotions of grief, sadness, worry, or concern. CMDs often cause symptoms in the physical, emotional, cognitive, and behavioural domains. People may seek medical attention for these symptoms, such as poor eating, weakness or sleep difficulties, but they may ignore the underlying causes of these issues, such as underlying depressive disorders or anxiety disorders.

3. **Mental Health Disorders in Children and adolescents:** These include illnesses which predominantly affect children and adolescents with early age of onset like Autism, Attention Deficit Hyperactivity Disorder, Intellectual Disability.

4. **Neurological disorders**: These conditions affect the brain more prominently along with set of behavioural symptoms such as delirium (difficulties in recognising time, place, or person; impaired attention – for example in high-grade fever), dementia (*described in details in the module 12*), and epilepsy (fits).

5. **Substance Use Disorder/ substance addiction**: A person may consume habit-forming substances in excessive quantity and/or frequency causing significant problems in personal, social or other areas of life due to addiction to the substances. *(described in details in the module 10).*

6. **Suicidal risk**: Thoughts of killing oneself or such attempts are possible in various mental health conditions, including depression, psychosis and also in distressed life-situations when associated with hopelessness.

In the further modules of the manual various mental health issues are discussed and the intervention required for them, here we shall briefly discuss the presentation of depression, anxiety disorder and psychotic disorders

Depressive illness:

Depressive illness comes under CMDs. It is characterised by the following clinical features when present for at least 2 weeks for the diagnosis.

Depressed Mood- Sadness through the day, lack of enjoyment, poor interest in daily activities	Depressed cognition - Hopelessness, Helplessness, and Worthlessness
Psychomotor activity - slowed thinking and activity, decreased energy	Physical symptoms - heaviness of head, pains and aches in the body, frequent and easy tiredness
Biological symptoms - sleep disturbances, loss of appetite, weight loss, loss of sexual pleasure and interest	Suicide - risk of suicide, suicidal ideas, expressing wishes to die

Anxiety Disorders:

Anxiety is an indispensable human emotion and is defined as 'fear' without any external threat/danger. The symptoms of anxiety are largely physical in nature (along with psychological symptoms including worries) and include palpitations, headaches, feeling startled easily, trembling, sweating, difficulty swallowing, body aches etc. If the combination of these symptoms occurs in an intensity that cause distress and dysfunction in an individual, then an 'anxiety disorder will result. An important caveat is that one needs to be aware that anxiety symptoms can be a manifestation of physical disorders as well.

Panic disorder:

- Recurrent attacks of severe anxiety
- It can occur in any situation.
- During a panic attack, an individual may experience a sense of impending doom, tension, rapid heartbeat, sweating, dizziness breathlessness and uncontrollable fear etc.
- These attacks last for few minutes
- An important feature is that the person is worried about having another such attack.

Obsessive Compulsive Disorder (OCD):

Two most distinct features of OCD are obsessions (repetitive thoughts) and compulsions (repetitive acts), when present they usually appear together or either of them can be present more prominently (e.g., obsession predominant OCD).

Obsessions - Obsessions are certain intrusive thoughts, doubts, images or urges that occur in one's mind which are unwanted and repetitive. Most of the people are able to recognise these obsessions as senseless or excessive but they are either unable to ignore them or experiences extreme anxiety while trying to suppress them. These thoughts cause significant distress and interference in daily life activities.

Compulsions - Compulsions are the repetitive urges or ritualistic mental/motor acts that the person is driven to carry out despite knowing that they are pointless, unwarranted or excessive. Compulsions are usually performed in response to obsessions, and usually to avoid the anxiety associated with the obsessive thought.

Example: An individual has repeated thoughts that his hands are dirty everytime he touches his officer table, he feels the need to wash his hands, if tries to stop himself he becomes worried and anxious and has to wash his hands with lots of soap and water, he does that at least 30-40 times in a day– here the thought that his are dirty is the 'obsession', where as washing hands repeatedly is the 'compulsion'

Episodic and Chronic Psychiatric Disorders:

These disorders refer to those with more than one episode i.e., clear onset and offset of the illness; and symptoms of the illness usually subside completely in between two episodes. It includes Bipolar Affective Disorder (BPAD) where there may be episodes of mania or depression, or recurrent depressive disorder. Chronic psychiatric disorders on the other hand runs a more indolent course and usually results in higher morbidity.

Psychotic Disorders

First/Acute Episode Psychotic Disorders:

It includes First/Acute episode of schizophrenia, first/ acute episode mania, acute severe depression. The rpesent with delusions, disturnaces in perception i.e hallucinations – most common being auditory hallucinations i.e hearing voices/sounds in the absence of an actual source.

Mania- It is characterised by the following symptoms:

Elevated and expansive mood	Markedly increased activity, restlessness, & excitement
More talkative than before, speaking with a lot of force, increased speed of speaking, difficult to stop once they start	Increased goal directed activity

Chronic Psychotic Disorders (Symptoms persist for more than 6 months): Includes mainly schizophrenia and related illnesses.

Diagnostic criteria of psychosis - Acute (up to 6 months)/Chronic (> 6 months)/Episodic (more than one episode):

1. Hallucinations.
2. Restlessness or agitated behaviour.
3. Bizarreness in behaviour.
4. Delusions (fixed and firm beliefs which are false, e.g., the patient is receiving messages from television, being followed, or plan to kill/harm or is from a royal family etc.)

References/Further reading:

1. Gautham, M S., Gururaj, G., Varghese, M., Benegal, V., Rao, G N., Kokane, A., Chavan, B. S., Dalal, P. K., Ram, D., Pathak, K., Lenin Singh, R. K., Singh, L. K., Sharma, P., Saha, P. K., Ramasubramanian, C., Mehta, R. Y., Shibukumar, T. M., & NMHS Collaborators Group* (2020). The National Mental Health Survey of India (2016): Prevalence, socio-demographic correlates and treatment gap of mental morbidity. The International Journal of Social Psychiatry, 66(4), 361–372. https://doi.org/10.1177/0020764020907941

2. Manjunatha, N., Jayasankar, P., Suhas, S., Rao, G. N., Gopalkrishna, G., Varghese, M., Benegal, V., & NMHS National Collaborators Group (2022). Prevalence and its correlates of anxiety disorders from India's National Mental Health Survey 2016. Indian Journal of Psychiatry,64(2), 138–142. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_964_21.

3. Icd-10, the Icd-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research. Geneva: World Health Organisation, 1993.

MODULE 8

Stress Management : Dealing with Common Mental Health Concerns

Objective of this module

To know what stress is

- Symptoms of prolonged stress
- Coping with stress
- To know about sleep disorders
- Sleep hygiene

What is stress?

Stress is:

- Physical and mental responses of the human body during a challenging/different/new situation
- It is a normal and natural reaction
- It is essential for adopting to new challenges (Eustress). It helps us to be positive, alert, motivated and avoid dangers
- Stress becomes problematic (distress) when it is experienced continuously without relief, or it is experienced out of proportion as compared to the magnitude of the problem. (1)

Physical symptoms of prolonged stress

- Pains and aches in the body
- Pounding/ racing heart with or without chest pain (palpitation)
- Extreme tiredness
- Difficulties in falling asleep
- Dizziness, and giddiness
- Raised blood pressure
- Stiffness of body and increased muscle tension
- Digestive difficulties and frequent stomach upset
- Difficulties in sexual activities

Psychological symptoms of prolonged stress

- Anxiety
- Irritability
- Low mood
- Panic attacks
- Sadness

Behavioural problems with person with chronic stress

- Smoking
- Drinking too much alcohol (excessive quantity or frequency)
- Using other drugs
- Gambling
- Poor performance at work
- Frequent altercation with family and friends

In order to prevent effects of stress and to mitigate the effects of stress, it is important to help an individual who is unable to cope stress.

Management of stress and counselling

1) Assessment :
- Assess if the person is stressed and is the presentation of stress
- Identification of the stressor(s)
- Coping methods adopted by the distressed person

2) Stress management strategy
3) Self- Evaluation

Assessment: Assess the reason for the current presentation, most often the distressed person presents only with the effects of stress and often unable to identify the reason for stress.

- Techniques: Active listening is important while providing stress counselling. It allows the individual to open up and trust the counsellor.
- Questioning: Questioning and clarifying if there are any stressors in their life allows the counsellor to set the targets for further intervention and also allows the person to focus on the stressors and not just the manifestations of the stress.

Stress management strategies

- Once a counsellor has identified the reason for stress, discuss the strategies that could help to decrease the reactions to stress and help in coping with stress.

1) Educating the caller:

- First step in mitigating the effects of stress is to educate the caller/individual regarding the stress, its effects - the physical, and psychological symptoms, and the behavioural disturbances one may be experiencing.
- Help identify the stressor, if multiple issues are present help them focus on one issue at a time

2) Relaxation exercises:

- There are several deep breathing exercises, some require expertise and taught in-person. However, certain types can be taught over tele-counselling and are helpful to tackle physical symptoms such as muscle tension, palpitations, erratic breathing(fast and shallow breathing), fatigue
- Technique:

  - Sit in a comfortable place, preferably a quiet place
  - Close your eyes, on the count of 5, breathe-in
  - Gradually breathe out on count of 5
  - Repeat the process for 15 minutes
  - Practise 2-3 times a day
- Breathing exercises/relaxation exercises inhibit body's response to stressful situation thereby preventing the individual from debilitating physical and in turn negative psychological responses to stress.

1) Problem-solving approach: Helps to address the stress, allowing the existing situation to improve and enables to take steps to reduce due to a situation.

- Identifying the stressor or stressors
- Identifying stressor that can be solved or can be handled. This allows the person to feel empowered by addressing one issue at a time
- Setting goals: What can be achieved and what cannot be achieved at least for time being
- Delegating: Identifying support systems and delegating tasks when possible such as identifying family members, in work place identifying co-worker who can help out thereby allowing to set achievable targets and thus mitigating stress
- Setting boundaries: In addition to delegating setting boundaries – i.e., identifying ones abilities and limitations is also important in managing stress, thereby, allowing to achieve goals that have been set
- Time management: Effectively and productively using time available, taking help of schedules. Effective time management prevents physical symptoms that may arise due to sleep disturbances, erratic eating habits, proneness to substance thereby effectively managing stress.
- Discussing and describing the problem: Looking for solution to a difficult situation and thus executing the action directed towards decreasing the problem leading to stress.

2) Emotion focussed approach
When in stress, an individual is often filled with negative emotions which further impair the person to cope with stress. In emotion focussed approach of managing stress, attempts to decrease the negative emotional responses to stress are taught/learnt.

Techniques for emotion focussed approach:

- Distraction techniques: engaging in activities that allow to relax, such engaging in hobbies, gardening
- Talking about emotions/ feeling experienced this allows feel less burdened. In some individuals psychotherapy may be required (such as in PTSD, face with loss – financial or death of loved one).
- Engaging in spirituality
- Relaxation techniques as discussed above are also helpful

3) Self- evaluation
Self-evaluation denotes the process in which persons learn from situations/experiences in a way that enhance their coping skills.

When an individual in stress does requires intervention by a mental health expert/professional?

The strategies discussed above may not be helpful always and as a counsellor one may encounter situations which require psychotropic medications and psychotherapy. The following are the situations

- When individuals are not reporting improvement after 3-4 sessions of counselling. The distress, dysfunction and severity of symptoms continue
- Individuals having psychological symptoms which are severe enough to qualify for a psychiatric disorder such as depression, anxiety disorder, somatisation disorder etc.
- When a person is faced with trauma such as being victim of sexual abuse or physical abuse. Faced with severe trauma such as victim/s of war or disaster which may manifest as Post Traumatic Stress Disorders.
- When there is recent suicidal attempt or person is voicing active suicidal ideas
- Stress leading to substance use disorder. Example: a person facing stress resorting to daily alcohol leading to alcohol addiction requiring medical treatment

Sleep disturbances

- Sleep disturbance can be experienced by everyone from time to time. They can be in the form of difficulty in going into sleep, frequent awakening, unsatisfactory sleep.
- There are various types of sleep disorders and they include : Insomnia, sleep apnoea.

Effects of poor sleep:

- Day time tiredness
- Difficulty in attention and concentration
- Decline in learning abilities
- Depression
- Irritability
- Risk of RTA and occupational accidents
- Obesity
- Diabetes

Causes of sleep disorders:

Sleep problems can be caused by different factors. The main factors are:

- Physical issues (ulcers, chronic pain)
- Medical (asthma, obesity)
- Mental Illnesses such as Depressive disorder and anxiety disorders
- Environmental factors (alcohol and other substances)
- Work related: such as requirement for frequent night shifts or prolonged work hours
- Genetics (narcolepsy)
- Medications
- Age related: elderly are likely to suffer from sleep disorders

What is insomnia?

Insomnia refers to difficulty falling or staying asleep. One or more of the following symptoms are manifested in individuals suffering from insomnia:

- Difficulties in the initiation of sleep
- Waking up during the night or difficulties in falling asleep again
- Waking up two hours or more earlier than usual in the morning
- Not feeling well rested even after adequate hours of sleep
- Having at least one daytime problem such as fatigue, sleepiness, problems with mood, concentration, accidents at work or while driving, due to poor sleep.

- Insomnia can be short-lived (acute or adjustment insomnia) or longer-lasting (chronic insomnia). Additionally, it may come and go, with intervals when a person experiences no sleep issues. Acute or adjustment insomnia can last from one night to a few weeks. When a person experiences insomnia at least three nights per week for a month or more, their insomnia is considered chronic.

- Acute or short-term insomnia may be brought on by life events (such as a job loss or change, a loved one's death), an illness, or environmental factors like light, noise, or extremely high or low temperatures.

- Long-term or chronic insomnia (defined as insomnia that lasts for three months or more and happens at least three nights a week) can be brought on by conditions including depression, ongoing stress, and nighttime pain or discomfort.

- A conditioned emotional reaction is a frequent contributor to persistent sleeplessness. Insomnia symptoms are often prolonged by thoughts about the sleep issue (such as "What if I don't fall asleep tonight?") and behaviours that emerge in response to the issue (such as sleeping in and taking naps, daydreaming in bed).

Sleep hygiene

- ***Have a fixed wake-up and slepping time:***
  Try to get up at the same time every day, whether it's the week or the weekend, as a variable schedule prevents you from establishing a pattern of regular sleep.
- ***Prioritise sleep:***
  While it may be tempting to put off sleep in favour of work, study, socialising, or exercise, it's important to prioritise sleep. Make every effort to get ready for bed at or around your goal bedtime, which you may calculate based on your regular wake-up time.
- ***Make gradual adjustments:***
  In order to avoid throwing your schedule out of sync, try not to change your sleep routine all at once. Instead, gradually change your schedule by no more than an hour or two at a time to give yourself time to acclimate.
- ***Don't overdo it with naps:***
  The daytime use of naps might be helpful for regaining energy, but they can interfere with night-time sleep. Try to confine your afternoon naps to the early hours of the day to avoid this.
- ***Keep your routine consistent:***
  The same routine every night, such as putting on pyjamas and brushing your teeth, might help you remember that it's time for bed.
- ***Budget 30 minutes for winding down:***
  Utilize anything that helps you relax, such as relaxing music, gentle stretching, reading, or relaxation techniques.
- ***Dim your lights:***
  Avoid bright lights as much as possible since they might prevent the body from producing melatonin, a hormone that promotes sleep.
- ***Unplug from electronics:***
  Include a device-free buffer period before bedtime of 30 to 60 minutes. Cell phones, tablets, and laptops emit blue light that may reduce melatonin synthesis and stimulate the mind in ways that are difficult to switch off.
- ***Test methods of relaxation:***
  It's frequently simpler to concentrate on relaxing rather than trying to fall asleep. You can get ready for bed using relaxation techniques including timed breathing, meditation, and mindfulness.
- ***Don't toss and turn:***
  Healthy mental connections between lying in bed and sleeping well are beneficial. For this reason, if after 20 minutes you still can't sleep, get up and do something relaxing in dim light like stretch, read, or something else. Then attempt to go asleep again.
- ***Get daylight exposure:***
  One of the primary regulators of circadian rhythms that can promote sound sleep is light, particularly sunshine.
- ***Be physically active:***
  Regular exercise has a variety of positive effects on the body, including the ability to sleep better at night.
- ***Don't smoke:***
  Smoking is associated with a variety of sleeping issues because nicotine stimulates the body in ways that interfere with sleep.
- ***Avoid alcohol consumption for sleep:***
  Alcohol may help people fall asleep more easily, but as the influence wears off, sleep disruptions later in the night occur. So it's recommended to limit alcohol intake and avoid drinking alcohol.
- ***Cut down on caffeine in the afternoon and evening:***
  Caffeine is a stimulant, so avoiding it later in the day might help you stay awake even when you want to sleep. Be cautious if you frequently drink coffee to try to make up for sleep deprivation.
- ***Don't dine late:***
  When it's time for bed, eating dinner late, especially if it's a large, filling, or spicy meal, may result in you still digesting. Any meals or snacks eaten before night should generally be on the lighter side.
- ***Restrict in-bed activity:***
  It's recommended to just use your bed for sleeping, with sex being the one exception, in order to create a mental association between sleeping and being in bed. (6)

Figure: Components of Sleep hygiene



Is sleep hygiene the same for everyone?

Almost everyone benefit from improving their surroundings and sleeping habits, according to the basic tenet of good sleep hygiene, although each individual will have different preferences for what good sleep hygiene looks like. Because of this, it's worthwhile experimenting with different changes to see which ones improve your sleep the most. Better sleep hygiene can be achieved with incremental changes rather than major ones.

It is also critical to understand that enhancing sleep hygiene won't always help with sleeping issues. Better sleep hygiene may help those with severe insomnia or sleep disorders like obstructive sleep apnea, but other therapies are typically required as well.

References:

1. Quick, J. C., & Quick, J. D. Stress and Stress Management. Wiley Encyclopaedia of Management (2015). 1–6.
2. Schneiderman N, Ironson G, Siegel SD. Stress and health: psychological, behavioural, and biological determinants. Annual Rev Clin Psychol. 2005; 1:607-28.
3. Najavits, Lisa M. Seeking Safety: a Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press, 2002
4. Doing What Matters in Times of Stress: An illustrated Guide by WHO 2020
5. An Illustrated Guide Institute of Medicine (US) Committee on Sleep Medicine and Research; Colten HR, Altevogt BM, editors. Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem. Washington (DC): National Academies Press (US); 2006. 3, Extent and Health Consequences of Chronic Sleep Loss and Sleep Disorders.
6. Edward J. Stepanski and James K. Wyatt. Use of sleep hygiene in the treatment of insomnia. Sleep Medicine Reviews, Vol. 7, No. 3, pp 215±225, 2003
7. Bhat S, Pinto-Zipp G, Upadhyay H, Polos PG. "To sleep, perchance to tweet": in-bed electronic social media use and its associations with insomnia, daytime sleepiness, mood, and sleep duration in adults. Sleep Health. 2018; 4(2):166-173.
8. NIMHANS. (2020, April 17). GUIDELINES FOR TELE-PSYCHOTHERAPY SERVICES. www.nimhans.ac.in. https://nimhans.ac.in/wp-content/uploads/2020/04/Guidelines-for-Telepsychotherapy-Services-17.4.2020.pdf

MODULE 9

Handling Mental Health Conditions Due to Death and Grief

Objective of this module

- Understanding death and various definitions
- Models of bereavement
- Symptoms of grief
- Dealing with grief

Understanding death:

It is difficult to accept the death of a loved one. We should be able to understand that death is irreversible, inevitable, and final. Knowing the cause of death also plays a major role in helping one cope with death.

Age, life experience, cognitive development and many other variables influence our ability to understand these concepts

Definitions:

1. Bereavement: It is the objective condition when someone or something significant is lost.
2. Grief: It is the reaction to bereavement. It is the psychological component of bereavement. The situation when a loved one or loved thing is lost, evokes the feelings of grief. It is the suffering following the significant loss
3. Mourning: Is the action and manner of expressing grief, which often reflect the practices of one's culture. It is influenced by the culture and by society.

Psychological models of bereavement:

Five stages of grief by Kubler Ross are as follows



Symptoms or expression of grief:

Physical symptoms	Cognitive symptoms	Behavioural changes
• Multiple body aches, lack of energy • Changes in eating, sleeping habits • Odd and frightening dreams • Throat tightness, skin rashes, breathing difficulties	• Inability to concentrate • Preoccupied about deceased, looking at their photos, carrying their objects • Adopting deceased roles and mannerisms.	• Anger and acting out • Denial, sadness, depression • Fear, anxiety, panic • Guilt, shame, self-blame • Regressive behavior • Acceptance

Complicated grief

When grief becomes so intense that a person engages in unhealthy behavior or refuses to move past their grief, they are said to be in a state of pathological grief.

Complicated grief reactions

- Suicidal thoughts and self-harm behaviour
- Prolonged sleep disturbances
- Persistent personality changes
- Excessive or inappropriate guilt
- Pervasive fantasies, phobias, fatigue that impair normal functioning
- Hypervigilance
- Drug / alcohol use

If the following persist for 6 weeks to 4 months, they deserve careful scrutiny and referral:

- Personal hygiene deteriorates
- Making simple decisions become difficult
- Fear, anger, and guilt
- Hyperactivity or inability to control excessive talking
- Memory problems and confusion in a sustained manner
- Hallucinations (seeing objects or hearing voices that are not actually present)
- Self-esteem is disturbed, pre-occupation with worthlessness, and self-condemnation
- Impaired social function
- Alcohol or drug abuse either initiated or increased
- Physical symptoms such as failure to eat, weight loss, extreme sleep problems

Commonly, death is the ultimate trauma for people, but some people experience similar emotional upset while facing significant life challenges e.g. divorce, serious illness etc.

Role of the healthcare professional:

- It is important to offer individualised care and support to the bereaved person. Healthcare professionals should tailor the interventions in a way that is appropriate to the person.
- The way a person grieves is determined by culture and gender.
- It is important to be sensitive, to consider all the factors that play a role during the grieving process.
- Assess when to deal with grief.

Dealing with Grief:

The grieving process facilitates dealing with loss, Grief should be a healthy adaptation to the tasks of mourning within a acceptable time frame.

Each person's grief is like: all other people's grief;
some other person's grief;
like no other person's grief.

When should we offer support for grief?

When the reaction to loss and dealing with grief is abnormal and complicated grief reactions. (Lasting longer than 6 months, associated symptoms of mental illnesses)

Steps	
1. Assessment: **A) Assess for any physical problems after the loss.** i. Ask about physical problems such as body pains, lack of energy, breathing difficulties, sleep disturbance ii. Ask about frequency of physical problem, and ask about severity **B) Assess to know what the patient is struggling with** i. Ask about emotional disturbance such as anger issues, fear, anxiety, and sadness ii. Ask about disbelief related to loss iii. Ask about behavioural problems: avoidance, arguing, fighting and violence IV.Ask about disturbance in everyday activities: Unable to focus on tasks, poor performance, continuous thoughts of loss interfering in everyday activities. ***Example*** How many times are you experiencing headache in a day? How long does it last for? On scale of 1 to 10, how severe is your pain, given 1 lowest and 10 is highest? Do you feel you pain is unbearable and need immediate consultation of doctor?	Open and Close Ended Questions
2. Dealing with emotional disturbances A) Frequency of negative emotions: sadness, anger, anxiety and fear. i. Ask about duration and times of negative emotions. ii. Let the person talk openly and freely about the emotions iii. Discuss about regulating emotions ***Example*** Caller: I feel very sad and sometimes fearfulness. TMC: Ok, can you tell me when do you feel sad? Caller: Whenever I'm alone or see my parents' pictures. TMC: Hmm… I see that you are having difficult times now. (Flowchart on Grief) B) If the duration and severity of emotional disturbance are creating dysfunction refer to T1	Open ended questions Listening, Empathy, Paraphrasing Acknowledging, Regulate emotions
<u>Dealing with behavioural problems related to Grief</u> A) Problems of poor performance, arguing, not involved in social activities and work. **Example** Caller: I am unable to do my work in the office. I frequently get thoughts and memories of my daughter. TMC: Hmm… it's been tough time for you, can you tell me what happens when you cannot work in office? Caller: I will walk out of office, but my boss screams at me. TMC: Ok. I see that you struggle to do work and feel your office is not supportive. Caller: Yes TMC: Can we think of any other ways where you are not troubled in your office? Caller: Yes (Intervention package on problem-solving and rescheduling daily activities).	Open ended questions Listening, Empathy, Paraphrasing Acknowledging, rescheduling daily routine and empowering to solve problems.

B) If the involved in violence, harm to self and others and more than two weeks, refer to T1

Do's	Don'ts
• Be sensitive to social and cultural factors • Give them sufficient time to talk openly and freely about their feelings • Let them share the memories of the deceased - voluntary and spontaneous • Help them to decide regarding buying or giving up electronic devices (mobile, laptop) • Stay calm and relax while listening to the caller's grief related to emotions • Use silence and pauses during the call to process the information provided by the caller. • Ensure clear communication if you are referring. Provide accurate information about the place, person and contact details.	• Avoid using the words "it's ok", "do not cry", "Not to worry", or "there are others for you" • Overgeneralise their loss in the initial phase • Avoid giving examples from your personal life which will reduce your dignity as a therapist and hinders therapeutic alliance • Do not lessen or overemphasise the memories, thoughts or emotions shared by responding with an increased tone. • Avoid distraction and interruptions during the caller's emotional breakout

References:

1. Kaplan, H. I., & Sadock, B. J. (1989). *Comprehensive textbook of psychiatry, Vols. 1-2*. Williams & Wilkins Co.
2. Tasman, A., Kay, J., Lieberman, J. A., First, M. B., & Riba, M. (Eds.). (2015). *Psychiatry, 2 volume set*. John Wiley & Sons.
3. Worden, J. W. (2018). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. Springer Publishing Company.

MODULE 10

Handling Couple and Family Conflicts

Objective of this module

- Definition of family conflict
- Types and forms of family conflict
- Goals of family counselling
- Stages of family counselling
- Techniques of family counselling

Introduction:

Family conflict - A conflict, in the context of family, is defined as an active opposition between family members.
Such conflicts can arise between any two or more family members, including

- Conflict between a couple (marital conflict)
- Conflict between parents and child
- Conflict between siblings
- Conflict between a person with mental illness (PWMI) and other family members

These conflicts could take various forms, i.e., verbal, physical, psychological, financial or sexual.

Couple (Marital) Conflict

Conflict between spouses, often known as couple or marital conflict, is a type of family conflict.

Internal (cognitive, affective) and external (behavioural) elements both contribute to the emergence and persistence of conflict in marital partnerships. Anger, for example, plays a significant role in interpersonal conflict because it drives spouses to increase hostile behaviour toward one another.

Common causes of conflict between couples:

- Goal-setting by one person prevents others from achieving their goals.
- Believing that your partner has the power or desire to sabotage your preferences and ambitions
- Incompatible goals between both partners

Family Counselling:

A type of intervention called family counselling is made to deal with particular problems that influence the well-being and operation of a family. It can be used to support a family during a trying time, a significant transition, or to address mental or behavioural health issues among family members.

Techniques from cognitive therapy, behaviour therapy, and interpersonal therapy are used in family counselling, among other types of psychotherapy.

Goals of family counselling:

The goals of family counselling are as follows:

(i) to understand the family dynamics
(ii) to restructure maladaptive interactional styles and improve the communication among family members
(iii) to strengthening the family's problem-solving behaviour and help them solve existing problems
(iv) to make the home environment more functional
to identify and utilise the inherent strengths of the family

Stages of family counselling (including marital therapy):



Figure 1 - Stages of family counselling

(1) Intake/screening:

This is the initial stage of family counselling. In this stage, the counsellor tries collecting basic information about the different family members, identifying problems and helping family members to decide the goals of the therapy.

This stage is also crucial for building a rapport with the family as well as each of the family members.

It includes:

- Collection of initial information, i.e., socio-demographic details, referral details, number of participants, relationship among participants etc.
- Identification of family problems
- Understanding the expectations of the family members
- Forming an informal therapeutic contract with the family members (e.g., who will attend the therapy, duration of therapy, time and place, method of payment etc.)
- Deciding goals of therapy
- Observing the interaction among the family members

(2) Family assessment:

This is one of the most important steps of this counselling. The aim is to understand the various structures and dynamics in the family. It includes:

- Understanding the composition of the family and creating a genogram
- Understanding the boundaries and rules in the family (whether they are clear and open; rigid and closed; or diffuse)
- Understanding the pattern of interaction among various family members (for e.g., positive affinity, triangulation, coalition etc.)
    - *Positive affinity:* A healthy relationship between two or more family members
    - *Triangulation:* A pattern of interaction in which two family members reject another family member.
    - *Coalition:* It is a dysfunctional alliance between at least two family members against another member
- Understanding the leadership pattern and decision-making process in the family (whether it is autocratic, authoritarian, democratic or chaotic)
- Understanding the role structure of various family members
- Understanding the communication pattern among various family members
- Understanding the cohesion or connectedness among the family members
- Assessing the adaptive patterns in the family (methods of conflict resolution, problem solving ability, and coping strategies)
- Assessing the availability of social support to the family and its utilisation

(3) Intervention:

A family counsellor uses multiple therapeutic interventions to help family to achieve their goals. These includes,

- Building a therapeutic alliance with the family
- Using problem solving techniques
- Communication training
- Negotiating for solutions

- Planning joint family activities
- Developing effective behaviour management skills
- Fostering healthy parenting and parental leadership skills
- Helping families develop conflict resolution techniques

(4) Termination:

This is the last stage of the counselling. However, it is crucial for consolidating and maintaining the gains achieved from the therapy.

The following points should be kept in mind in the termination phase

- It should be planned well ahead
- Gradual tapering off of sessions should be done
- Follow up sessions may be taken to help families to handle new issues

Techniques used in family counselling:

- Building a rapport with each of the family member and the family
- Allowing family members to interact with each other during the sessions
- Arguments between participants may also be allowed
- The counsellor should remain neutral and avoid taking sides
- The emotional changes in each session should be noted
- Individual sessions should not be encouraged, unless absolutely necessary

Reframing techniques should be used to reduce family conflict and eliciting motivation for change

Conclusion:

Family conflicts are common and they may take various forms. Family counselling is an evidenced based technique to help families learn how to develop effective communication styles, work together to solve problems and maintain healthy relationships within the family.

Conflicts among couples exists both in cognitive and behavioural realms and counsellors working with troubled couples need to design their management approaches in a way to address both types of factors.

References:

1. Ahluwalia H, Anand T, Suman LN. Marital and family therapy. Indian J Psychiatry. 2018 Feb;60 (Suppl 4):S501-S505. doi: 10.4103/psychiatry.IndianJPsychiatry_19_18. PMID: 29540921; PMCID: PMC5844162.
2. Epstein N, Baucom DH, Rankin LA. Treatment of marital conflict: A cognitive-behavioural approach. Clinical psychology review. 1993 Jan 1;13(1):45-57.
3. Marta, E., Alfieri, S. Family Conflicts. In: Michalos, A.C., editor. Encyclopedia of Quality of Life and Well-Being Research. 1st ed.Dordrecht: Springer; 2014. pp 2164–2167. https://doi.org/10.1007/978-94-007-0753-5_997
4. Tuerk EH, McCart MR, Henggeler SW. Collaboration in family therapy. J Clin Psychol. 2012 Feb;68(2):168-78. doi: 10.1002/jclp.21833. PMID: 23616297; PMCID: PMC4490859.
5. Varghese M, Kirpekar V, Loganathan S. Family Interventions: Basic Principles and Techniques. Indian J Psychiatry. 2020 Jan;62(Suppl 2):S192-S200. doi: 10.4103/psychiatry.IndianJPsychiatry_770_19. Epub 2020 Jan 17. PMID: 32055062; PMCID: PMC7001353.
6. Zarnaghash M, Zarnaghash M, Shahni R. The influence of family therapy on marital conflicts. Procedia-Social and Behavioural Sciences. 2013 Jul 9;84:1838-44.

MODULE 11

Handling Problems Associated with Addiction

Objective of this module

- **To understand what are habit forming substances**
- **To identify problems due to habit forming substances**
- **To screen a person for substance use disorder**
- **Approach to substance use disorders**
- **To understand the myths & facts, and Do's & Don'ts**

Habit Forming Substances and Its Abuse:

Habit forming substances are substances which can be a drug or medication which on using for longer periods can cause the person to become addicted, here the person continues to use it despite negative consequences to his health, his functioning (studies, job) and family relationships.

Habit forming substances can be broadly divided into legal and illegal. Legal are the substances which are allowed by the law to be produced, consumed and kept in one's possession (although the government usually imposes some rules and restrictions in these activities). On the other hand, it is prohibited by the law to produce, consume or possess illegal substances.

Substances can be obtained legally in India: Tobacco and tobacco products, Alcohol (Banned in certain states), Prescription drugs such as sedatives (sleeping pills), oral painkillers, cough syrups, solvents such as Glue/ Petrol/Thinner.

Illegal substances in India: Cannabis, Opium and its products (both natural and synthetic), Cocaine, amphetamine derivatives, LSD are some of them.

When an individual experiences stress, substance use can increase. Many people use substances such as Alcohol, Tobacco, sleeping pills etc. to deal with the stress, believing that substances relieve stress.

Substance abuse is a harmful pattern of use of substances, characterised by regular use despite troubles and difficulties in social, occupational, psychological or physical problems due the substance use

Classification:

Psychoactive substances can be classified into 3 groups based on their pharmacological property:

a) **Sedatives:** These substances cause sedation. E.g., alcohol, opioids, cannabis etc.
b) **Stimulants:** These substances cause stimulation, i.e., they arouse the Central Nervous System. E.g., nicotine (cigarettes and chewable tobacco), cocaine, caffeine etc.
c) **Hallucinogens:** These substances cause hallucinations. E.g., Psilocybin, Lysergic acid diethylamide (LSD) etc.

S.NO.	Substance/ Drug	Mode of use	Street names and forms that are available
1.	Alcohol	Drinking	
2.	Tobacco	Smoking, chewing	Smoking can be in the form of beedis, cigarettes, chutta (tobacco leaves rolled and smoked in certain parts of India) Chewable can be gutka/ khaini
3.	Solvents	Sniffing	Thinner, glue, petroleum products
4.	Cannabis	Smoking, drinking	Ganja/weed: Smokable form Hashish/ Hash : Comes as resin (sticky substance from the plant) Charas Bhang: Leaves are crushed and mixed with water and taken
5.	Cocaine	Sniffing / Snorting injection, oral	Coke
6.	Opioids	Oral, Injection	Heroin: Brown sugar, smack, dope Afeem
7.	MDMA	Oral	Ecstasy
8.	LSD (Lysergic acid diethylamine)	Common is oral It is also used in injection. Inhalation	Acid
9.	Psilobin	Oral	Magic mushrooms
10.	Sedative drugs	Oral/injection	Sleeping Pills - Alprazolam(Alprax), Diazepam (Valium)

Risk Factors for Substance Use Disorder:

Genetics and environment, both play a role in the development of substance use disorder. The common environmental factors for substance use disorder can be classified into 4 categories, i.e., family factors, school factors, community factors and peer factors.

1. Family factors - Physical or Sexual abuse (ongoing or past), substance use in other family members, disruptive conflicts in family, poor communication and supervision, parental approval of substance use, parental rejection etc.
2. School factors - Poor involvement in school related activities, lack of appropriate school environment, discriminatory rules, failure or difficulty in academics and co-curricular activities etc.
3. Community factors - poor social relations, disorganised neighborhoods, crime, prevalent substance use in the community, unemployment, poverty, community norms that accept substance use
4. Peer factors - peer pressure for substance use, bonding with peers engaged in substance use or other anti-social behaviour

Understanding The Pathology:

There are certain criteria that need to be fulfilled to state that a person is dependent or addicted to the habit-forming substance.

- **Loss of control:** taking larger quantities of substances or for longer duration than initially planned to take, i.e the person decides to take a certain amount but once he starts he is unable to stop.
- **Salience:** giving excessive importance and priority to substance use over other activities like work, social relationships, health, other interests or enjoyments etc.
- **Use despite harm:** Continuing use of a substance despite having overtly harmful consequences
- ***A person is considered dependent on a substance if she/he meets any 2 of the above three criteria:***

Other symptoms, which usually manifest along with the above symptoms are-

- **Craving:** strong desire to take the substance
- **Tolerance:** Need to take more amount of the substance in order to experience pleasure (Commonly described as 'high' or 'kick')
- **Withdrawal symptoms**: When not taking the substance developing physical symptoms (example: in alcohol they can develop tremors, sweating, worry, sleep disturbances) or psychological symptoms (feeling restless) and serious withdrawal symptoms such as seizures (commonly known as fits) and confusion (not able to identify time, place, person, memory problems) which require to be referred to hospital immediately.

Questions to ask to assess problematic substance use:

1. When did they start? -- Ask about age at first use, what and how much
2. When did it become daily use?
3. How much and how often do they take it? -- Get the exact quantity and frequency ** as this would determine what medication doctor has to give them
4. What are the substances they take? -- Most often many people take more than one substance. Example: Alcohol and Tobacco dependence is very common
5. What are the problems they face when they don't take the substance?
6. Check for craving, withdrawal symptoms
7. Whether they have got into legal trouble anytime recently? -- Ask for any case pending against them
8. Did they face any recent medical problems or psychological symptoms? -- Jaundice, head injury etc. Psychological symptoms such as depression. anxiety, suicidal thoughts or psychotic symptoms

ALCOHOL:

- ✓ Alcohol is one of the commonly used and licit psychoactive substance
- ✓ The immediate and long term effects of alcohol consumption on a person's health depends on 2 factors - (1) the amount of alcohol consumed and (2) drinking pattern.
- ✓ There are various patterns of alcohol consumption. These include:

- **Social drinking:** drinking occasionally, when it is socially appropriate. This pattern of drinking does not usually cause any adverse consequences
- **Harmful drinking:** This pattern of drinking leads to adverse physical, mental and/or social consequences.
- **Alcohol dependence:** In this pattern of alcohol consumption, there are physiological, psychological and behavioural changes that results in the person giving excessive importance and priority to alcohol consumption as compared other important activities in his life.

Alcohol consumption in harmful or dependent pattern leads to physical, mental and social problems

- **Physical problems due to excessive alcohol consumption:** Damage to liver, gastro-intestinal problems, damage to peripheral nerves, increased risk of accidents and injuries
- **Mental health issues due to excessive alcohol consumption:** Remaining preoccupied with alcohol use, memory disturbances, impaired attention and concentration, sleep disturbance, mood disorders, anxiety disorders, irrational thoughts, emotions or beliefs (e.g., false beliefs that one's partner is unfaithful), increased risk of self-harm.
- **Social problems due to excessive alcohol consumption:** Interpersonal relationship issues with family members, domestic violence, neglectful parenting, marital conflicts, inability to perform social responsibilities adequately, inability to concentrate in work, work absenteeism, loss of job

Withdrawal symptoms:

- Seen in a person who is dependent/addicted, when the amount of alcohol consumption is less than the usual amount or is completely stopped.
- These symptoms are usually seen after 6-8 after the last intake of alcohol.
- Some patients with severe dependence start consuming alcohol in the morning itself this is also referred to as 'eye opener' drink, this is to avoid withdrawal symptoms
- Common withdrawal symptoms that are seen in alcohol dependence are inability to sleep, feeling restless, getting angry for trivial reasons, tremors- shaking of hands and body, sweating, tachycardia- increased heart beat, increased blood pressure.
- In severe cases, people in alcohol withdrawal may experience hallucinations (hearing voices or seeing things without any actual stimulus), disorientation (the person becomes confused and unaware of his surroundings) and seizures (fits)

Severe withdrawal symptoms could be potentially life-threatening. All cases of complicated withdrawal should be immediately referred to a doctor (preferably a secondary or tertiary care hospital.)

Tobacco

Tobacco is another commonly used substance, which is legal to use across the globe. Unfortunately, the number of deaths due to tobacco consumption is way more than other psychoactive substances. Tobacco is available in many different forms. These can be classified as either smoking (e.g., beedis, cigarettes, chillum, hookah, etc.) or chewable (gutka, khaini, snuff, mishri, betel quids) products.

Tobacco consumption in either of the forms is associated with number of harmful physical consequences. These include,

- Cancer of various sites like lungs, esophagus, stomach, mouth, head & neck etc.
- Respiratory problems like infections, asthma, emphysema etc.
- Diabetes mellitus
- Hypertension
- Heart disease
- Stroke

OTHER PSYCHOACTIVE SUBSTANCES

- Apart from alcohol and tobacco, there are many other psychoactive substances which are abused.
- These include opioids (natural opium, synthetic opioids and opioid analgesics), cannabis, LSD, cocaine, inhalants, benzodiazepines etc.
- Most of these substances are illicit.
- The effects of each of these substances are different and depends on the chemical compound of those substance.
- Following are some of the serious effects of consuming illicit substances,

- ✓ Hallucinations
- ✓ Anxiety symptoms
- ✓ Psychosis and Paranoia
- ✓ Altered blood pressure and heart rate
- ✓ Delirium
- ✓ Impaired coordination
- ✓ Anxiety
- ✓ Irrational thoughts, feelings and judgement
- ✓ Aggressive and violent behaviour

Routes of Administration

- There are various methods to administer psychoactive substances. For example, intravenous injection, swallowing, chewing, smoking, inhalation, patches etc.
- The route of administration might cause various health problems. For example, due to use of injectable substances many diseases like HIV, Hepatitis etc. are transmitted by sharing the contaminated needles. Similarly, patients may acquire local or generalised infection from using contaminated needles.

Management of Substance Use Disorders:

Step 1 : Establish rapport with patient

- If the person refuses to talk or take help, do not force
- Request politely to answer few questions
- Check for any immediate medical issues - if present refer to nearest hospital , if no medical issues; Encourage to come back

Step 2 : Patient agrees to take help - Assesment for addiction

- Are you drinking alcohol heavily or regularly
- Do you have difficulty getting sleep without alcohol
- Does your hands/body parts tremble whenever you abruptly reduce or stop using alcohol
- IF YES FOR ANY OF THE ABOVE 2 QUESTIONS THEN IT IS LIKELY TO BE ALCOHOL ADDICTION
- Check for any diffculties currently - if withdrawal(shaking of hands, sleep disturbances, wanting to take alcohol present) - then refer to nearest health facility if patient is in the community

Step 3 : Intervention

- Encourage abstinence, if not then focus on harm reduction-minimise use
- Encourage to seek help from friends and family
- Engage in other activities to distract from substance use
- Discuss how to handle craving:
  - Delay the use of substance
  - Distract: engage in activities and home, indoor games
  - Discuss with friends and family about substance use
  - When craving occurs - drink water or eat some food - a full tummy helps in curbing craving

Pharmacological Management

If an individual has features such as seizures (fits), episodes of unconsciousness, confusion, memory problems, fever, headache, vomiting of blood, using injectable drugs - they must be advised to reach out to nearest hospital soon.

The above symptoms are indicative that the person has serious medical problems which may even lead to death if left untreated

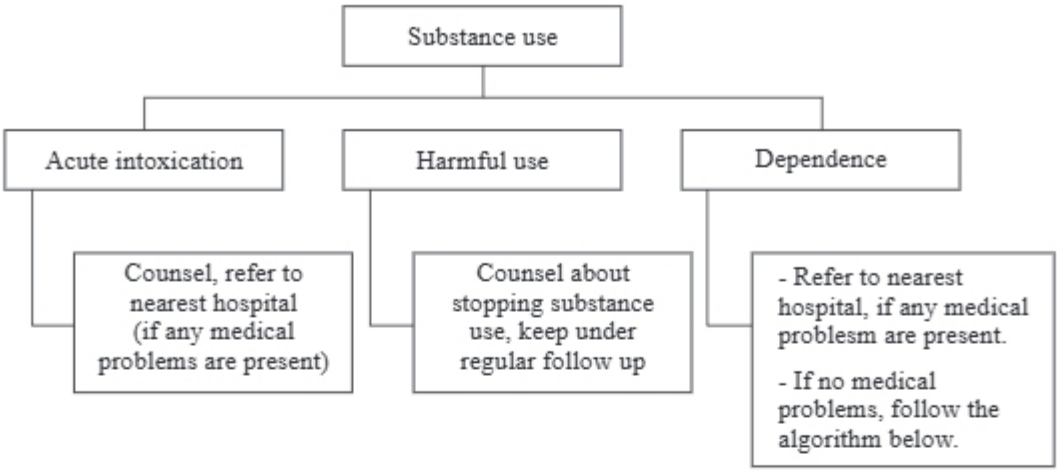
Counselling and psychosocial management:

- ✓ Explain to the person about the health, social, and psychological harms of the substance use. This information may be used to motivate them quit substance use.
- ✓ Try to identify the situations in which the person uses substance. For example, a person might to be using drugs to relax, to get better sleep, to enjoy with his peers etc. Once these specific situations are identified, help the patient to devise ways to overcome these situations.
- ✓ Help the person to realise the various problems and harms he/she is experiencing because of the substance use
- ✓ Try to find out other sources of relaxation and enjoyment for the person, based on his/her interests.
- ✓ Teach adaptive coping styles to deal with problems
- ✓ Explain methods to reduce craving. For example, they can eat something or distract themselves with some enjoyable activities when they experience craving. Explain to them that 'craving comes like the waves of a sea' and it will pass after sometime.
- ✓ Suggest the individual to avoid friends who might pressurise him/her to use substance.
- ✓ Advice the individual to be assertive, in case his peers insist that he/she must use substance.
- ✓ Information, education and counselling programmed should be organised to increase public awareness about harmful effects of substance use. Local leaders and social media can be used to spread awareness about the same.
- ✓ Affiliation with self-help groups should be encouraged.
- ✓ Self-help approach/improving motivation to discontinue substance use:

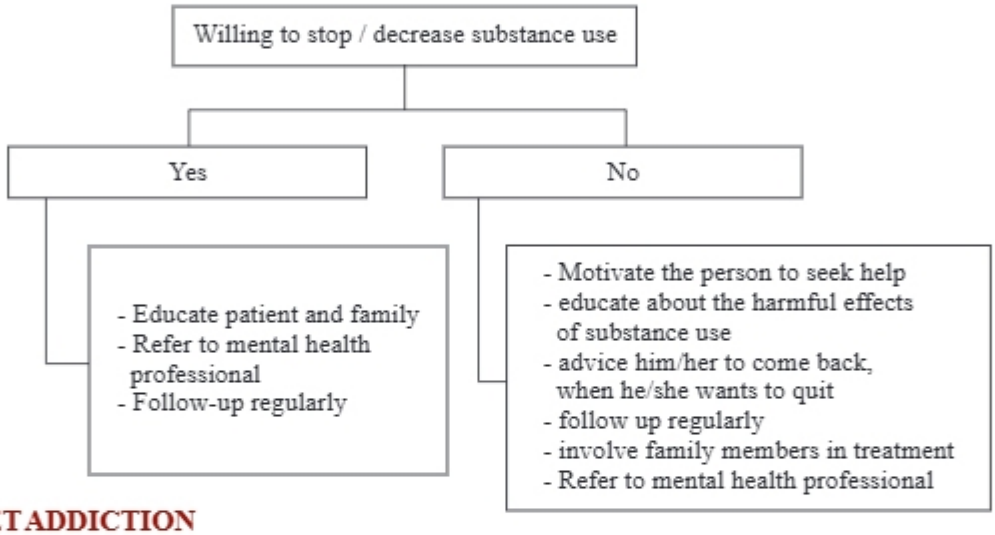
  (a) Try to identify stressors and help clients deal with them effectively
  (b) Identify any other psychological symptoms like depression, anxiety or insomnia, which should be addressed simultaneously
  (c) Give clear advice to quit or reduce the amount of substance use
  (d) Decide a quit date and anticipate possible hurdles
  (e) Help them identify trigger situations and prepare strategies to avoid them
  (f) Discuss about problem solving techniques and healthy coping styles to deal with everyday problems
  (g) Discuss about other enjoyable activities that they like to do and try to include them in the individual's daily routine
  (h) Empathise with the individual and be respectful
  (I) Enhance the self-efficacy of the individual by encouraging him/her to be hopeful and modify in substance use behaviour.

Medical Management:

- ✓ There are many medications which might be prescribed to patients in order to reduce the craving for alcohol, tobacco or other psychoactive substances. These medications are prescribed by registered medical practitioners.
- ✓ Medications to manage withdrawal symptoms may be required in the initial phase (e.g., benzodiazepines like diazepam and lorazepam are used in patients with alcohol withdrawal)
- ✓ Patients with any complications like delirium tremens, alcohol withdrawal seizures, opioid intoxication etc. should be immediately referred to a secondary or tertiary care centre.
- ✓ Patients should be advised to remain adherent to the prescribed medications. In addition, they should report immediately to their treating doctors, in case of any adverse effects



Dependence, But No Immediate Medical Problems



INTERNET ADDICTION

In last two decades, the internet as become part of our everyday life. It has revamped our everyday life with upgraded technologies providing services that previously took long hours of travel easily available at the tips of our fingers, catering to everyday needs age groups. Users of internet have increased to 1000% and among them India has more than 900 million internet users making it second in the world with more than 1 billion users. Reports have showed excessive internet use have a negative impact on health leading to internet addiction. As per Young (1998) "Internet Addiction is defined as the excessive use of internet; any online-related, compulsive behavior which interferes with normal living and causes severe stress on family, friends, loved ones, and one's work environment". Internet addiction is umbrella term it includes several online gaming, online gambling, recreation and social media, online pornography, browsing for news, compulsively checking messages, and online shopping. Usage of internet for social media has rampantly increased in last one decade, where it has become essential part of our life. Younger generation between age group of 20-30 years, spends good amount of time online and exposing for negative impact of internet and social media.

Consequences of Internet addiction and excessive social media usage

Evidence on negative effect of Internet addiction and social media highlights the following:

a) Depression and internet user have bidirectional relationship, individual use more internet develop depressive mood, and further depressed individual tend to overuse internet
b) Restlessness when unable to access internet or social media.
c) Adolescents are targets of online harassment, and cyber bullying
d) It also leads to fatigue, sleep disturbance and stress
e) Adolescents also develop faulty methods of cope by falling back to use of internet and social media for sharing emotions rather seeking help from professionals
f) It increases the vulnerable individuals for substance abuse to get addicted to internet especially online gambling, shopping and pornography

Myths and Facts About Substance Use:

Myths	Facts
Consumption of alcohol, tobacco or other substances causes health problems only if used in excessive quantities.	Health issues can occur at any time regardless of the quantity. There is no known safe limit for consumption of any psychoactive substances like alcohol and tobacco.
Consumption of substances makes a person look attractive and improves sexual performance.	Substances can damage the skin and lead to rapid ageing. As a result, they might make a person less attractive. In addition, they can also damage blood vessels, leading to sexual problems such as erectile dysfunction and infertility.
Alcohol induces good sleep.	Alcohol disrupts the natural sleep cycle, resulting in sleep disturbances in long term. In addition, an individual usually feels tired and drowsy the next morning, after an alcohol-induced sleep
Smokeless (chewable) tobacco is less dangerous.	Smokeless forms are also harmful. They might lead to oral ulcers and cancer in the mouth, head and neck region as well as the digestive tract.
Substance use (e.g., alcohol and tobacco) improve work performance.	Work performance is severely affected in states of intoxication with alcohol and other substances. In addition, once a person in dependent on a substance, he has difficulty in concentrating when not using the substance.
Substance use makes a person brave.	A person might behave in a disinhibited manner while he/she is under the influence of psychoactive substances like alcohol. As a result, he/she behaves in a socially inappropriate manner, rather than brave.

QUITLINES TOBACCO-

A National Tobacco Quitline Service has been launched by the Government of India and the helpline number for the service is 1800-11-2356. In addition, M-Cessation services for quitting tobacco has also been launched by the Indian government where the client will receive a series of messages over few months, which will assist him/her to quit tobacco. To utilise this service, clients may give a missed call to 011-22901701. Clients may also be directed to the following website for assistance in quitting tobacco - https://www.nhp.gov.in/quit-tobacco

Patients with long standing substance related problems will require specialist mental health input and hence, they should be referred to a mental health professional.

References/Further reading:

1. International Classification of Diseases, Eleventh Revision (ICD-11), World Health Organisation (WHO), 2021 https://icd.who.int/browse11.
2. Miller W R, Rollnick S Motivational interviewing: Helping people change. 3rd ed. USA: Guilford press; 2012
3. Murthy P, Nikketha B. Psychosocial interventions for persons with substance abuse: theory and practice. National Institute of Mental Health and Neuro Sciences, Bangalore. *Developed under the WHO-GOI Collaborative Programme.* 2006 - 2007. http://nimhans.ac.in/cam/sites/default/files/Publications/Psychosocialintervention_2.pdf
4. Murthy P, Dhawan A, Basu, D, Gupta M, Chandra M, Chand PK et al. Standard Treatment Guidelines for the Management of Substance Use Disorders and Behavioural Addictions. Tobacco Control & Drug De-Addiction Programme Ministry of Health and Family Welfare, Government of India, New Delhi: 2020.
5. World Health Organisation. 2022. Alcohol. [Internet] Available at: https://www.who.int/health-topics/alcohol#tab=tab_3 [Accessed 22 August 2022].

MODULE 12

Mental Health Issues in Women and Handling Issues Related to Gender Based Violence

Objective of this module

- To know about mental health issues in women and how they are different
- Perinatal mental illness
- Concept of gender-based violence
- Types of gender-based violence
- Gender based violence cycle
- Risk factors for gender-based violence
- PWD act 2005
- Approach to gender-based violence

Women's mental health

Men and women differ from one another not just in overtly physical characteristics but also in psychological make-up. Women play many different responsibilities in society, making them more susceptible to mental diseases than other members of the population. Age of symptom onset, clinical characteristics, frequency of psychotic symptoms, course, social adjustment, and long-term prognosis of serious mental diseases are observed to differ across the sexes.

Women are 2-3 times more likely than males to experience the symptoms of common mental disorders including anxiety and depression. Due to the hormonal changes that occur during childbirth, women must also deal with other stressors. Due to less opportunities for education and decent work, women are also less empowered. It appears that social difficulties make even financially affluent women vulnerable.

Significant mental disorders and problems experienced by women

Women are more likely than men to be adversely affected by

- Specific mental disorders, the most common being depression
- Effects of gender-based violence
- Effects of sexual violence

Perinatal mental illness

An important complication of pregnancy and postpartum period are perinatal mental disorders. One may also encounter depression, anxiety disorders, psychosis, and bipolar disorder during the peri-natal period. Among these, anxiety and depression are particularly prevalent. Even though they are somewhat less common, bipolar illness and psychosis can have disastrous effects on the mother and her family.

Additionally, perinatal mental illnesses include conditions that existed prior to conception, or that recur along with conditions that manifest during pregnancy or after delivery.

The postpartum blues are a common and less severe form of affective disturbance that first arises during this time but has few unfavourable effects. Perinatal psychiatric illnesses affect a woman's ability to function and are associated with delayed child development. A risk factor for these diseases includes a prior history of mental illness during pregnancy or at other periods. Women who have substantial life difficulties, have a troubled marriage, or lack the social support of family and friends are also at risk. Additionally crucial to the perinatal mental disease development are biological variables. These patients require a psychiatrist's evaluation because using psychotropic medicines while pregnant or nursing can have an adverse effect on the unborn child.

Mental Disorders

Common mental disorders

Women are more likely to experience somatic problems, anxiety, and depression. Women are twice as likely as males to experience unipolar depression.

Women have a 2-3 times greater lifetime chance of developing an anxiety condition than do men. Women are more likely than males to experience unusual or "reverse vegetative" symptoms of depression, such as an increase in hunger and weight gain.

Severity of anxiety symptoms are greater in women in case of anxiety disorders and have more often comorbid depression and complicated course.

Severe mental illness

The prevalence of serious mental diseases like schizophrenia and bipolar disorder does not differ significantly based on gender. As was already established, these diseases in women differ in terms of clinical characteristics, course, social adjustment, and long-term adjustment.

Social repercussions such as marital family rejection, homelessness, vulnerability to sexual assault, and exposure to HIV and other infections make it challenging for women with severe mental illness to recover. Additionally, stigmatisation of mentally ill women has reportedly been higher than that of men.

Sexual violence

The prevalence of sexual and physical abuse in women with severe mental illnesses is twice that of the general female population. Rape has well-known severe mental health consequences, including major depression, generalised anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorders, and alcohol and drug use disorders.

Many women in impoverished populations experience sexual abuse on a more subtle level in their day-to-day interactions. Women are under cultural pressure to forego having sex with partners. Condom usage decisions are also predominantly made by male partners. Because of this, women have limited control over their libido and are more likely to develop STDs.

Gender based violence or domestic violence (DV)

A severe public health problem that affects 40% of women worldwide and plagues our society is gender-based violence. A male household member who engages in actual or threatened behaviour against a woman, whether it be his wife, girlfriend, or another female family member, in an effort to exert control or influence over her is said to be engaging in gender-based violence. Gender-based violence is more prevalent among women who have mental illness (MI), and psychiatric disease has been connected to gender-based violence. They consequently suffer from both MI and GV. GV is widespread, affecting all cultural and socioeconomic groups, and is usually committed by those who are assumed to play a protective role in the family. Until recently, to address the complexities of this problem, there was no separate civil law in India. The "Protection of Women from Gender based Violence Act, (PWDA) 2005" was enacted in September 2005, ensuring that women's rights are protected and upheld.

Types of Gender Based Violence:

Physical abuse includes slapping, hitting, or beating for trivial reasons or without cause. It can range from a single or multiple assaults to death.

Emotional abuse includes insulting, stalking, threatening to separate from the children, acting out on infidelity fears, and intimidating.

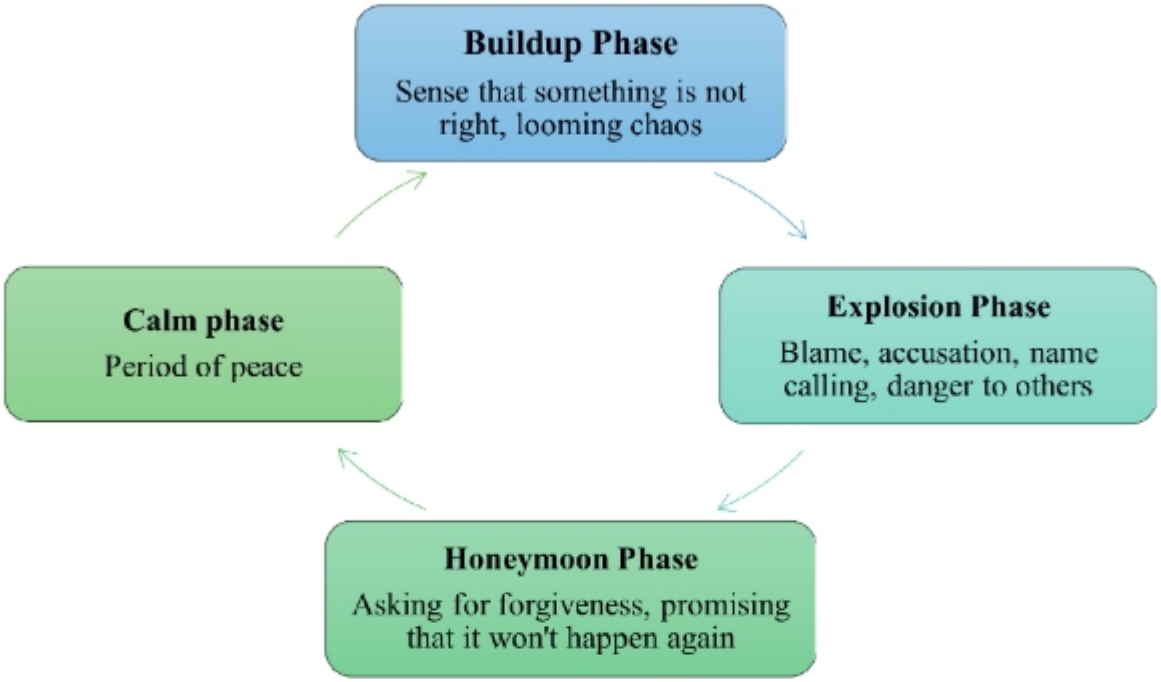
Sexual abuse includes sexual coercion, refusal to use contraception, and intentionally transmitting STD.

Economical abuse includes limiting financial access and other resources to which she is entitled.

Controlling behaviours include isolating the victim from friends and family, depriving them from their support system, denying her freedom of choice, and convincing her that she is incapable of surviving alone.

Gender Based Violence Cycle:

This follows a cycle of interaction that culminates into gender based violence as depicted below.

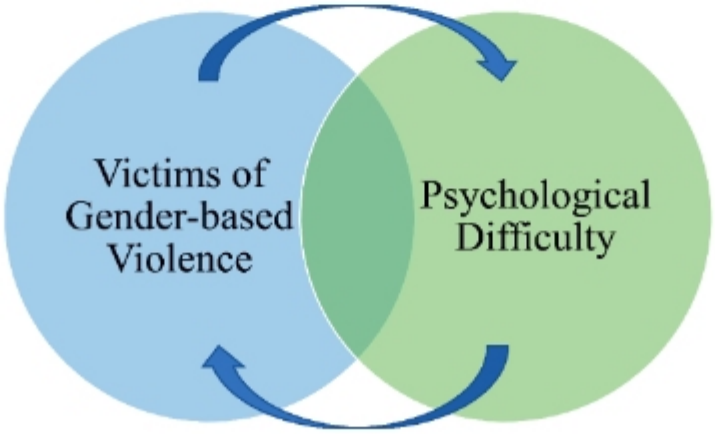


Risk Factors for Gender Based Violence:

Gender-based violence has many different root causes, which can be categorised as environmental, victim, or perpetrator factors. Both the victim and the perpetrator of gender-based violence are at risk for mental illness. The double disadvantage that women with mental illnesses experience as a result of gender-based violence is known as "double disadvantage."

Environmental factors	Victim factors	Perpetrator factors
Socio-cultural traditions	Young age	Low income
Weak community sanctions	Low education	Low education
Patriarchal societal norms	Financial dependency	Recent job loss
Poverty and weak legal and criminal justice system	Separated/divorced marital status	Antisocial personality & Substance abuse
Decreased outside access (e.g.: COVID -19 pandemic)	Exposure to violence as a child – Parental violence	Exposure to violence as a child– Parental violence, Sexual abuse

Vicious Cycle of Gender Based Violence and Psychiatric Illness:



PROTECTION OF WOMEN FROM DOMESTIC VIOLENCE ACT 2005:

The Ministry of Women and Child Development implemented the Protection of Women from Domestic Violence Act on October 26, 2006. The following are the highlights of the Protection of Women from Domestic Violence Act of 2005:

- Domestic violence includes not only actual abuse but also the threat of abuse and includes physical, sexual, verbal, emotional, and financial abuse.
- Under the law, only a woman can be an aggrieved person and must be in a domestic relationship with the respondent/abuser.
- Although reporting DV is not required, anyone who has reason to believe that DV has occurred can contact the information officer.
- The Act protects a woman's right to live in a matrimonial or shared household, regardless of her position in the household.
- The Act calls for the appointment of protection officers to help the woman with legal aid, safe shelter, and medical examination.
- The Act defines a breach of a protection order by the respondent as a cognisable and nonbailable order punishable by imprisonment for a term of up to one year or a fine of up to Rs 20,000, or both.
- Economic abuse in the Act would include deprivation of financial resources to which she is legally or customarily entitled. According to the Act, even restricting access to resources or disposing of household effects that a woman in a relationship is entitled to is considered abuse.

Stepwise Approach to Gender Based Violence:

Step 1: Whenever gender based violence is suspected: Patients who come with injuries but give conflicting explanations, wait a long time to get care, or disregard medical advice can be suspected of having GV.

Step 2: Assessment of intimate gender based violence: Interviews with the patients who may be victims of gender-based abuse ought to be conducted in private. Confidentiality should always be upheld, unless reporting is required or there is a major threat.

Step 3: Offer support: When DV is revealed, helping is the first thing that comes to mind. Empathy, acknowledgment, and demonstrating continued support for the victim are effective ways to do this.

Step 4: Ensure safety: Although survivors frequently downplay their risk, protecting them should be a top priority. In order to establish a strategy for their protection, it is crucial that their anxieties and concerns are addressed.

Step 5: Empowerment of the victim: Although survivors frequently downplay their risk, protecting them should be a top priority. In order to establish a strategy for their protection, it is crucial that their anxieties and concerns are addressed.

Step 6: Assessment and treatment for Mental Health: Regardless of whether the lady has a clinical diagnosis, it is imperative to check for mental health problems and offer support. A lady should receive a thorough evaluation for her sexual dysfunction, substance use, somatoform disorder, depression, anxiety, and post-traumatic stress disorder (PTSD). After thorough examination, a detailed management strategy should be developed.

Step 7: Referral to Legal Aid Clinic: Reporting and advice can be obtained by being directed to a Legal Aid Clinic. It is advantageous to look for legal protection and provide the offender a warning. According to Section 27 of the MHCA-2017, everyone with a mental disorder is entitled to free legal representation.

Step 8: Liaison with other professionals: It is advantageous to establish a network of NGOs, police officers, and attorneys that a woman can quickly access if she needs temporary housing. She could be referred to a social worker to evaluate and fortify her support network.

Step 9: Reporting to the protection officer: In order to stop the perpetrators from contacting the patients, severe DV will need the clinician to report to the DV protection officer. It is wise to "release Information if it is required to safeguard any other person from injury or violence," in accordance with MHCA Section 23, which addresses confidentiality, to ensure the patient's security.

Telephone resources

Women helpline (WHL) for domestic abuse	181
Women Helpline – Women in Distress	1091
Lawyer's collective women rights initiative (LC WRI): Legal Aid cell for Domestic Violence cases	(011) 24373993/ 24372923 010
All India Women's Conference	10921
Shakti Shalini	10920
Action India	011-26692700
SAARTHAK	011-26853846
Saheli (Saturday only)	011-24616485
Jagori	011-26692700
Nirmal Niketan	011-27859158
Nari Shakti Samiti	011-23973949

Case Scenario

Mrs X is 23-year-old female who had multiple visits to emergency of the hospital with bruises and injuries for which she was giving different explanation. Her live-in partner was with her constantly as she was being interviewed. She was being interviewed with multiple patients around in the emergency and denied of any one inflicting the injuries.

Questions:

1. What are the pointers suggesting gender-based violence in the case
   A- Inconsistent explanation, multiple visits
2. What can be done to help the client better in this case
   A- Providing privacy, ensuring safety, and empowering through liaison
3. If the client is in a live-in relationship, does she get legal protection- Yes
4. Is it mandatory to report without the patients consent if suspecting gender-based violence- Yes

Question and Answer:

1. Name the act which protects women from gender-based violence in India:
   A-Protection of Women from Domestic Violence Act 2005
2. What are the various types of gender-based violence described:
   A- Emotional abuse, Physical abuse, sexual abuse, economical abuse, and controlling behaviour
3. Name three psychiatric illness more common in survivors of gender-based violence:
   A-Depression and suicidality, Anxiety disorder, Eating disorder, PTSD, Substance use disorder, Dissociative disorder

True /False

4. Even threatened abuse constitutes gender based violence: True
5. Live in partner cannot be held responsible for gender based violence: False
6. It is mandatory to report gender based violence as per the act, or else it is punishable False
7. As per the law in India only woman can be an aggrieved person in domestic violence :True

References and further reading:

1. Naik, S., Damodharan, D., Kumar, C., & Bada Math, S. (2021). Forensic Psychiatry in India - Interface of Indian Laws and Mental Health. National Institute of Mental Health and Neuro Sciences (An Institute of National Importance), August.
2. SOCIAL WELFARE DEPT | PROTECTION OF WOMEN FROM GENDER BASED VIOLENCE ACT, 2005. (n.d.). Retrieved August 22, 2022, from https://www.tnsocialwelfare.tn.gov.in/swdswd/pages/view/protection-of-women-from-domestic-violence-act-2005
3. Malhotra, S., & Shah, R. (2015). Women and mental health in India: An overview. Indian journal of psychiatry, 57(Suppl 2), S205.
4. Huband, F. L. (2005). A focus on women. Asee Prism, 15(2), 5.
5. O'Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: definition, description and aetiology. Best practice & research clinical obstetrics & gynaecology, 28(1), 3-12.
6. www.ncw.nic.in

MODULE 13

Mental Health Issues in Vulnerable Populations

Objective of this module

- Overview of mental health issues of elderly
- To know about behavioural changes in elderly
- Overview of depression and dementia in elderly
- Overview of mental health issues in children and adolescents
- Overview of mental health issues in differently abled individuals
- How can we help them?

Mental health issues do not impact all individuals in the same way. It is important to know that there are multiple factors at play and some groups are more vulnerable in having mental health issues as compared to the general population. The presentation of mental health issues may also be different among these individuals.

Some of the vulnerable groups discussed here are:

A. Children and adolescents
B. Elderly
C. LGBTQA groups

Children and adolescents

Most of social, emotional and cognitive development occurs in the growing years of childhood and adolescence making this group of special importance. It is found that as high as 10% of all children and adolescents are affected from one or the other mental disorder. WHO data suggests, among the ages of 15-19 years, suicide is the 4th leading cause of death' (1). If these issues are left unaddressed, they affect the overall development of children and adolescents, spilling over the difficulties into adulthood and thus affecting adult mental health.

Factors increasing risk for mental illness in children and adolescence

- Difficult early childhood experiences in homes, schools etc
- Presence of mental illness in a parent or other caregiver
- Exposure to violence
- Bullying
- Poverty
- Substance use
- Lack of access to education

WHO describes childhood as a phase of life till 10 years of age and adolescence from 10 to 19 years of age(2). Although children and adolescents are one group but problems faced by sub groups of children and adolescents are different. Hence, let us consider problems of each sub-group separately and discuss each of them in brief.

Mental health concerns in children: -

- Developmental problems
- Harsh parenting
- Single parenting
- Poverty
- Bullying
- Behavioural problems
- Emotional problems

Mental health concerns in adolescents(3): -

- Developmental problems
- Behavioural problems
- Emotional problems
- Bullying
- Mental illness-psychosis, depression etc.
- Drug use
- Poverty
- Suicide
- Lifestyle
- Stigma, exclusion and discrimination
- High risk sexual behaviour and sexually transmitted infections

I. Developmental problems in children and adolescents(4) : -

- Intellectual developmental disorder/intellectual disability
- Autism spectrum disorder
- Attention deficit hyperactivity disorder
- Specific learning disorder
- Motor disorder

A. Intellectual developmental disorder/intellectual disability

Up to 3% of all children and adolescents are diagnosed to have intellectual disability (4) worldwide at any point of time. Intellectual disability is characterised by deficits in intellectual functions like reasoning, new learning, problem solving etc., and deficits in adaptive functioning like social communication, independent living etc. Some of the causes include deficiencies in nutrients, hormonal deficiencies which improve on replenishing them. Whereas some other causes include genetic causes which will guide the clinician in treating the child better in terms of other disorders of the body. Hence, identifying and diagnosing early becomes important in serving the child and family as a whole. Government of India also offers disability benefits for such individuals in various forms starting from education, occupation, social schemes etc.(5).

How to identify signs of IDD?

Warning signs to be noticed by the family or teachers in school remain at paramount importance for early help seeking. These include'(6): -

- Learning to roll over, sit, stand, walk, run, speak later than similar age children
- Slower than similar age group children in learning new things, e.g.: new language, simple calculation etc.,
- Difficult to express one's needs, feelings
- Not toilet trained beyond 5 years of age
- Needing assistance for day-to-day activities like dressing, bathing, eating beyond the children of same age group
- Difficulty in remembering things appropriate to age
- Slow learning in school (mostly observed by teachers)

What to do once identified?

Approach the nearest doctor (pediatrician/neurologist/psychiatrist) immediately. After thorough evaluation and treatment, a formal referral is made to pediatrician/psychiatrist/clinical psychologist to assess the IQ (Intelligence Quotient). Child is made available several therapies as per the requirement, like(7): -

a. Physical therapy for gross motor deficits
b. Occupational therapy for fine motor skill deficits
c. Speech and language therapy
d. Behavioural therapy
e. Special education

According to IQ levels, child is entitled to disability benefits offered by the Government of India like provision of free education till 18yrs for individuals with benchmark disability, accommodation in number of subjects learnt, relaxation of passing marks, provision of scribe in exams, opportunity to take open schooling etc.(5).

Family support and family education is crucial for any child having developmental disorders. These services can be availed by linking the family with a mental health professional.

B. Autism spectrum disorder (ASD)

This is a group of disorders where there is deficit in social communication along with presence of repetitive behaviours/interests. Intelligence may or may not be normal. Most children exhibit signs as early as less than 5 years but due to lack of awareness, there may be delay in diagnosing.

How to identify signs of ASD(8) ?

Red flag signs for identifying ASD in children are as follows: -
a. Inability to point at objects
b. Inability to show one's interests
c. Inability to share enjoyment with others (kids or elders)
d. Does not respond to name
e. Inability to maintain gaze
f. Repeating certain words or movements

What to do once identified?

Approach the nearest psychiatrist/pediatrician/ clinical psychologist for further assistance. Reassure the parents about improvements in behaviour and adaptive skills with appropriate and timely interventions which in-turn motivates the parents to seek help. In severe cases, children are protected under the Rights of Persons with Disability Act 2016.

C. Attention deficit/hyperactivity disorder (ADHD)

This disorder is characterised by extensive, constant inattention and/or hyperactive behaviour/ impulsive behaviour. Mostly these children are described as 'difficult' by the teachers in school for their hyperactivity.

How to identify signs of ADHD (9)?

Some of the signs of inattention and hyperactivity commonly seen are: -

a. Inability to focus during classes in school
b. Frequent day dreaming in classes
c. Frequent forgetting simple tasks and making simply mistakes
d. Difficult to do work which require organising
e. Difficulty in waiting for one's turn during games
f. Interrupting others while speaking
g. Running around, disturbing other kids during classes

What to do once identified?

Approach the nearest psychiatrist/pediatrician/clinical psychologist for further assistance. Educate the parents about the various available treatment modalities including medications to improve restlessness, behaviour therapy by teachers and parents at home. Treating at appropriate age prevents progressing into more severe mental disorders (e.g., anti-social personality disorder etc.) in adulthood thus improving the productivity of the child.

D. Specific learning disorder

This disorder is seen when the child starts attending school and learns to read and write. Deficits can be in reading, writing, spelling of words, following the rules of grammar, arithmetic and languages but with normal IQ. This is identified by school teachers and intervention also focusses majorly on school environment. RPWD Act 2016 considers it as a distinct entity requiring special provisions in school e.g.: exempting the mistakes and focusing on larger structure of answers during the exams etc. Interventions help children succeed beyond expectations as IQ is normal in such children.

The following are some of the myths about childhood and adolescent developmental disorders which when busted makes a world of difference to the sufferers and their families.

Myths	Facts
IDD is curable with medicines	IDD results due to arrested brain development for various reasons, where children can be taught and trained but there is no cure for it.
Behaviour therapies for children are all costly	All behavioural therapies for children can be done at home/school with absolutely no cost
Children with ASD are lazy to speak	One of the core symptoms of ASD is language and communication deficits and not because children are lazy
Hyperactive children should be punished to reduce restlessness	Hyperactivity is a core symptom of ADHD. Children cannot control it unless intervened appropriately
Parents' inputs are unnecessary for detection of developmental disorders	Parental observation is the key to diagnosis and management

I. Behavioural and emotional problems

There are a variety of behavioural and emotional problems seen during childhood and adolescence which go unnoticed by the family/teachers leading to untreated mental illnesses. This progresses to adulthood for more severe disorders either of the same type or different type disorders (10). Warning signs are seen as per different age groups in addition to those discussed already are mentioned below.

- a. Pre-school age group: - excess clinging to parents, excessive stranger anxiety, not-sharing toys, disrespecting adults, disobedience, tantrums.
- b. School age group: - refusing to go to school, difficulty learning, inability to focus on studies, lying, engaging in fights with others, inability to make friends, not sharing one's emotions, bullying, stealing, bunking school, erratic sleep and eating tendencies, bed-wetting, stubbornness, aggression, repetitive behaviours, crying spell, reduced energy, disinterest in activities
- c. Adolescence: - In addition to above, usage of drugs, engaging in anti-social behaviour, self-injurious behaviour.

What to do once detected?

All such children must be referred to nearest psychiatrist for a thorough evaluation. In case of emergency like significant aggression/self-harm behaviour children may need an in-patient management as well. Interventions are focused at both children as well as parents. For children, appropriate medications and behavioural therapy is initiated, social skills training, coping skills enhancement, environment modification is done wherever needed. For parents, the key lies in managing the unpredictable situations using reinforcements and punishments wherever appropriate(11).

II. Substance use in adolescence:

One of the major causes of substance abuse in adolescence is experimentation. In biologically predisposed individuals (e.g. ADHD etc.) this experimentation soon turns to harmful pattern and dependence thus causing public health concern. Peer pressure, being felt as a part of social group are some of the important factors where teens consume substances. Occasionally children and adolescents consume volatile inhalants to suppress hunger in extreme conditions of poverty. The key step lies in identifying the various vulnerability and providing appropriate services to reduce such vulnerability as reducing access to substances is not a practical option in most places(12).

Risk factors for substance use in adolescents: -

a. Lower socio-economic status
b. History of ADHD, conduct disorder etc.
c. Co-morbid mental illnesses like depression, mania, psychosis etc.
d. Exposure to abuse, violence, bullying
e. School dropout
f. Family history of substance use

Interventions for substance use: -

a. Evaluating and treating co-morbid mental illnesses
b. Understanding vulnerabilities leading to substance use
c. Use of medications during withdrawal and subsequently to reduce craving
d. Provision of safe environment away from substances
e. Provision of alternate reward in the form of encouraging academics/sports/hobbies etc.
f. Parental education for identification early signs of relapse
g. National toll-free helpline is set up for drug dependent individuals by Government of India (1800-11-0031)

IV. Suicide in adolescence

Suicide in adolescents is a social issue with multiple stakeholders similar to that in adults. An increasing trend in completed suicides is seen in the adolescent over the years to the extent that it is the 4th major cause of death in adolescents. Not all suicides are secondary to mental illnesses. The increasing trend of suicides in adolescents is attributed to increased availability of means of self-harm worldwide. Student suicides are showing an increasing trend which can be attributed to increasing academic performance pressure in this never ending competitive world(13).

Risk factors for suicide: -

a. Primary mental illness like depression, psychosis, eating disorder, etc.
b. Stigma
c. Lack of access to help
d. Lack of awareness about mental illness
e. Poverty
f. School drop-out
g. Substance use
h. Exposure to violence or abuse
i. Increased access to firearms, pesticides etc.
j. Digital space negative experiences
k. Family history of suicide
l. LGBTQIA community
m. Chronic illness

Warning signs for suicide: -

a. Social withdrawal
b. Academic decline
c. Increased usage of substances
d. Unstable relationships
e. Recent change in behaviour (aggression, impulsivity)
f. Vulnerabilities like poor self-esteem
g. Expression of statements like 'wish I was not there to face this', 'I am useless' etc.
h. Previous aborted attempts
i. Talking about suicides/ self-harm
j. Searching for methods of harming oneself

How to handle such a situation?

Suicide is a medical emergency. Anyone showing any warning signs must be brought to health set-up immediately. Some of the mandatory steps needed are: -

a. Listening empathetically to the individual in distress
b. Being non-judgemental about the reason for thinking of suicide
c. Maintaining a stable connection with the person until professional help is sought
d. Regularly checking on high-risk individuals for suicidal ideas
e. Removing access to agents of suicide (pesticides, firearms, drugs etc)
f. Increasing awareness about mental illness and thus reducing stigma
g. Imparting life skills training in schools and colleges
h. Access to helplines like 9152987821, 9820466726

A moment of impaired judgement leads to an irreversible consequence in suicide. Hence hypervigilance is the key. The collective effort of governments and healthcare system makes it possible to prevent suicides.

Myths and facts about adolescent mental health

Myths	Facts
Removing access to suicide is a foolish step	It is proven that reducing access reduces suicide rates
Talking about suicide increasing risk of suicide	Talking about suicides encourages a person to express such ideas and seek help
Suicide is a criminal act	Suicide is decriminalised in India as per Sec 115(11) of MHCA 2017
A person who has never seriously attempted earlier will never attempt suicide in future	Past history of aborted suicide attempt is an important risk factor for suicide

Elderly

Who is an elderly?

- In India, as per various laws like Maintenance and Welfare of Parents and Senior Citizens Act (MWPSC) 2007, "Elderly is anyone of age 60 and above." (14)
- Across the world, generally elderly are considered as ages 60 or 65 and above.
- At most places retirement is around the similar age cut off.
- Hence, rather than considering the 'number' as a social construct, old age can be considered to be based on
    - The new roles assigned- e.g. becoming a grandparent
    - Cessation of certain roles- e.g. not being the earning member of the family after retirement.

Ageing: -

Biologically speaking, ageing is a cumulative effect of molecular and cellular damage resulting in progressive decrease in physical and mental capacity. The deterioration of physical and mental capacity is neither linearly correlated nor consistent with age. However, they have a loose association with age. This may lead to growing risk of disease and ultimately death.

Overall, the damage to the cells occurs in two ways:

- Programmed death of cells: after a number of times of cell divisions
- Wear and tear: accumulation of toxic substances such as free-radicals.

There are many changes associated with ageing, which we can understand by classifying them as:

- Physical changes
- Psychological changes
- Social changes

1. Physical changes associated with ageing:

a) Sensory system:
- Impaired vision: leading to reduced mobility, and dependence on others
- Impaired hearing: leading to reduced social interaction
- Impaired smell and taste: leading to loss of appetite

b) Dental problems- owing to poor oral hygiene, pain and discomfort in oral cavity that ultimately leads to loss of appetite

c) Muscular loss- weakness and fatigue, decreased mobility, requirement of support

d) Reduction in total number hours of sleep, causing fatigue, daytime drowsiness, irritability, headaches.

e) Memory loss (reduction in brain volume and neurons): The rate of loss of neurons is around 1% every year after the age of 60 years, approximately (15). Greater loss in neurons and connections in certain parts of the brain, such as:

- Frontal lobe- affects executive functions
- Hippocampus- affects memory
- Sub-cortical regions- affects sleep and gait.

In Dementia, there is neuron loss and accumulation of deposits within neurons of different regions hence different types and manifestations are seen. (16)

Other physical illnesses – chronic conditions such as diabetes, hypertension, stroke and other non-communicable diseases.

2. Psychological changes

a) Changes in intellectual functioning:

- Slowing in the speed of processing
- Familiarity vs novelty: discomfort in new situations and with new people, wanting to be in familiar surroundings
- Reduction in problem solving skills
- Reduction in creativity

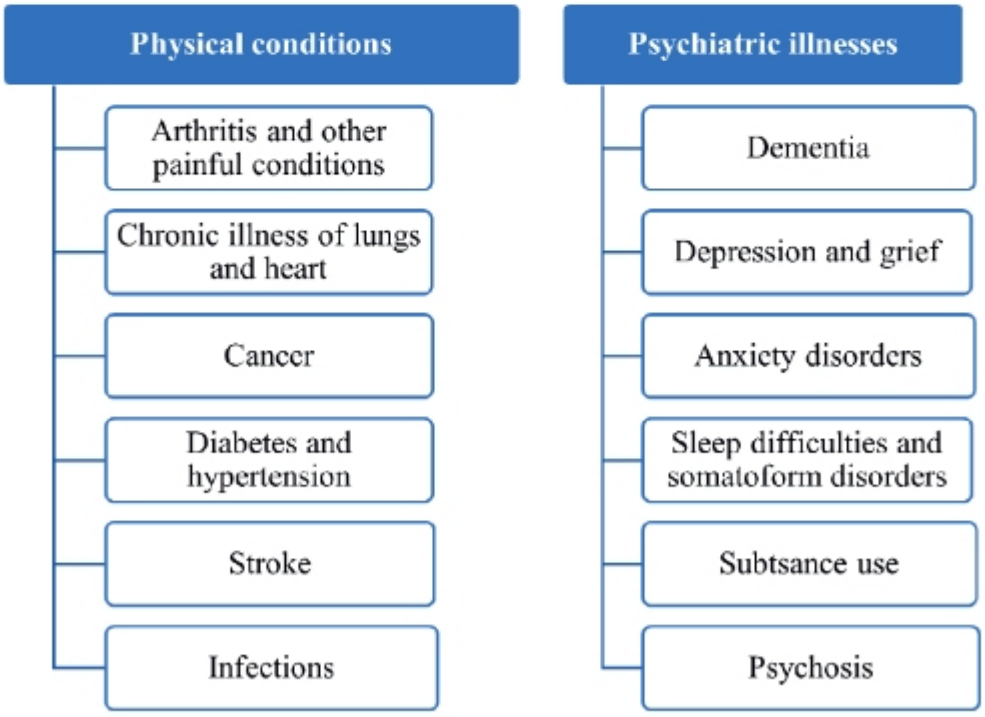
b) Memory functions: reduction and slowing of:

- Working memory - memory of seconds to minutes (ability to understand and register what is being spoken to them)
- Short term memory - memory of few hours to days
- Long term memory - memory of months to years

3. Social changes

- Retirement- in most places 60 years and above is the retirement age. People may have difficulty in adjusting with the new lifestyle, may have boredom, will have change of role of not being the bread-winner of the family.
- Death of spouse/family members/friends: dealing with the grief
- Home and other possessions: change in place of residence
- Income: surviving on the pension money (if any) or being dependent on the other earning family members
- Dependent for activities of daily living: mainly due to physical difficulties of vision, movements, further there is feeling of burden on others by being dependent on them.

Elderly are at higher risk of the following:



Elderly can also have new onset severe mental disorder such as psychosis, substance use disorders or worsening of pre-existing illnesses. We shall focus on the two **"D"** s increasing the risk of one another**: Depression and Dementia**.

Depression in elderly

Symptoms: (MEETS-Help)

- **M**ood: "feeling empty" more often than sadness
- **E**motion: expressing irritability more often than sadness and worrying
- **E**nergy levels: can be "agitated"
- **T**houghts: Nihilism, minimisation/denial
- **S**peech: reduced speech with low voice
- **H**elp-seeking attitude: less

Depression in elderly is mostly associated with medical illness, psycho-social adversities, and memory disturbances. But most individuals are noted to have "well-adjusted" personality with good "resilience" to handle stress earlier. Hence, it is concluded that "biological" factors play major role rather than environmental alone (17).

Dealing with Grief/loss: Each person deals with loss differently. The feelings have a wide range of emotions which includes guilt, sense of helplessness, loneliness, rigidity/stubbornness, anger/rage, reminiscence, sad mood, feeling tensed/anxious.

Interventions: -

- Active listening
- Providing them support
- Differentiate between grief and depression: "biological" symptoms of reduced sleep, marked loss of appetite and weight, neglect of self-care, excessive guilt, ideas of helplessness, worthlessness, hopelessness, withdrawn to self, reduced interaction and death wishes are usually noted in depression rather than in grief
- Refer to higher centre for detailed evaluation and need for further management.

Dementia

With progress of normal aging - some amount of memory loss is usual which is gradual, more for short term/recent memory than long term memory. Person might forget 'name' but not the face 2, might forget 'where the key is kept' rather than about the 'key' totally. Most of the dysfunctions are gradual and worsen progressively.

With dementia there is marked change in:

- memory functioning
- naming and language
- behaviour and personality
- difficulty in carrying out routine activities, even that of self-care

Approach to elderly person with behavioural disturbance:

- Preserve their "dignity" and ensure privacy
- Empathetic listening
- Speak slowly and clearly, repeat if needed
- Check if they are able to 'comprehend'
- Able to identify people correctly
- Assess for social support and their perception of available support
- Show affection and support whenever possible
- Identify if 'substance' use is contributing to current situation
- Refer to doctor/mental health professional

Approach to elderly person with behavioural disturbance:

- Preserve their "dignity" and ensure privacy
- Empathetic listening
- Speak slowly and clearly, repeat if needed
- Check if they are able to 'comprehend'
- Able to identify people correctly
- Assess for social support and their perception of available support
- Show affection and support whenever possible
- Identify if 'substance' use is contributing to current situation
- Refer to doctor/mental health professional

Sleep disturbances in elderly:

Sleep disturbances are common in elderly. Any change in routine, medical or psychological problems may worsen sleep. Causes include the following (19)

- Physiological/without cause
- Primary sleep disorder
- Physical causes – pain, urinary, gastrointestinal, respiratory
- Psychiatric causes
- Behavioural reasons
- Environmental causes such as excess light, sound, uncomfortable bedding etc.
- Medications – laxatives, sympathomimetics, caffeine, antiparkinsonian drugs

Intervention:

Sleep problems are quite common, before considering medications, explain sleep hygiene techniques:

- Practice deep breathing and relaxation exercises
- Take warm water bath in the evening hours
- Take warm glass of milk in the night
- Listen to music, read books in the night which help your body and mind to relax
- Avoid sleeping during the day
- Avoid excess consumption of coffee, tea, tobacco, and alcohol
- Go to bed only when you feel sleepy
- Do not use the bed for other activities such as reading, working, watching movies/social media etc., except for sleep.
- Avoid bright lights in the night or using mobile/TV/computer for long hours in the night

Dealing with boredom and loneliness:

- Engage in activities within home such as helping with chores, spending time with grand-children
- If staying alone: check regarding their safety, ensure that help is available if needed, inform with regard to various helplines available
- Spend time in activities such as gardening, exercise inside the house, keep physically active
- Connecting with friends and family through telephone

Interventions and tips for the caregivers:

- Empathetic listening to the care-givers account of their feelings and their concerns
- Reassure the families that these behavioural problems are common during old age
- Ensuring dignity and privacy (especially during activities such as dressing, bathing)
- Establishing a daily routine
- Safety: keeping a chair to sit while bathing, a mat to prevent slip, a support rod, ramp etc.
- Speak clearly and slowly, in case the elderly does not understand use simpler and shorter words. Minimise background noise

- Correct the elderly's spectacles appropriately or provide a magnifying glass. Also check that the person does not need hearing aids.
- Use of identification bracelet/necklace in case of history of wandering behaviour and getting lost
- Locking doors in the night in case of wandering
- Using clothes that can be easily removed
- Limiting water intake in the evening and night
- Ensuring hygiene with special Covid19 related precautions such as hand washing, maintaining social distancing, going out only if necessary, wearing masks
- Use of bed-pan if needed
- Try and identify the triggers for anger and avoid it
- Identify activities that soothe them: e.g. music/walking
- Avoid confrontation and argument
- Doing simple tasks together
- Use of memory aids: such as "labels"
- Having a daily sheet calendar visible
- Encouraging to write 'day date year' in a white board
- Spending time looking at photo albums and encouraging them to speak about the 'memories': old memories may not be affected as much as recent memory and this can bring the person pleasure.
- Memory aids are to be used like naming doors of bathroom etc., a writing board where every day's date day is written.

Elderly abuse:

Suspect elder abuse

- If unexplained injuries/frequent injuries
- Marked distress by the person when care giver is around
- Person is guarded to speak
- Care giver is impatient with the person, has behavioural issues, substance use

Elderly abuse in the family context can be of Physical, Psychological, Emotional, Financial or Sexual in nature. Report to authorities whenever you come across abuse.

Government schemes for elderly to know:

- National policy for older people - 1999
- Maintenance and welfare of parents and senior citizens -2007
- Indira Gandhi national old age pension scheme - 1995
- National programme for healthcare for elderly - 2010
- Integrated programme for senior citizens - 1992
- Mental Health Act 2017

Mental Health issues in the LGBTQ Community:

LGBTQ is an acronym that stands for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, recently Asexual/Agender and additional sexual orientations and gender identities have been added under the umbrella term LGBTQA+.As per Indian census 2011, the LGBTQ community comprises of 3.8 %, i.e., an estimated 45.4 million of our total population.

Sexual orientation describes the way a person feels towards people of a particular (or more than one) gender, physically, sexually, romantically and/or emotionally.

Gender identity is the personal sense of one's own gender, it can align with a person's assigned gender or can differ from it.

Gender role is described as the outward expression of the inner sense of gender identity

The terms sex and gender are often used interchangeably but they are not the same.

Sex refers to the physical differences between people who are male, female, or intersex. A person typically has their sex assigned at birth based on biological characteristics, including their genitalia and chromosome composition.

Gender, on the other hand, involves how a person identifies. Unlike natal sex, gender is not made up of binary forms (i.e., man and woman). Instead, gender is a broad spectrum. A person may identify at any point within this spectrum or outside of it entirely.

Understanding the terms:

Lesbian: a person who identifies as a woman who is physically, sexually, romantically and emotionally attracted to other women and who identifies as lesbian

Gay: A person who identifies as a man and who is physically, sexually, romantically and /or emotionally attracted to other men and who identifies as gay.

Bisexual: Bisexuality is romantic attraction, sexual attraction, or sexual behaviour toward both males and females, or to more than one gender. It may also be defined to include romantic or sexual attraction to people regardless of their sex or gender identity, which is also known as pansexuality

Transgender: A term used to describe people whose gender identity differs from the sex they were assigned at birth. People whose gender falls outside of the gender binary (i.e., the idea that only 2 genders exist -man and woman), may also call themselves trans.

Queer: An umbrella term used to include all sexual orientations and gender identities within the LGBTQ+ acronym. Originally meaning "strange" or "peculiar", queer came to be used as a slur against those with same-sex desires or relationships in the late 19th century.

New inclusions:

Agender: a person who doesn't identify with any gender, or identifies as being genderless

Questioning: includes those who feel unsure about their sexual orientation and/or gender identity and describe themselves as questioning

Plus: A term used to include additional sexual orientations and gender identities under the LGBTQ+ umbrella.

Myths and Facts:

- *Myth:* People choose to be homosexual and can change if they really want to
- *Fact*: No one can change their sexual orientation. ***Sexual orientation is something that is biologically inherent within us and cannot be changed***.

- *Myth: Homosexuality* is a disease, that can be cured with conversion therapy
- *Fact*: The Indian Psychiatric Society has in 2018 categorically stated that ***homosexuality is not a disease and must not be regarded as such.*** There is no scientific evidence at all that attempts to convert a person's orientation (using any form of 'treatment/therapy' succeed in any manner. The Indian Psychiatric Society totally disapproves of any such treatments and urges that such therapies must cease forthwith

- *Myth*: Lesbian, gay and bisexual people can be identified by certain mannerisms or physical characteristics.
- *Fact*: LGBTQIA+ people come in many different colors, shapes, sizes, and from many cultures - just as those who are heterosexual do.
-
- *Myth*: LGBTQIA+ people are much more promiscuous and flaunt their sexuality more than heterosexual people.
- *Fact: This* is a stereotype, LGBTQIA+ people are just as capable of stable, monogamous, committed relationships as anyone else
- *Myth*s and AIDS are only seen in homosexuals.
- *Fact*: STIs can affect people of any sexual orientation

LGBTQ Rights:

The honorable Supreme Court of India passed a judgement in 2018, decriminalising ***same sex relations between consenting adults***. LGBT individuals are now legally allowed to engage in consensual sexual intercourse.

The honorable Supreme Court in a landmark judgement dated 15th April 2014 granted legal ***recognition for "third gender".*** This paved the way for the legislation, which is now known as The Transgender Persons (Protection of Rights) Act, 2019. This came into effect on 5th December 2019. The act directs the government for formulating welfare schemes and programmes, including healthcare provisions, to facilitate and support livelihood for transgender persons, including their vocational training and self-employment. It safeguards the rights of the transgender and gender diverse individuals and aims at providing a safe space in the society. Section 3 of the Act ***prohibits any and all forms of discrimination against transgender individuals*** either in public or private, educational institutes, offices, healthcare facilities or public places, and any individual who is found to be guilty of the same, directly or indirectly leading to harm or endangerment to the life of transgender individuals shall be liable to punishment with imprisonment. Sections 4-6 deals with acquiring a ***transgender status and identity card*** and Section 7 with gender change status and identity card.

Conclusion:

The society is divided on their stand regarding the LGBTQ community. While there are many prevalent prejudices against the LGBTQ community, it is essential that as a therapist/counsellor, that we put aside any personal bias/prejudice and attend to them in a non-judgmental environment, where they feel safe to confide in us, as with any other client.

References:

1. Child and adolescent mental and brain health [Internet]. [cited 2022 Sep 6]. Available from: https://www.who.int/activities/improving-the-mental-and-brain-health-of-children-and-adolescents
2. Adolescent and young adult health [Internet]. [cited 2022 Sep 6]. Available from: https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions
3. Adolescent mental health [Internet]. [cited 2022 Sep 6]. Available from: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
4. 2013 - Diagnostic and statistical manual of mental disord.pdf.
5. RPWD 2016.pdf.
6. CDC. Facts About Intellectual Disability [Internet]. Centers for Disease Control and Prevention. 2019 [cited 2022 Sep 6]. Available from: https://www.cdc.gov/ncbddd/developmentaldisabilities/facts-about-intellectual-disability.html
7. Scott JG, Mihalopoulos C, Erskine HE, Roberts J, Rahman A. Childhood Mental and Developmental Disorders. In: Patel V, Chisholm D, Dua T, Laxminarayan R, Medina-Mora ME, editors. Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition (Volume 4) [Internet]. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2016 [cited 2022 Sep 6]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK361938/
8. C.2-ASD-2014-v1.1.pdf [Internet]. [cited 2022 Sep 6]. Available from: https://iacapap.org/_Resources/Persistent/261d6507ffa885c4a64f1a40f240e75f45938e46/C.2-ASD-2014-v1.1.pdf
9. de A de F. Anthony de Freitas de Sousa, Isabel Meneghetti Coimbra, Julia Marrone Castanho, Guilherme V Polanczyk & Luis Augusto Rohde. :28.
10. Copeland WE, Shanahan L, Costello EJ, Angold A. Childhood and Adolescent Psychiatric Disorders as Predictors of Young Adult Disorders. Arch Gen Psychiatry. 2009 Jul 1;66(7):764–72.
11. Ogundele MO. Behavioural and emotional disorders in childhood: A brief overview for paediatricians. World J Clin Pediatr. 2018 Feb 8;7(1):9–26.
12. Das JK, Salam RA, Arshad A, Finkelstein Y, Bhutta ZA. Interventions for Adolescent Substance Abuse: An Overview of Systematic Reviews. J Adolesc Health. 2016 Oct;59(4 Suppl):S61–75.
13. Suicide [Internet]. [cited 2022 Sep 7]. Available from: https://www.who.int/news-room/fact-sheets/detail/suicide

14. Maintenance_and_welfare_of_parents_and_senior_citizens_act.pdf [Internet]. [cited 2022 Aug 23]. Available from: https://www.indiacode.nic.in/bitstream/123456789/6831/1/maintenance_and_welfare_of_parents_and_senior_citizens_act.pdf
15. Peters R. Ageing and the brain. Postgrad Med J. 2006 Feb;82(964):84–8.
16. Serrano-Pozo A, Frosch MP, Masliah E, Hyman BT. Neuropathological Alterations in Alzheimer Disease. Cold Spring Harb Perspect Med. 2011 Sep;1(1):a006189.
17. Fiske A, Wetherell JL, Gatz M. Depression in Older Adults. Annu Rev Clin Psychol. 2009;5:363–89.
18. Omelan C. Approach to managing behavioural disturbances in dementia. Can Fam Physician. 2006 Feb 10;52(2):191–9.
19. Suzuki K, Miyamoto M, Hirata K. Sleep disorders in the elderly: Diagnosis and management. J Gen Fam Med. 2017 Mar 30;18(2):61–71.
20. Senior Citizens| National Portal of India [Internet]. [cited 2022 Aug 23]. Available from: https://www.india.gov.in/people-groups/life-cycle/senior-citizens

MODULE 14

Ethical and Legal Aspects of Tele-counselling

Objective of this module

- To know about the concept of medical ethics
- Overview of national and international guidelines for tele psychotherapy
- Overview of national and international laws on tele-consultation

Introduction to Tele-consultation:

As per WHO, telemedicine is defined as "the delivery of healthcare services, by all healthcare professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of healthcare providers, all in the interests of advancing the health of individuals and their communities". Telemedicine encompasses all forms of communication with patients that use information technology platforms, such as voice, audio, text, digital data exchange, and their combinations. Telemedicine can occur between a physician and a patient, as well as between two or more physicians and other healthcare professionals.

Ethics in Counselling:

Ethics are moral principles that guide a person's behaviour while performing a task. Ethics is concerned with making the best decisions under all circumstances. It is concerned with the distinction between what is right and wrong at a given time in a given culture.

Medical ethics is concerned with doctors' and hospitals' obligations to patients, as well as other health professionals and society. The principles and standards that govern the relationship between counsellors and clients are the focus of ethics.

Morality, on the other hand, entails action judgement and evaluation. It is related to the words good, bad, right, wrong, ought, and should.

Major moral principles of healthcare are:

1. AUTONOMY- It is the patient's ability to give informed consent or participate fully in decision making; along with behavioural adjustments, understanding of the system and giving them the desired independence.

2. BENEFICENCE: Telehealth can benefit patients by providing education, information, and support in their familiar environment, by providing assurance, increasing an individual's confidence in managing their health, and reducing reliance on professional caregivers or family. Improving access, the availability of high-quality healthcare, and the continuity of care are all examples of how telehealth can be beneficial.

3. NON-MALEFICENCE: It refers to the ethical principle of non-maleficence, or preventing harm, in relation to telehealth practice. The harm can be seen in the form of stigmatising a patient through videophones, difficulty for the patient to understand technology and its use, especially in the marginalised population.

4. JUSTICE: Justice refers to the fairness of equal access to telehealth technology, balancing the needs of the individual with those of the larger community, and ensuring that no group is disadvantaged in favour of another.

5. PROFESSIONAL PATIENT RELATIONSHIP: Includes the domains of confidentiality, privacy, fidelity, loss of human touch, trust and mutual respect which needs to be undertaken while providing a tele-consultation.

Moral principles of healthcare are-

1. Autonomy
2. Beneficence
3. Non-maleficence
4. Justice
5. Professional patient relationship

Professional Codes of Ethics for Counsellors:

A professional code of ethics is a set of conduct standards based on an agreed-upon set of values that professionals in a given occupation, such as counselling or psychology, must follow. The American Counselling Association (ACA) is a non-profit professional and educational organisation dedicated to the advancement and development of the counselling profession. ACA, which was founded in 1952, is the world's largest association representing professional counsellors in a variety of practice settings. ACA laid down ACA code of ethics. Similarly, there is RCI code of ethics by Rehabilitation council of India (RCI).

American Psychological Association Guidelines for Psychologists Practicing Telepsychology:

The eight core guidelines appear below.

Competence of the Psychologist:

Guideline 1: Psychologists who provide telepsychology services make every effort to ensure their competency with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals.

Standards of Care in the Delivery of Telepsychology Services:

Guideline 2: Psychologists make every effort to ensure that ethical and professional standards of care and practice are met from the beginning to the end of the telepsychology services they provide.

Informed Consent:

Guideline 3: Psychologists work hard to obtain and document informed consent that addresses the specific concerns associated with the telepsychology services they provide. Psychologists are aware of the applicable laws and regulations, as well as organisational requirements that govern informed consent in this area when doing so.

Confidentiality of Data and Information:

Guideline 4: Psychologists who provide telepsychology services make reasonable effort to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks to loss of confidentiality inherent in the use of the telecommunication technologies, if any.

Security and Transmission of Data and Information:

Guideline 5: Psychologists who provide telepsychology services make a reasonable effort to protect and maintain the confidentiality of their clients'/patients' data and information, and inform them of any potentially increased risks to confidentiality inherent in the use of telecommunication technologies.

Disposal of Data and Information and Technologies:

Guideline 6: Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information, as well as the technologies they use, in a way that allows for protection from unauthorised access and accounts for safe and appropriate disposal.

Testing and Assessment

Guideline 7: When providing telepsychology services, psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation.

Interjurisdictional Practice

Guideline 8: When providing telepsychology services to clients/patients across jurisdictional and international borders, psychologists are encouraged to be familiar with and comply with all relevant laws and regulations.

Guidelines for Tele-psychotherapy (nimhans):

Following are some important points from guidelines for tele-psychotherapy published by NIMHANS:

- In the case of minor clients (those under the age of 18), informed consent from a parent/guardian and assent from the minor are required.
- Those with severe psychopathology and/or a high risk of suicide are not candidates for tele-psychotherapy sessions as sole treatment. In all cases, the need for emergency services/referral for psychiatric evaluation or medication should be determined.
- Discontinue tele-sessions if (i) there is no significant improvement/worsening (ii) emergency services/referral is required (iii) either party is in significant discomfort (iv) in-person sessions are required.
- The client has the option to discontinue participation in these sessions at any time. Tele-psychotherapy sessions cannot involve use of artificial intelligence (AI) based intervention unless the same has been approved by a relevant agency in the country.
- All tele-sessions should be documented in a consistent format, including details such as date, time, duration, modality of sessions, client and therapist information, and brief session notes. Details of any crisis, as well as recommendations for contacting emergency services or other services, should be kept.
- Attempt to ensure confidentiality, inform clients about confidentiality limits, and address confidentiality risks associated with the use of technology in service delivery.
- Clients should not be added by the therapist to any virtual support group or other online group/forums without discussion and explicit consent.

LEGAL CONSIDERATIONS:

INTERNATIONAL LAWS - TELEMEDICINE OR TELE-CONSULTATION

International telemedicine laws are based on the location of the patient or the physician. It also applies to a physician's ability to prescribe and fulfil medicine in a specific jurisdiction. The patient-location-law is similar to other laws governing Internet-based services in that it clarifies the jurisdiction/procedure for filing a "medical malpractice or negligence complaint against the treating physician." "Peer to peer consultation laws" vary widely, but "the foreign physician typically must be licensed in the jurisdiction where they are located, and the local physician must be licensed in the jurisdiction where they and the patient are located."

Patient-location-law is similar to other laws governing Internet-based services in that it clarifies the jurisdiction/procedure for filing a "medical malpractice or negligence complaint against the treating physician." "Peer to peer consultation laws" vary widely, but "the foreign physician typically must be licensed in the jurisdiction where they are located, and the local physician must be licensed in the jurisdiction where they and the patient are located."

Best practices recommended for any global teleconsultation service by the International Society for Telemedicine & eHealth.

- Physicians providing teleconsultation services should be appropriately licensed in the patient's location and follow local health regulations.
- Physicians should be allowed to prescribe remotely to patients (when clinically necessary), with a thorough understanding of local drug names, availability, and prescribing regulations.
- Patients should be informed about the benefits and risks of teleconsultation services before consenting to such care.
- Personal health information gathered during the teleconsultation should be managed in accordance with applicable local data protection regulations. The organisation providing, or coordinating, the teleconsultation service should be certified to appropriate quality management standards
- The standard of care should be the same whether the patient is seen in person, via teleconsultation, or other electronic healthcare methods.
- If the physician is unable to diagnose or treat the patient competently and confidently via teleconsultation, the physician should refer the patient to an in-person examination before making a diagnosis or prescribing therapeutic treatment.
- A teleconsultation should not be undertaken in isolation, but should include the capability of facilitating the patient's post-teleconsultation medical care and assistance requirements.
- The physician at the patient's location should be fluent in the local language to ensure proper documentation and referral pathways when necessary.

Hipaa Guidelines and Telemedicine:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a piece of US legislation that establishes data privacy and security safeguards for medical information. Its goal is to reduce healthcare fraud and abuse by establishing industry-wide standards for healthcare data on electronic billing and other processes. It also necessitates the safeguarding and secure handling of sensitive patient health information. The Privacy Rule and the Security Rule address this, and it is extremely important in telemedicine.

HIPAA Privacy Rule:

The HIPAA Privacy Rule establishes national standards for the protection of individuals' medical records and other personal health information. It applies to health plans, healthcare clearing houses, and healthcare providers who conduct certain healthcare transactions electronically.

HIPAA Security Rule:

The HIPAA Security Rule (SR) governs electronic Protected Health Information (ePHI). The HIPAA Security Rule contains an element of the HIPAA guidelines on telemedicine that stipulates

Only authorised users should have access to ePHI.

- To protect the integrity of ePHI, a secure communication system should be implemented.
- To prevent accidental or malicious breaches, a system of monitoring communications containing ePHI should be implemented.

Third party data storage:

A medical professional or a healthcare organisation that creates ePHI that is stored by a third party is required to have a Business Associate Agreement (BAA) with the party storing the data. The BAA must include the third party's methods for ensuring data protection and provisions for regular auditing of the data's security.

INDIAN LAWS RELATED TO TELE MEDICINE:

Right to health and the Constitution of India:

The right to health has not been explicitly recognised as a fundamental right. The right to health was brought under the purview of Article 21 of the Indian Constitution by the Hon'ble Supreme Court of India. As a result, the scope of Article 21 has been expanded. Article 21 guarantees the right to life and liberty to all individuals, whether citizens or non-citizens. The concept of personal liberty is intended to include rights that may or may not be directly related to a person's life and liberty; this now includes the right to health as well. Article 21 of the Constitution's right to life has been liberally interpreted to include more than just human existence and includes the right to live with dignity and decency. Furthermore, in the Paschim Banga Khet Mazdoor Samity case, the scope of Article 21 was expanded; the court held that it is the responsibility of the government to provide adequate medical aid to everyone and to work for the general welfare. Furthermore, Article 21 imposes obligations on the State, requiring the State to protect and safeguard the rights of all people.

Right to privacy verdict:

The Supreme Court of India's Right to Privacy verdict, officially known as Justice K. S. Puttaswamy (Retd) and Anr Vs Union of India and Ors, is a landmark decision that holds that the right to privacy is protected as a fundamental right under Articles 14, 19, and 21 of the Indian Constitution. This decision clearly settled the legal position and clarified that the Right to Privacy could be violated only when there was a compelling State interest to do so. This was the same position as with the other fundamental rights. The current Indian legal regime classifies biometric data as Sensitive Data under the Privacy Rules, and the Aadhaar Act specifies a specific use-case for biometric data, which is authentication.

INFORMATION TECHNOLOGY ACT-2000:

The Information Technology Act, 2000, also known as the ITA, 2000 or IT Act, is an Indian law that addresses cybercrime and electronic commerce. It was notified on October 17, 2000. By recognising electronic records and digital signatures, this Act establishes a legal framework for electronic governance.

Salient Features of the Information Technology Act, 2000:

- All electronic contracts created through secure electronic channels are legally valid.
- Legal recognition for digital signatures.
- Security measures for electronic records as well as digital signatures. A procedure for appointing adjudicating officers to conduct inquiries under the Act has been finalised.
- Provision for establishing a Cyber Appellant judicature which can hear all appeals filed against the Controller's or Adjudicating Officer's order.
- Digital Signatures uses an uneven cryptosystem and conjointly a hash operate.
- Provision for the appointment of a Controller of Certifying Authorities (CCA) to license and regulate Certifying Authorities' operations. All digital signatures are stored in the Controller.
- The Act applies to offences or contraventions committed outside India.
- Senior law enforcement officers and alternate officers can enter any public place and conduct warrantless searches and arrests.
- Provisions for the constitution of a Cyber laws committee to advise the Centre.

Amendments in the Act:

A major modification was created in 2008, introducing Section 66A which has penalised the causation of "offensive messages".

As per the section 66-A Act, any person who sends, via a computer resource or a communication device, any information that is grossly offensive or has a menacing character; or any information or electronic mail that is known to be false and misleading, but for the purpose of causing annoyance, inconvenience, danger, obstruction, insult, injury, criminal intimidation, enmity, hatred, or ill will, shall be punished. In teleconsultation, if any of the above are discovered, the ongoing call will be terminated immediately, and strict action will be taken against the caller.

Mental Healthcare Act-2017:

The Mental Healthcare Act of 2017 went into effect on May 29, 2018. This act's ideology is to protect, promote, and fulfil the rights of people suffering from mental illnesses. It grants over 1.3 billion Indians a legally binding right to mental healthcare. While practising telepsychiatry, the MHCA 2017 should be strictly followed. All provisions of the MHCA 2017 are applicable to telepsychiatry practice, such as the definition of mental illness, capacity in relation to mental healthcare, advance directive, nominated representative, right to mental healthcare, and broad social rights for the mentally ill, among others.

Right to privacy - Section 20 MHCA 2017
Right to information - Section 22 MHCA 2017.
Right to confidentiality - Section 23 MHCA 2017
Restriction on release of information with respect to mental illness - Section 24 of MHCA 2017
Right to access medical records - Section 25 of MHCA 2017
Right to legal aid - Section 27 of MHCA 2017
Right to make complaints about deficiencies in provision of services - Section 28 of MHCA 2017
Presumption of severe stress in case of attempt to commit suicide - Notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code.

Right to privacy - Every person with mental illness shall have a right to privacy under Section 20 MHCA 2017

Right to information- Under Section 22 of MHCA 2017, a person with mental illness and his nominated representative shall have the rights to know the nature of the person's mental illness and the proposed treatment plan which includes information about treatment proposed and the known side effects of the proposed treatment and to receive the information in a language and form that such person receiving the information can understand.

Right to confidentiality (Section 23 MHCA 2017) - 1) A person with mental illness shall have the right to confidentiality in respect of his mental health, mental healthcare, treatment and physical healthcare.

2) All health professionals providing care or treatment to a person with mental illness shall have a duty to keep all such information confidential which has been obtained during care or treatment with the following exceptions, namely: –

(a) Release of information to the nominated representative to enable him to fulfil his duties under this Act;
(b) Release of information to other mental health professionals and other health professionals to enable them to provide care and treatment to the person with mental illness.
(c) Release of information if it is necessary to protect any other person from harm or violence. Only such information that is necessary to protect against the harm identified shall be released.
(d) Release only such information as is necessary to prevent threat to life.
(e) Release of information upon an order by concerned Board or the Central Authority or High Court or Supreme Court or any other statutory authority competent to do so.
(f) Release of information in the interests of public safety and security.

Restriction on release of information in respect of mental illness (Section 24):

(1) No photograph or any other information relating to a person with mental illness undergoing treatment at a mental health establishment shall be released to the media without the consent of the person with mental illness.
(2) The right to confidentiality of person with mental illness shall also apply to all information stored in electronic or digital format in real or virtual space.

Right to access medical records (Section 25)

(1) All persons with mental illness shall have the right to access their basic medical records as may be prescribed.
(2) The mental health professional in charge of such records may withhold specific information in the medical records if disclosure would result in – (a) serious mental harm to the person with mental illness; or (b) likelihood of harm to other persons.
(3) When any information in the medical records is withheld from the person, the mental health professional shall inform the person with mental illness of his right to apply to the concerned Board for an order to release such information.

Right to legal aid (Section 27)

(1) A person with mental illness shall be entitled to receive free legal services to exercise any of his rights given under this Act.
(2) It shall be the duty of magistrate, police officer, person in charge of such custodial institution as may be prescribed or medical officer or mental health professional in charge of a mental health establishment to inform the person with mental illness that he is entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered and provide the contact details of the availability of services.

Right to make complaints about deficiencies in provision of services (Section 28)

(1) Any person with mental illness or his nominated representative, shall have the right to complain regarding deficiencies in provision of care, treatment and services in a mental health establishment to: (a) the medical officer or mental health professional in charge of the establishment and if not satisfied with the response; (b) the concerned Board and if not satisfied with the response; (c) the State Authority
(2) The provisions for making complaint in sub-section (1) is without prejudice to the rights of the person to seek any judicial remedy for violation of his rights in a mental health establishment or by any mental health professional either under this Act or any other law for the time being in force.

Presumption of severe stress in case of attempt to commit suicide

1) Notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code.
(2) The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.

- The POCSO ACT 2012 defines a child as anyone under the age of 18, and it protects all children under the age of 18 from sexual assault, sexual harassment, and pornography.
- It also provides for the establishment of special courts to hear such offences and related matters and incidents
- The Act is gender neutral
- It defines "child pornography" as any visual depiction of sexually explicit conduct involving a child, including a photograph, video, digital or computer-generated image indistinguishable from an actual child, and an image created, adapted, or modified but appearing to depict a child

The Ministry of Women and Child Development introduced the Protection of Children from Sexual Offenses (POCSO) Act in order to effectively address the heinous crimes of sexual abuse and sexual exploitation of children through less ambiguous and more stringent legal provisions. The Act was passed in the Indian Parliament in May 2012, and it defines a child as anyone under the age of 18, and it protects all children under the age of 18 from sexual assault, sexual harassment, and pornography. It also provides for the establishment of special courts to hear such offences and related matters and incidents.

The Act is gender neutral, and it prioritises the child's best interests and welfare at all stages to ensure the child's healthy physical, emotional, intellectual, and social development.

It distinguishes between different types of sexual abuse, such as penetrative and non-penetrative assault, as well as sexual harassment and pornography, and considers sexual assault to be "aggravated" in certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by someone in a position of trust or authority over the child, such as a family member, police officer, teacher, or doctor. People who traffic children for sexual purposes are also punishable under the Act's abetment provisions. The Act provides for harsh punishment graded according to the gravity of the offence, with a maximum term of rigorous imprisonment for 10 years or life, as well as a fine. It defines "child pornography" as any visual depiction of sexually explicit conduct involving a child, including a photograph, video, digital or computer-generated image indistinguishable from an actual child, and an image created, adapted, or modified but appearing to depict a child, with a 5-to-7-year prison sentence and a fine. (Amendment Bill 2019)

The Act was amended in 2019 to make provisions for enhanced punishments for various offences in order to deter perpetrators and ensure a child's safety, security, and a dignified childhood.

This Act is divided into nine chapters-

- Chapter 1 discusses the definition of a child, assault, harassment, child pornography, and special courts.
- Chapter 2 discusses various offences involving children, such as sexual assault and harassment, as well as their respective penalties.
- Chapter 3 goes into detail about child pornography, its storage, and related crime.
- Chapter 4 discusses abetment and attempting to commit an offence.
- Chapters 5 and 6 describe the procedure for reporting cases and recording a child's statement, respectively.
- Chapter 7 discusses special courts, including the designation of special courts, the presumption of certain offences and culpable mental state, the application of the criminal procedure code, and the availability of public prosecutors.
- Chapter 8 covers the procedures and powers of the special courts, as well as the recording of evidence, which includes the procedures and powers of the special courts, the period of recording of evidence of the child and the disposition of the case, the child not to see the accused while testifying, and trials to be held in camera. (POCSO 2012).
- Chapter 9 covers miscellaneous aspects like guidelines for the child to take assistance of experts etc.

The Ministry of Women and Child Development amended the POCSO in July 2019, increasing the minimum punishment for penetrative sexual assault by 10 years, including the death of the child and crime committed in natural calamity in aggravated penetrative sexual assault and increasing the punishment up to 20 years and maximum death sentence along with fine. The amendment also increased the penalty for child pornographic use from 5-7 years to death, depending on the crime. (Amendment 2019)

Domestic Violence Act, 2005

Definition of domestic violence - For the purposes of this Act, any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it:

a. harms or injures or endangers the health, safety, life, limb or well-being, **whether mental or physical,** of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or

b. harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet **any unlawful demand for any dowry or other property or valuable security**; or

c. has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or (d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person.

A service provider - Any voluntary association registered under the Societies Registration Act, 1860 (21 of 1860), or a company registered under the Companies Act, 1956 (1 of 1956), or any other law for the time being in force with the goal of protecting the rights and interests of women by any lawful means, including providing legal aid, medical, financial, or other assistance, shall register with the State Government as a service provider for the purposes of this Act, and shall have the authority to provide legal aid, medical, financial, or other assistance.

(a) **If the aggrieved person wishes, record the domestic incident report in the prescribed form and forward a copy to the Magistrate and the Protection Officer** with jurisdiction in the area where the domestic violence occurred.

(b) **Get the aggrieved person medically examined and send a copy of the medical report to the Protection Officer and the police station** where the domestic violence occurred.

(c) **Ensure that the aggrieved person receives shelter in a shelter home**, if necessary, and forward a report of the aggrieved person's lodging in the shelter home to the police station within the local limits of which the domestic violence occurred.

No suit, prosecution, or other legal proceeding shall lie against any service provider or member of the service provider who is, or is deemed to be, acting or purporting to act under this Act for anything done or intended to be done in good faith in the exercise of powers or discharge of functions under this Act to prevent the commission of domestic violence.

MAINTENANCE AND WELFARE OF PARENTS AND SENIOR CITIZENS ACT, 2007:

Maintenance and Welfare of Parents and Senior Citizens Act 2007, is a legislation initiated by the Government of India's Ministry of Social Justice and Empowerment to provide more effective provisions for the maintenance and welfare of parents and senior citizens. It was enacted to provide senior citizens with financial security, welfare, and protection. It requires children to support their parents and the government to provide old-age homes and medical care for senior citizens. In 2019, it was amended into a bill with changes (amendment 2019). It states:

"An Act to give effect to the provisions for the welfare of parents and senior citizens as guaranteed and recognised under the Constitution by providing for the maintenance and welfare of parents and senior citizens, ensuring their overall physical and mental well-being, establishment, management and regulation of institutions for senior citizens and services therefor and for other matters connected therewith or incidental thereto."

This Act includes provisions to protect senior citizens' lives and property. This Act also calls for the establishment of old age homes to care for indigent senior citizens and parents. It applies to the entire country of India, with the exception of the State of Jammu and Kashmir, which has its own Act for Senior Citizens. It also applies to Indian citizens living outside of India.

This act has 7 chapters and 32 sections.

- The first chapter is the Preamble, which includes a brief title, the country's scope, and various definitions (of senior citizen, children, property, tribunal etc.).
- The second chapter discusses parental and senior citizen maintenance, jurisdiction and procedure, the constitution of the Maintenance Tribunal, the deposit of maintenance amount, the constitution of the Appellate Tribunal, various appeals, the right to legal representation, and so on.
- The third and fourth chapters, respectively, address the establishment of old-age homes and medical assistance for senior citizens.
- Chapter 5 discusses the protection of senior citizens' lives and property under the headings of publicity and awareness for senior citizens' welfare, authorities responsible for the same, and property transfers that are void in certain circumstances.
- Chapter 6 covers offenses and procedure for trials for exposure and abandonment of senior citizens, as well as cognizance of offences, are covered in Chapter 6.
- Chapter 7 is titled Miscellaneous.

The Amendments proposed by the Maintenance and Welfare of Parents and Senior Citizens (Amendment) Bill, 2019 includes step and adoptive children, grandparents and in-laws, include healthcare, safety, and security for parents and senior citizens, housing, clothing, and safety, changes in punishment, and inclusion of elder abuse with imprisonment between three and six months, or a fine of up to Rs 10,000, or both. It also includes homecare services and police protection. (**Amendment Bill 2019).**

LEGAL SERVICES AUTHORITIES ACT, 1987:

This Act provides free legal services to scheduled castes or scheduled tribes, women and children, victims of human trafficking, persons with disabilities, persons with mental illness, victims of disasters, persons in custody, and persons with an annual income of less than Rs 9,000 or such other higher amount as the State Government may prescribe. Persons covered by the Act are entitled to legal counselling (advice and guidance on a legal matter), legal advice (interpreting the law to a given set of facts), legal representation (legal work performed on behalf of a client by a licensed attorney), and legal adjudication (legal procedure for settling a dispute) free of charge. After examining an applicant's eligibility criteria and the existence of a prima facie case in his/her favour, Legal Services Authorities should provide him/her with counsel at State expense, pay the required court fee in the matter, and bear all incidental expenses in connection with the case. Once a Legal Services Authority has approved legal aid, the person receiving it is not required to spend any money on the litigation.

Case Scenario

Mr A gives a call on Tele-MANAS saying his friend is suffering from mental health issues such as low mood, crying spells, frequently expressing that he wished he were dead, but despite his requests to consult with a mental health professional, his friend declined and has apparently continued to suffer from the same issues. Mr A called on his behalf. He has not informed his friend regarding this. How would you proceed as a tele-counsellor?

A- Educate Mr A about the availability of services (Online and offline)

1. What are the ethical considerations in this case?
   A- Autonomy, Informed Consent

2. What should Mr A do, as he is very concerned about his friend expressing death wishes?
   A- Reassure Mr A and ask him to inform his friend's family members regarding his concerns and in-turn ask them to contact nearest health professional for early intervention and appropriate treatment to be started.

How would you handle this call as a Tele-MANAS Counsellor?

- ✓ Express appreciation for the person to taken up the initiative
- ✓ Collect basic details of caller and enquire regarding relationship to the patient if any (to enable call back if required)
- ✓ Explain to them the procedures required to seek help
- ✓ Reassure that the person is not liable financially or legally as the person is not related
- ✓ Advice to approach nearest police station to take the individual to the nearest mental health establishment where he can be evaluated further.
- ✓ Respond to their myths and misconceptions about mental illness, if any.
- ✓ Reassure that once treated, the individual is likely to significantly improve and educate regarding the availability of treatment free-of-cost for such individuals at govt facilities.
- ✓ Ask if the caller needs any further assistance
- ✓ Close the Call

MODULE 15

Challenging Situations in Counselling

Objectives of this module

To know about mental health crisis and situations which can lead to it
To know role of counsellors in mental health crisis
To learn to deal with challenging situations in counselling

What is Tele-Counselling?

Tele-counselling is a service by which trained counsellors provide telephone-based mental health support.

What as a Crisis?

Crisis refers to unplanned events that occur without forewarning which cause major disturbances in the individual's life and trigger a feeling of being threatened or incite fear in the person. When an individual's coping mechanisms are affected due to the circumstances in the absence of mental illness it leads to a crisis.

What are the Stressors/ Situations that can lead to crisis?

- Loss: Loss through any near and dear one's passing away, separation, divorce, financial loss, physical illness (loss of health)
- Changes in life situations: Job, shift of place, marriage, retirement
- Problems: At work, in relationships, finances, legal issues

What are the normal reactions to a crisis?

- Helplessness
- Confusion
- Anxiety
- Sadness
- Anger
- Erratic thought process
- Sleep disturbances
- Physical symptoms: Body aches, headache

What are the abnormal or serious reactions to crisis??



What are the extreme responses which require immediate referral??

- Recent Suicidal attempt: To address immediate medical complications and to assess the need for medications without prescription
- Resorting to aggression not amenable to the discussion (verbal de-escalation)
- Developing new-onset psychiatric symptoms: Such as suspiciousness, having odd experiences such as hearing voices, not eating, or not sleeping at all, forgetfulness
- Substance use: Intoxication-related problems, dependence/addiction to the substance if substance use increases

What is the role of a counsellor in crisis?

- Counsellors who are community members, volunteers etc. have a central role in handling crisis
- "Counsellor" helps to identify and intervene at the earliest
- Reaches out and provides immediate help required before the crisis causes long-term damage
- Providing Psychological First Aid

What is the goal of counselling in a crisis situation?

Crisis counselling:

- Help individual return to the previous mind set / equilibrium
- Provide relief of emotional disturbances
- Provide support – without any conditions
- Provide reassurances whenever situation warrants
- Focus on the current situational difficulty and find ways to cope with the situation

What is purpose of crisis counselling?

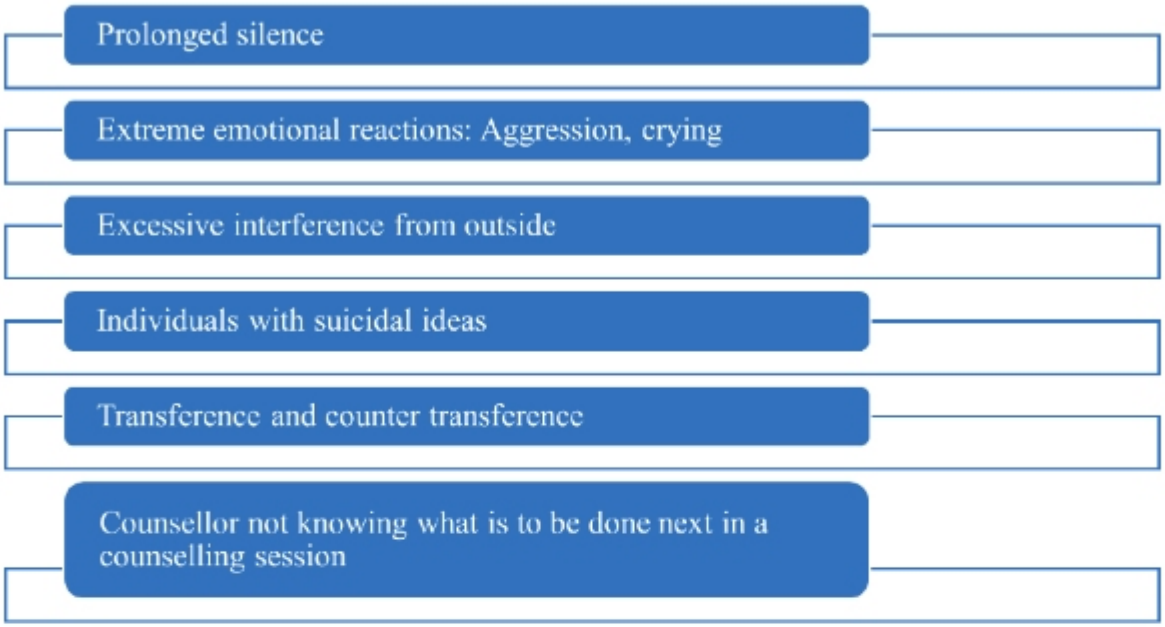
- Reduce the individual's physical, emotional, behavioural reactions to the crisis
- Focus on short term strategies to mitigate the effects of the situation
- Help individual to cope with the current situation and return to normalcy at the earliest – to prevent long-term effects such as risk of future mental illness - depression, post-traumatic stress disorder etc.
- To help individual return to normal functioning at the earliest
- Educational component – ability to cope with the current situation will be beneficial in terms of future problem-solving skills

What are the strategies to be employed in crisis counselling??

- Remaining calm and in control of the situation
- Allowing ventilation: Letting a person cry if he/she wants to or is crying already
- Allowing the anger / sadness to be displayed
- Listening and explore the situation the person is facing
- Statements which can help normalise the reactions: "It is OK to feel like this"
- Acknowledging the perceived severity of the situation (What the crisis means to the person is more important) "you must be feeling hopeless about the situation, all your attempts have not been successful"
- Identifying the already existing mental strengths
- Problem solving should focus on one issue at a time

Dealing with challenging situations during counselling:

What are the likely challenging or difficult situations?



How to deal with difficult situations?

- Accept the situation and try to process the hurdle you are facing
- Do not give up at an initial stage
- Go back to the counselling process: Components of active listening, reflective listening, being empathetic
- Revisit your role as a counsellor and the targets for the counselling session
- Clarify with questioning with the client when you feel you haven't understood their problem fully
- Seek advice from your peers or supervisor whenever you feel it's needed

Dealing with prolonged silence:

Silence in a session may indicate many things. The client:

- May be hesitant in discussing the conflict/concern further
- May be overcome by emotion
- May be experiencing a block mentally and unable to go onto the next thought
- May be thinking over some important thoughts which may have just occurred to him or her ; or thinking over counsellor's suggestions
- May expect some reassurance from the counsellor regarding an issue which has just been spoken about
- May be feeling angry towards the therapy or the counsellor.
- May have finished what he had to say
- May be thinking of what to say next

Dealing with crying during counselling:

- Crying is very common when you are dealing with a crisis
- May occur in an unexpected time during the session

What not to do?

- Stopping the person from crying
- "Its OK don't cry, don't worry" - is inappropriate in such a situation
- The counsellor should not feel embarrassed while the person is crying

Dealing with crying…

- Crying indicates the client "TRUSTS" the counsellor
- He/she is ready to discuss and let his/her innermost emotions visible to the counsellor
- As a counsellor you take this as an opportunity to discuss their emotions and inner turmoil
- Acknowledge the distress – Example - "This must be very upsetting for you"

Dealing with inappropriate emotional expression:

- Display of anger or hostility, extreme closeness can be difficult to handle during a session
- Progress of the sessions is often hindered by this
- Display of anger should be allowed to a certain extent
- Indicate your discomfort when the client is unable to stop
- Avoid aborting the session abruptly
- If client attempts to get too personal /seeks physical reassurance – explain your role as a counsellor.
- Be firm in your statements – Example - "I am here to listen and help you"

Dealing with suicidal ideas:

- Work in similar lines of handling crisis
- Ask about it
- Let the person talk about suicidal ideas "Talking about suicide or asking if a person has suicidal thoughts does not increase risk of suicide"
- Assess the immediate risk of suicide – ask if the person has active plans, recent attempts
- Check for depression
- Involve other support systems –family and friends or other social agencies

What to do……. when you are not aware of what to do in a counselling session?

- Counsellors may sometimes face situations in which they are stuck
- Do not know what to say or ask, or how to continue with the counselling session
- Ask questions which will help you explore the problem more…
- Enquire about what they like about themselves?
- Enquire regarding how they take care of themselves?
- Enquire regarding their support systems?
- How do you seek or recieve help from people around them?
- How do they allow individuals around them to help, when in need?

Case vignette

- A 32-year-old female calls tele helpline number, stating that she has recently had a break up and feels very alone and distressed. She says that her boyfriend cheated on her and she never expected this. She starts crying and asks for help. What should be done next?
- Allow her to express her emotions freely and avoid making statements like "Don't worry", "Don't cry". Try to calm her down by being empathetic and non-judgemental.
- Acknowledge her condition by making statements like "This must be very upsetting and difficult for you right now", "You have had a difficult time dealing with these over last few days", "I am here to listen and help you".
- Ask questions which help to explore the situation more.
- Ask about family support and contact family/friends in whom she confides in and request them to be supportive and caring.
- Ask about other symptoms like persistent low mood, ideas of self-harm/suicide, disturbed sleep and decreased appetite. If any such symptoms are present, she should be referred to nearest mental health facility and advised to seek professional help from a psychiatrist.

References/ Additional readings:

1. Abbas, J., Wang, D., Su, Z., & Ziapour, A. (2021). The role of social media in the advent of COVID-19 pandemic: crisis management, mental health challenges and implications. Risk management and healthcare policy, 14, 1917.
2. Wang, D., & Gupta, V. (2020). Crisis Intervention.
3. Rosen, A. (1997). Crisis management in the community. Med J Aust, 167(11-12), 633-8.

MODULE 16

Handling Difficult Scenarios : Suicide / Aggression / Risk of Harm to Others

Objective of this module

- What is suicide and how is it different from other self-harm behaviours?
- What are the signs and symptoms of suicide?
- What are the warning signs and symptoms of suicide?
- What are the Do's and Don'ts in a suicidal patient?
- How to approach a family of a suicidal patient?
- What are the helplines for suicide?
- How does aggression present in severe mental disorders?
- What is disorganisation and how does it present?
- How to interview patients with aggression?
- What are the Do's and Don'ts while dealing with aggressive individuals?

Importance of the problem

As per World Health Organisation (WHO) Report 2014, one person dies of suicide every 40 seconds and more than 8 lakh people commit suicide every year, and suicide attempts are 10 times the number of completed suicides. In India Family problems are the commonest cause of suicide as per the National Crime Bureau Record (NCRB) 2020 report. There is no single explanation of why people die by suicide. However, many suicides appear impulsive but can often be identified timely and prevented.

What is suicide?

Suicide has been defined as 'self-inflicted death with evidence (either explicit or implicit) that the person intended to die'. It is complex and tragic but often preventable. This chapter will attempt to describe how to identify suicidal tendencies in people and help them.

"A 25-year-old woman N, widowed, has lost her job recently, living with family, belonging to low socioeconomic status has symptoms of sad mood, feels tired, has decreased concentration and has lost interest in enjoyable activities for the past 6 months. Although she never attempted suicide, she reports she has been having thoughts regarding jumping into the river nearby but has not got opportunity to do so."

Imagine a scenario where you have been encountered with a problem like this. How will you identify, assess the family and the patient? What will you advise the family?

Handling suicidal patients can be a challenging task and you need to have good communication skills and understanding in order to handle the situation.

Ask direct questions -

If you suspect a person of having suicidal ideas, it is advisable to approach them promptly and directly. You can express your concerns directly to the person and also describe the changes in them that have led you to be concerned. The person can be directly asked the following questions:

- When people are stressed or troubled, they often think of death, have you had any such thoughts?
- When people are feeling low and depressed, they may have thoughts or plans of hurting themselves, have you had any such thoughts recently?
- Avoid questions like "Are you suicidal?" as these questions may convey a lack of understanding from you.

Do not hesitate to use the word suicide. Using the word suicide doesn't put the idea of suicide in a person's mind as many people falsely believe. Also, any expressed thoughts of suicide are to be taken seriously and not to be dismissed.

While interviewing, you need to determine how serious the threat of suicide is. Ask the person about issues that draw attention to their immediate safety. It is important to assess the immediate risk of the caller attempting suicide. In order to determine the risk, ask the following questions:

- Any plans for suicide: If "Yes" then ask, how the caller plans to end life. Ask the person where and when he/she has planned to attempt?
- If they have already secured the things to carry out their plan (like searching on Internet for methods, finalising the method to attempt)
- Past history of suicidal attempt ** If past history is present then the risk of repeat attempting is high
- Alcohol or other drug use increases the further risk of suicide as it affects their decision-making capacity.

Signs and Symptoms -

Also, actively search for any signs and symptoms that are present in people with suicidal tendencies which are as follows. These symptoms and signs may also point towards presence of a mental disorder which will also require additional intervention in the form of medication.

- Reduced interaction with other people, including loved ones.
- Feeling tired constantly, both physically and mentally.
- Appearing unhappy most of the time. Frequent crying spells may be present.
- Increased anxiety, irritability.
- Significant changes in sleep (disturbed sleep or sleeping excessively) and food intake.
- Increased alcohol, tobacco or other drug use.
- Excess anger or talking about seeking revenge.
- Experiencing rapid mood swings (feeling extremely happy and then suddenly becoming angry without reason or context).
- Expressing negative views of self and the future like "I am going to fail".
- Expressing, in words or actions, that they feel trapped in life, like there is no way out, or that they are unable to find a solution to their problems (**Feeling Helpless**)
- Talking more often about death, expressing wishes of dying as a means of escape to end their suffering (**Feeling Hopelessness**)
- May start planning for the future after their demise by trying to get their affairs in order (giving away valued possessions, creating a will) or entrust others with responsibilities like taking care of loved ones.

Brief History: (look for warning signs or symptoms, suicidal intent, any signs of depression or stress, social support. There are three scenarios one may encounter while addressing an individual with possible suicide risk

i. Recent suicide attempt and has active plan
ii. Active plan, but no attempt
iii. Occasional wish to die, but no active plan

- **Immediate referral to the nearby hospital (for hospitalisation) * - preferably to a mental health professional when there has been recent attempt**
- Follow up regularly after the discharge
- Talk to the family
- **Continuous monitoring of the person: Family or caregiver should keep an eye and accompany the individual at all times**
- Support patient
- Emergency referral SOS
- Looking for ways to kill themselves including seeking information about the possible methods (ease, the lethal dose of drugs, amount of pain) and/or seeking access to drugs, weapons, etc.

While talking to these patients, keep in mind the Do's and Don'ts-

DO'S –

- Be patient and calm
- Express concern like "I understand your feelings" "I will be able to help you".
- Reassure them and encourage them to express their feelings and also vent their emotions by crying, etc.
- Be non-judgemental
- Summarise from time to time to show you are listening
- Do not hesitate to clarify if you have any doubts
- Thank the person for sharing their feelings

DON'T'S-

- Argue or debate about their feelings
- Being judgemental about the person or the concept of suicide
- Minimising their problems
- Using guilts or threats to prevent suicide
- Giving hollow and empty reassurances like "cheer up", etc.
- Interrupting with our own stories, drawing comparison between their problems and ours or others'
- Attempting to diagnose them yourselves

Helping a suicidal person:

A basic approach that can be followed for suicidal person are: *Hospitalisation is needed if.

- Active psychopathology present i.e., person has mental illness such as depression, psychosis or substance addiction
- Attempt was violent or near-lethal
- Intent persists
- Patient regrets surviving
- Limited family or social support

As a counsellor helping a suicidal person and their family, following advice has to be given

- Make sure that the family members don't leave the person alone for any period of time.
- Patients can be encouraged to distract from suicidal thoughts by listening to music, do exercise and reaching out to people offering help.
- Patients can be encouraged to call you at any time and share their concerns or worries. You can reassure them saying that you are available to them via phone or message all the time.
- Gain the person's trust and try to place the means of suicide (drugs, weapons, etc.) out of their reach.
- Involve other loved ones of the patient.
- Seek professional help preferably after taking the person into confidence. If the person refuses to seek professional help, you should still consult a professional and express honestly to the person that you will be doing so.
- No-suicide contracts: Try to draw an agreement with the person, not to act on the thoughts of suicide for a specified period of time.
- It is highly important for you to take care of yourself as providing support to a suicidal person can be exhausting.

There are several suicide prevention helplines in India.
Some of them are listed below-

- Aasra (Navi Mumbai)– 91-22-27546669
- Connecting India (Pune)– 9922001122, 18002094353
- Maithri (Kochi)– 91- 484 – 2540530
- Maitreyi (Pondicherry) – +91-413-339999
- The Samaritans Mumbai – 022 6464 3267, 022 6565 3267, 022 6565 3247
- Sneha (Chennai) – 91-44-2464 0050, 91-44-2464 0060
- Lifeline Foundation (Kolkata) – +91 33 24637401, +91 33 24637432
- Nagpur Suicide Prevention Helpline – 8888817666
- Roshni (Secunderabad)– 040 790 4646
- Saath (Ahmedabad)– 079 2630 5544, 079 2630 0222

Some of the Myths and Facts to be aware while helping individuals at risk of suicide and to educate their caregivers.

Myths about suicide	**Facts**
Once suicidal is always suicidal	Short-term and situation-specific
Using the word "Suicide" induces suicidal thoughts	Talking openly gives the person an option to discuss
Occurs only in persons with mental illness	Not so. Mostly situational basis
Happens without any warning	Warning signs are present, either verbal or behavioural
Someone who is suicidal is determined to die	They are ambivalent about living or dying. Hence emotional support will help them
People who talk about suicide do not mean to do it	Expression of anxiety and depression.

Aggression and disorganised behaviour

Severe mental disorders (SMDs) include a diagnosis of schizophrenia, bipolar disorders and other psychotic disorders. These illnesses are usually chronic illnesses and results in significant disability in day-to-day functioning. It is also associated with poor physical health and reduced life expectancy and often present with aggressive behaviours and disorganisation

Let's see few common scenarios one may encounter while dealing with SMDs.

1. Mr A is becoming very irritable!

Mr A is a 20 year old student. He used to help his father on the farm, but for the last 10-15 days, he is neither attending college nor going to the farm. Father noted that for the last 3-4 months he preferred to be alone, he spoke less. He refused to take bath and rarely changed his clothes. When family attempted to engage him in conversation, he would get angry and had also become aggressive suddenly. He has also been suspicious towards his family and often told that the neighbours are doing black magic and has been talking to himself. Father reported that he had never seen his son behave this way before.

What is the problem?

Mr A is suffering from psychosis as he is hearing voices and becoming suspicious of others without any reason or logic.

2. Don't worry! We have tied him with ropes

Mr B is a 28-year-old man who is married and a respected member of his community. However, since the past few months he has been behaving oddly as per his wife and friends. He has stopped eating and stays awake throughout the night. He has been noted becoming violent too. His wife took him to local dargah, as they believed this might be due to 'Evil Eye'. However, since he did not improve and there was increasing risk of him hurting others, family tied him and kept him indoors. Neither Mr B, nor his family, have any understanding of psychotic illness.

Like the scenario discussed above, many people failed to recognise the symptoms described are signs of Severe Mental Disorder, they often resort to magico-religious methods to help the suffering individual.

Clearly, Mr B behaviour posed risk to himself and others around him. However, the best way to manage these risks would be for the family to acknowledge that he is ill and needs to see a doctor for appropriate treatment.

3. I don't know what is happening to my wife!

Mrs C recently has been the talk of the town. She is been observed to behave in an unusual manner for the past few weeks. She appears quite restless and constantly on the move. For the past few days, she has not slept at all. She is talking much more than usual, even with strangers walking on the road. She is spending all her money in buying new clothes and accessories which was not her previous self. She is not taking care of the children and household and the family is very worried regarding this change in her behaviour. On asking about it, she says that she is the daughter of the state's chief minister and need not worry about the money at all (which is not true in her case as the family belongs to lower socio-economic status and her father is a factory worker)? Now, her husband has called to Tele-MANAS and has asked for help.

A person with SMDs particularly psychosis loses touch with reality and cannot differentiate between reality and their symptoms of mental illness. Psychosis is an illness which not only causes distress to the patient but the behaviours cause distress to others around them too. **The level of distress and the disability due to illness increases if the illness remains untreated.**

A person with severe mental disorder can be observed to have/ be:

- Talking or muttering to self
- Firm beliefs that are plainly false
- Withdrawn socially
- Poor self-care
- Odd behaviour that is not understandable and not logical
- Socially unacceptable behaviour
- Un-understandable speech
- Fearfulness
- Restless & irritable for no reason
- Difficulty in thinking and concentrating
- Wandering aimlessly - patient goes out without reason or without destination at odd hours which could be even at the middle of the night.
- Lack of emotional response
- Overactive, over cheerful, reduced sleep and talking loudly and fast.

So, once you have correctly identified the mental illness, referral may be required to the health centre where appropriate medication and evaluation can be carried out. It will be better if you keep the address and the phone number of the place in your notes to ensure follow-up is done.

Also, you will have to decide whether this patient would need **urgent or non-urgent referral**. As a general rule, it is best to refer urgently to specialists after discussion with Tier 2 MHPs in the following conditions-

- Patient has uncontrolled seizures.
- Patient looks confused and has abnormal behaviour.
- Patient's change in behaviour has started with physical symptoms like high grade fever.
- There is an evidence of head injury.
- Patient has made a serious suicide attempt and needs urgent care.

Early identification is important in the management of severe mental illness. Medication is a vital component of treatment and is often highly effective in reducing the patient's difficulties. Please remember that effective treatments are available for management for severe mental illness.

Wow to provide counselling?

To pateint:

- Communicate with respect
- Be calm and reassure the person by talking to them
- Listen actively- do not give an impression to the patient that you are distracted. Try not to interrupt them. Show them that you are listening actively by keeping still and focused.
- Respect the confidentiality of the patient - never discuss the story of the person except the treating team.
- Communicate to them that –

  -The symptoms are a part of mental illness and can be treated
  -Smoking tobacco & drinking alcohol or any other kind of drug use will worsen illness and decrease effect of medications.

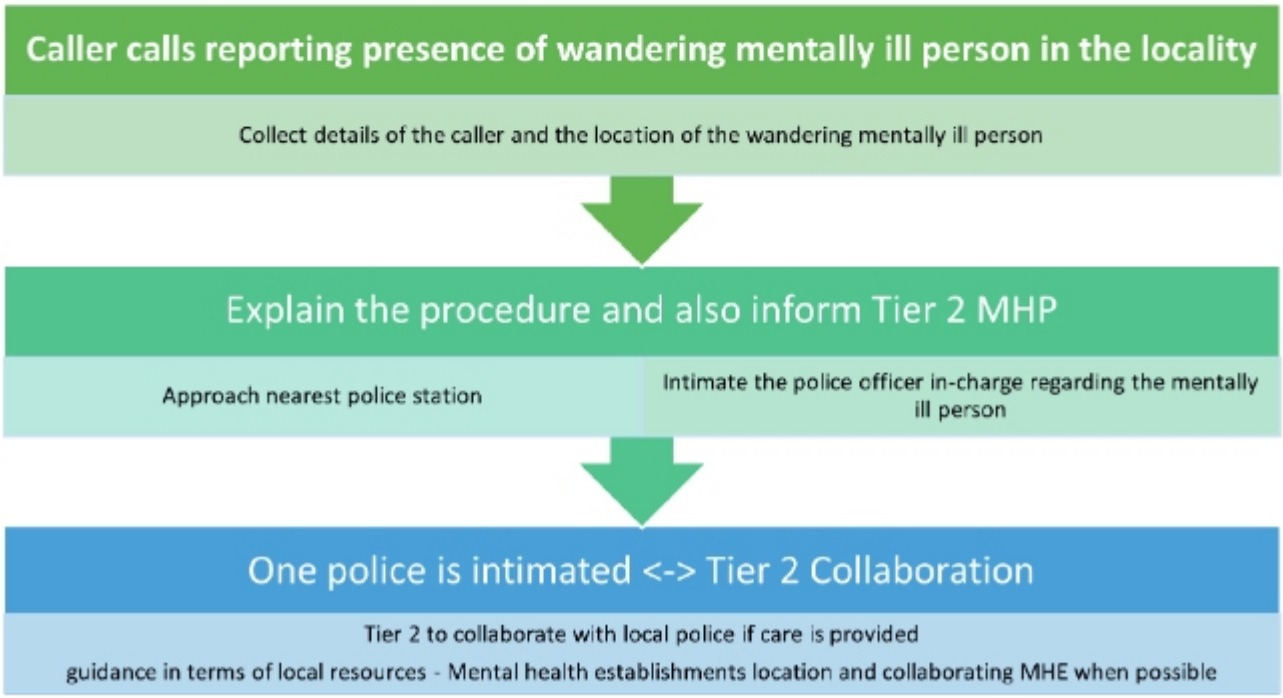
To family:

Advise/suggest the family that –

- Black magic or bad food or bad parenting does not cause these problems
- These problems can be treated effectively
- To continue the medications as advised and consult the doctor regularly as advised
- One person in the family should supervise the medications.

Dos and Don'ts

- Keep the patient engaged in some activity.
- Encourage the patient to talk to others, but, don't force.
- Encourage the patient to do simple tasks, but, don't criticise him if he/she's unable to do so.
- Do not argue or challenge patient's beliefs as there are chances that they become more irritable.
- Do not try to comment or criticise patient in front of others or alone.



Homeless Wandering Mentally ill Person:

Another challenging situation as counsellor one may encounter is when advice/assistance is sought for homeless wandering mentally ill individuals. In India there are approximately 5 lakh wandering mentally ill and several of these individuals suffer from severe mental disorder Schizophrenia.

With increasing awareness regarding mental health issues, general public too has often come forward to seek help for wandering mentally ill. Therefore, persons who are unrelated to the affected individual with mental illness can call the helpline services seeking assistance and guidance to help the person access mental healthcare.

Case Scenario

A middle aged male has been found wandering around a market in a disheveled manner since 2 weeks and nobody in the locality recognise this person, he has been noted to be wearing dirty clothes, when people of the community have tried to talk to him, he does not respond and only mumbles. He has also been noted to be talking to himself and people have seen him making gestures as though there is somebody talking to him. A person in the public residing nearby sees the plight and decides to help him as he believes the person may be having mental illness and requires treatment. He calls the Tele-MANAS helpline asking for assistance.

What is the likely problem?

Based on the description, there is possibility the person is suffering from severe mental disorder possibly schizophrenia.

What to do next?

As discussed wandering mentally ill individuals are quite huge in number and with early and correct treatment, most of them respond well and return to their homes or in a position to be rehabilitated.

As per MHCA 2017 Section 100, police officer of the jurisdiction should take up the responsibility to get an individual who is homeless and likely to be mentally ill for medical evaluation. The police officer should facilitate transport and getting the person evaluated for medical problems and mental illness. If the MHP through evaluation reports that the person has mental illness, then the person is to be admitted to a mental health establishment to ensure adequate treatment is provided and once improved rehabilitation can be undertaken. It is important to note that a person in the community who identifies such individual can approach the nearest police station for help and the police should carry out the necessary interventions required. No liability lies on the individual of the community who is unrelated to the person with mental illness.

Responding to the caller

It is important to respond such that the caller may take steps to provide assistant to the wandering mentally ill person.

- Express appreciation for the person on his initiative
- Collect basic details to enable call back if required
- Explain to them the procedures required to seek help
- Reassure that the person is not liable financially or legally as the person is not related
- Advice to approach nearest police station or mental health establishment (government medical college or mental health establishment) with the details of the person
- Respond to their myths and misconceptions:
  - Example: Not all mentally individuals are dangerous
  - If not aggressive the person may approach and attempt to collect details of the mentally ill if cooperative
  - No legal or financial liability on the caller
- Explain once presence of mental illness is confirmed the treatment and care will be ensured and taken care by respective government departments.
- A follow-up call and referral to Tier 2 has to be done
- Tier 2 can collaborate with the local police to ensure evaluation and care is provided

References:

1. World Health Organisation. Preventing suicide: a global imperative. Geneva; 2014
2. Manjunatha N, Kumar CN, Math SB, Thirthalli J. Clinical Schedules for Primary Care Psychiatry. 2nd ed. Vol. Version 2. 2020. 1–10 p
3. Baker AL, Turner A, Beck A, Berry K, Haddock G, Kelly PJ, Bucci S. Telephone-delivered psychosocial interventions targeting key health priorities in adults with a psychotic disorder: systematic review. Psychological Medicine. Cambridge University Press; 2018;48(16):2637–57.
4. Gentile JP, Niemann P. Supportive psychotherapy for a patient with psychosis: schizophreniform disorder. Psychiatry (Edgmont). 2006 Jan;3(1):56-61
5. NIMHANS. (2020, April 17). GUIDELINES FOR TELE-PSYCHOTHERAPY SERVICES. www.Nimhans.Ac.In. https://nimhans.ac.in/wp-content/uploads/2020/04/Guidelines-for-Telepsychotherapy-Services-17.4.2020.pdf

MODULE 17

Mental Health First Aid

Objectives of this module

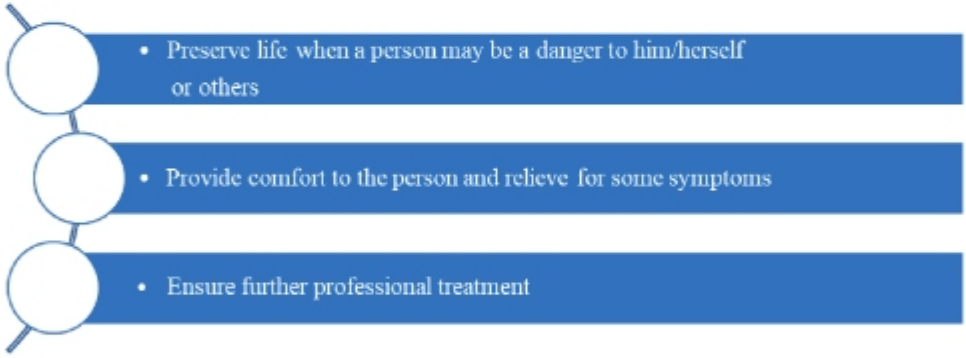
- To know what is mental health first aid
- Principles of mental health first aid
- Components of mental health first aid
- Essential steps in mental health first aid

Mental health first aid or Psychological First Aid (PFA) is not very different from first aid given in any physical illness or injury. The aim of the first aid is not to cure the illness, but to save life and provide immediate relief. The same is done in cases of mental illnesses or mental distress.

Psychological first aid refers to a supportive and empathetic response provided to anybody who is suffering. PFA involves not just psychological, but also social support.

PFA should be provided to all who are suffering and can be provided by anyone who wishes to help individuals in distress. This included everyone starting from psychiatrists, doctors specializing in other fields, nurses, field level workers (ASHAs, VRWs, CHWs) and lay persons or volunteers who wish to help.

PFA is given until the person can reach a trained mental health professional or until the crisis is averted. The goal of providing first aid is:



Principles of Psychological first aid

LOOK–LISTEN–LINK

LOOK - for individuals who require help

LISTEN - openly to all of their concerns

LINK - them with the available options to build support systems

Components of PFA

It is a fact that no two individuals will react the same way to any stressful situation.

PFA involves:

- Provision of required care
- Understanding the person's needs
- Listening to both verbal and non-verbal cues
- Helping them regain their calm
- Ensuring that they are not in way of further harm
- Empowering them with information / services / social support

We have to ensure the safeguarding of every individual's rights. Dignity is always to be respected and safety is to be ensured and also adapting to every individual needs and understanding their cultural differences is important.

Important aspects of Mental Health First Aid



1. Listening without any judgement:

- The person providing first aid should ensure to Listen without being critical or imposing personal judgements.
- Advice like 'pull yourself together' does more harm than good
- Avoid argumentation
- Don't question forcefully. If you feel them being reluctant to answer, don't continue pursuing the topic.

2. Assessing suicide risk:

People who are suffering/dealing with a crisis sometimes become very overwhelmed leading to feeling hopeless about their life and future. This might lead to them trying to end their life. Engaging such people in conversation about how they are feeling and why helps them. Never hesitate from asking a person if they have any suicidal ideas. If they do, further enquire if they have a suicide plan. This is important to find out because we can help or refer for appropriate help only if we know.

If there is risk of suicide-

- Ensure someone stays with the person all the time.

- Refer to someone who knows about mental health disorders (psychiatrists/psychologists)
- Avoid access to any means of harming themselves.
- Try and stop the person from consuming alcohol or drugs.

3. Providing reassurance and adequate information:

The individual and his/her family members should be reassured and given adequate and appropriate information regarding the condition and available treatment options. Things the you should tell the person and family-

- Whether the person has a psychiatric disorder or is dealing with mental distress/crisis
- Mental health disorders are just like any other physical illness.
- There is no reason for shame or this not because of weakness of character
- Effective treatments options are available
- Recovery takes a little long and that they will have to be patient
- Regular follow up is very important
- Appreciate them for reaching out and ensure them that help is always available

4. Encouraging the individual to seek further professional help:

You should encourage the person to connect with a **psychiatrist/psychologist.** If there are any red flag signs, i.e., if they are refusing to visit a doctor, you can speak to the family and ask them to reach out to a **psychiatrist**.

5. Encouraging self-help strategies:

Steps to ensure the following should be taught-

- Regular sleep
- Healthy diet
- Relaxation techniques and yoga
- Regular exercise
- Avoiding consuming sleeping pills for better sleep
- Avoid use of alcohol and other substances
- Ensure adequate support system

6. Advice for sleeping problems:

- Maintain regular hours for sleeping and waking up
- Keep the bedroom cool, dark and quiet
- If hungry, take light snack before sleeping
- Avoid naps during the day
- Avoid tea and coffee after 5 pm
- Avoid smoking or consuming sleeping pills or alcohol for sleeping
- Maintain a regular exercise schedule
- Avoid exercising right before bedtime
- Avoid reading, eating, using phone in bed

7. Advice for maintaining a healthy diet:

- Meals should be taken at regular time periods
- Even when you don't have an appetite, eat at least small portions
- Try and include fruits and green vegetables in diet
- Fibre (whole grains, chapattis, cereals etc) should be an important component of daily diet

8. Regular exercise and recreational activities:

- Choice of any activity that one enjoys (e.g., morning walks)
- Do not start with rigorous exercise. Start with 10-15 mins and gradually increase the time
- Put some time aside to spend with friends and family
- For people who are religious, encourage being regular with prayers
- Encourage restarting hobbies that they had when they felt better
- Being active helps to feel less tired and more energetic

Relaxation techniques:

- Choice of any form of relaxation as per their preference
- Breathing exercises can be practiced in the morning and night
- Daily practice of yoga is advisable
- Yoga sessions can also be attended at the nearest Health and Wellness
- Centre (HWC)

- Relaxing activity is any activity that brings joy to a person. It includes listening to songs, watching movies, reading novels or books of interest and going for walks.

Avoiding smoking, alcohol and sleeping pills:

Why to avoid:

- Highly addictive
- Alcohol causes damage to multiple organs including liver, heart and brain
- Alcohol impairs judgement making people do things which they usually wouldn't
- Substance use very often leads to financial problems
- Arguments at home and with loved ones
- Neglect of other pleasures,
- Poor work/academic performance

Ensuring adequate support system:

- Open up about your feelings with people who understand
- Meet friends and family regularly
- Get in touch with people going through similar problems eg, support groups

References/ Further readings:

1. Everly Jr, G. S., & Lating, J. M. (2022). The Johns Hopkins guide to psychological first aid. JHU Press.
2. Minihan, E., Gavin, B., Kelly, B. D., & McNicholas, F. (2020). COVID-19, mental health and psychological first aid. Irish Journal of Psychological Medicine, 37(4), 259-263.
3. World Health Organisation. (2011). Psychological first aid: Guide for field workers. World Health Organisation.
4. Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. Journal of Mental Health Counselling, 29(1), 17-49.

MODULE 18

Mental Health Promotion

Objectives of this module

- To know about mental health promotion and different methods of mental health promotion
- To understand stigma and discrimination
- To know how to promote mental health through various platform

The practise of empowering people to improve the control they have over their health enabling them to improve it is known as health promotion. These initiatives aim to improve the general population's health. Health personnel are not the only ones responsible for promoting health. The entire community is involved and benefits from this concerted effort.

Any activity that improves the potential for better mental health via action at various levels including individual, society and community is considered to be mental health promotion. The promotion of mental health places an emphasis on social and personal growth as well as on life skills including parenting, self-efficacy, resilience, and coping mechanisms. Individual-level treatments improve mental health outcomes by lowering risk and raising protective factors. Communities promote social connection and integration, which are important social factors of mental health.

What are components of Mental Health Promotion?

- Working to improve the facilities for treatment of mental health disorders;
- Engaging in efforts to promote community harmony through social networking
- Working towards decreasing violence in the community
- Attempting to free people from stigma, thus decreasing discrimination
- Protecting the rights of people with mental illness
- Raising awareness of mental health disorders among the general public

It is crucial that strategies in mental health promotion and implementation of programmes be adjusted to the local requirements for it to be effective.

Ways to promote mental health in the community:

1. **Mental health education:** The World Mental Health Day, World No Tobacco Day, etc., campaigns can be seen as opportunities to promote awareness and education in mental health. It is the most economical strategy for eradicating stigma and increasing awareness. The public, patients, carers, at-risk groups and decision-makers are among the target audiences.
2. **Environmental Modifications**: Playgrounds and parks in schools, communities and workplaces help improve the environment.
3. **Life skills education:** It aims to prepare teenagers for the problems of everyday life. (WHO 1997). The skills include problem solving, interpersonal & communication skills and stress management etc.

4. **Nutritional interventions:** Ensuring enough nutrition for pregnant women and children, preventing substance misuse and thus improving mental health.
5. **Modifications to lifestyle and behaviour:** For a good mental well-being, it's crucial for people to avoid substance abuse, violence, and to lead active lifestyles that include yoga, meditation & being physically active.

Stigma & Discrimination:

Stigma is a sign of shame and disapproval, which leads to certain individuals being shunned by others (WHO). Any form of unjust and unfavourable treatment of stigmatised individuals is called discrimination. People may face discrimination due to their colour, gender, or caste, among other factors. Isolation and shame may result from prejudice and stigma.

Origins of Stigma:

When someone learns that a person has a mental health condition, they may begin to see them negatively because of a certain trait or quality that they identify with them. For instance, the mental picture they have developed as a result of the inaccurate representations of people with mental health disorders that appear in movies. Discrimination occurs when someone treats someone negatively due to their mental illness. For example, treating someone harshly or rudely or denying them a job even if they are qualified and capable might be considered discrimination due to the stigma.

The social stigma and prejudice that those with mental health concerns face, can exacerbate their symptoms, put them at risk for relapses often, and make their disease chronic.

Stigma & discrimination in the context of mental health disorders:

There is a significant treatment gap and a shortage of qualified mental healthcare workers as a result of low knowledge of the signs and symptoms of mental disease, stigma attached to those who suffer from mental illness, and a lack of mental health services.

Reason for stigma and discrimination

As people with mental disorders may think and behave differently, they are frequently stigmatised and subjected to discrimination

Poor knowledge of the facts about these conditions, some people may fear those displaying any signs of mental illness.

Effects of stigma & discrimination on people with mental health disorders

People who have mental health issues may not be accepted by their friends, family, neighbours, or co-workers.

Being rejected can lead to increased feelings of loneliness and unhappiness, which can make recovery much harder.

Although stigma is not restricted to mental illness, it appears that the community discriminates against people with psychiatric disorders more than those with physical illnesses.

As seen in Table 1, stigma has two distinct effects. The common people's attitude to people suffering from a mental illness is called public stigma. The attitude that persons with mental illness have towards themselves is called self-stigma. It is stereotypes and prejudices that contribute to both types of stigma.

Table 1: **The impact of stigma:**

Public stigma:	
Stereotype	Negative views regarding a group of people (e.g., they are dangerous, inefficient and weak)
Prejudice	Agreeing with such negative views and/or showing negative emotional reactions (e.g., fear, anger)
Discrimination	Behaviour in response to negative views (e.g., Not giving them a job)
Self –stigma:	
Stereotype	Negative views regarding self (e.g. I am inefficient)
Prejudice	Agreeing with such negative views and/or showing negative emotional reactions (e.g., no confidence)
Discrimination	Behaviour in response to negative views (e.g. not applying for jobs)

Addressing stigma & discrimination:

To start, you should offer advice, persuade the community to reconsider, and inform people that mental illness must be handled similarly to physical illness.

1. Educate the client and their caretakers: Give the person seeking treatment for mental illness and their family the necessary knowledge. Make sure they take their prescriptions on time. Maintaining one's mental health can give one more confidence and improve one's quality of life.
2. Being non-judgmental: Always refrain from passing judgement on the patient and his family. They will be more likely to attend appointments for treatment and follow-ups if we provide them the support and consideration they need. Point out the accomplishments the patient has made in his or her quest for recovery.
3. Educating the general public about the myths, misunderstandings and negative bias that they hold related to people with mental illness. This will result in them being treated more respectfully. Hence, changing the public's perception is the key to eradicating stigma, hence it is important to educate the public to stop accepting false information about mental illnesses.
4. Find support groups to which you may refer people who are suffering from mental health illnesses and their care-givers. This will assist them in staying updated on treatments, skill development, advantages, and any applicable ways.

Promotion of Mental Health at various platforms:

Family Enrichment:

In a healthy family, every member has an interest in the other family members. Parents like spending time with their kids and feel good about their relationship with each other. They communicate well. They like being around one another. They are ready to help one another out in difficult situations. They are significant to the other family member. They try to comprehend the other family members and be understood by them. Instead of wanting their family members to be something they are not, they respect them for who they are.

A healthy family seeks out the positive qualities in one another. They organise activities they can do as a group, including family outings, visits with relatives, and attendance at important events like school programs. They respect the other person's unique characteristics. They acquire dispute resolution skills.

The most important thing is the mutual respect all members of the family have for each other.

Characteristics of a healthy family:

- The family environment is one of security, consideration, and love.
- Parents are reliable enforcers. They say what is appropriate and follow through on their instructions.
- It is acceptable and encouraged for children to have and express their emotions, ideas, and perspectives. These might not be like their parents.
- parents understand that mistakes are a normal part of a child's learning process and is thus accepted and pardoned
- Children are respected as unique individuals. They are invited to participate in creating the rules.

It is crucial to offer support to families that have a person suffering from a mental illness. and assist them in managing any stress they may be experiencing.

Ways that a family can support people having mental health disorders:

The family is the major source of support for people with mental health issues. Thus, the family should also receive adequate assistance to be able to take care their unwell relative. It is hard to live with and care for someone who has a mental problem (just like a bodily ailment). Family members may exacerbate stress for the individual with the mental illness since they frequently lack an understanding of the signs of a mental health issue.

The behaviour of family members affects the individual with a mental health problem either favourably or unfavourably. Stress-inducing behaviours include labelling someone as unreliable or embarrassing, yelling, critical comments, or doing everything on their behlaf and treating them like a child.

Conversely, if family members are talking clearly & calmly, openly discussing issues, allowing personal space, especially when they are troubled, and encouraging them to take charge of their own business, it can help the person to reduce stress

You may also promote family engagement in the treatment. Individuals suffering from mental illnesses will usually be accompanied by their family members. Occasionally, a family member takes initiative and asks for assistance. Always ask the individual suffering from the mental health problem for permission if a family member wishes to speak to you in private. If someone arrives alone, ask them if you can contact a close relative for more details and assistance (who is there to aid the person?). It's crucial, though, that the family members also pursue their own interests.

Supporting family members:

While caring for people with mental health conditions, family members experience stress as well. Additionally, you want to take care of their worries and offer them mental assistance. Caregiving might last from a few months to years. Caregivers must accept the possibility of a relapse of the illness. Caregiving may be taxing in a variety of ways, and if the difficulties and stress it causes are not addressed, it will negatively impact the health of the caregiver and also their relationships, capacity to perform at job, and ability to provide for the patient.

Inform the caregiver that providing care may be difficult and cause stress. As a result, it's critical for the caregiver to prioritise self-care.

Signs of caregiver stress are:

Feeling very low or down
Feeling like there is no energy in the body
Not being able to concentrate
Getting angry easily
Not having good sleep
Not enjoying previously enjoyable activities
Using alcohol, tobacco or any other substances in greater amount

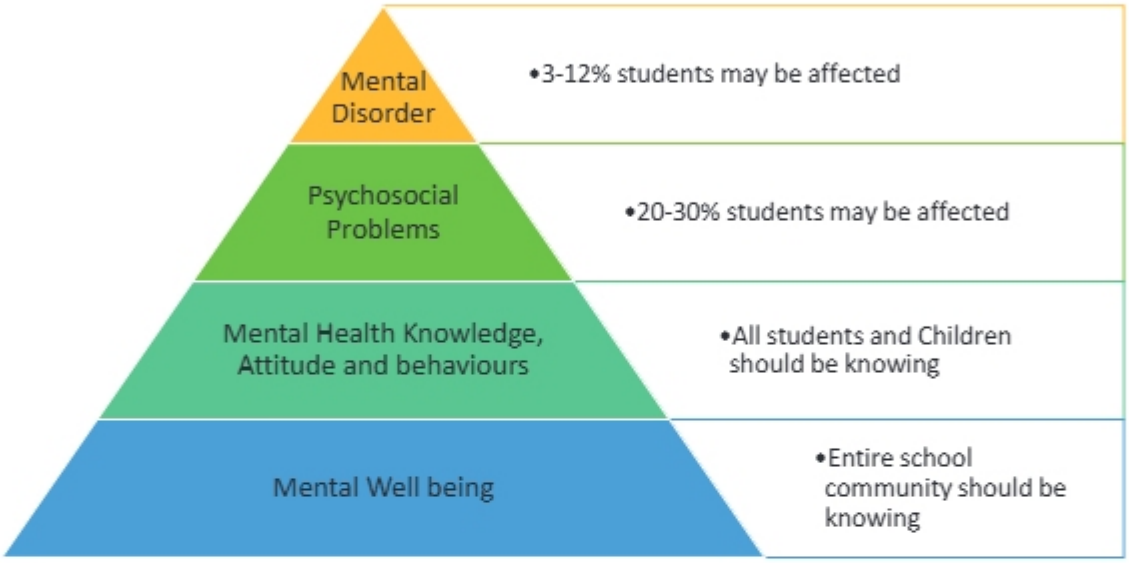
Steps to support family members:

- ✓ Intently listen to problems
- ✓ Provide gentle reassurance
- ✓ Guide them towards professional help
- ✓ Discuss about behaviours which would decrease stress in the family
- ✓ Encourage them to be socially active and keep some time to follow their own interests
- ✓ Try to link them with any support groups

Mental Health Promotion in Schools:

Why schools are essential part of mental health promotion?

- Schools are one of the most effective social institutions.
- They have a significant impact on families, communities, and children.
- They frequently serve to shield kids from dangers that can jeopardize their development and mental well-being.
- With the aid of teachers, the interventions may readily reach kids.
- As a kid attends school for a longer period of time, teachers frequently identify developmental issues early.



The following differentiating characteristics will assist you in recognising children who may be experiencing problems. It's crucial to avoid categorising kids depending on how they behave. One has to keep an eye out for any problems and let their relatives know.

Normal Development	May Need Attention
Preschool – Ages Three - Five • Exhibits interest and inquiry; • Shows a strong enthusiasm for learning new skills; • Imitates and uses imagination (play, for instance, may entail a made-up companion); • Might have an even stronger bond with a transitional object (such as a blanket, thumb, toy, etc.); • Develops an interest in gender disparities; • May use language to show their rage, occasionally using foul language; • Keeps displaying a range of emotions.	***Preschool – Ages Three - Five*** • Is too hesitant or passive; • Has no interest in other kids; has frequent worries or nightmares; • Often retreats into daydream; • Frequently loses control (for instance, a young kid who becomes enraged and starts biting people). Although all children occasionally behave in this manner, a parent should be worried if it happens frequently); • Has persistent, serious issues with sleeping, eating, potty training, and separation from parents.
Ages Six – Eleven: • Enjoys social connection with peers and is friendly; • Acknowledges the necessity of rules; exhibits confidence in oneself; • Appreciates successes;	***Ages Six -Eleven:*** • Has poor self-esteem and experiences anxiety and dread; • Is very reserved and silent; seems sad; • Lacks drive; is irate, hostile, and disruptive;
• Has a strong imagination and frequently creates dramatic play scenarios with their favourite toys.	• Has issues with bedwetting; • Might experience issues in school. (Hyperactivity, poor behaviour)

Ages Twelve – Fifteen: • Develops deep ties, especially with friends of the same sex; enjoys close relationships with peers; is diligent; • Shows mastery and gradually starts assuming responsibility for own work (homework, chores); exudes pride and self-assurance; occasionally displays anger and disobedience, but is typically enthusiastic, active, and cooperative; • Participates in complicated games and sports teams during their free time. By the age of fifteen, play and leisure activities become an integral part of a child's personality and includes listening to music, relaxing, or taking calculated risks like pulling harmless pranks or participating in sports that require extreme bravery.	***Ages Twelve - Fifteen*** • Has a poor sense of worth; • Doesn't have any pals or has issues with peers; • Does poorly academically; • Demonstrates aggressive acting out behaviours (lies, steals, loses control when angry, fights frequently, is destructive, injures people or animals), is overly scared and worried, and is sensitive. • Is persistently uncontrollable, staying out late, misbehaving at home or school, acting distant and unhappy, and complaining a lot of headaches and stomach pain.
Ages Sixteen - Eighteen Is self-assured; exudes pride and competence; Takes pleasure in intimate relationships with peers of both sexes; Is taking steps toward independence; believes that his actions and health are under his control Engages in extracurricular activities;	***Ages Sixteen - Eighteen*** • Has a poor sense of self-worth; • Has no friends; • Does poorly academically; • Is afraid and nervous; • Exhibits violent and erratic behaviour; • Is reclusive and depressed
Is typically ardent, spirited, and idealistic; Typically, helpful and respectful (even though some rebelliousness may be present).	

Children must also be taught about the importance of their mental health. Additionally, they need to know about their emotional and mental health. You can accomplish this on your own or through their teachers. It is also possible to coordinate with the RBSK team for the same.

Self-Care activities that help to maintain Mental Health:

Self-care practices can support a person in keeping their mental health in check. In order to preserve excellent physical and mental health, it's essential to get enough sleep, eat well, engage in regular physical exercise, practice relaxation methods, connect with loved ones, and refrain from using drugs and alcohol like cigarettes.

Mental health disorders & vulnerable groups:

Poverty:

Due to the stressors of poverty, people are more likerly to suffer from mental health issues, and mental health illnesses are more likely to make poverty worse, creating a vicious cycle. This has been demonstrated In Figure 3.

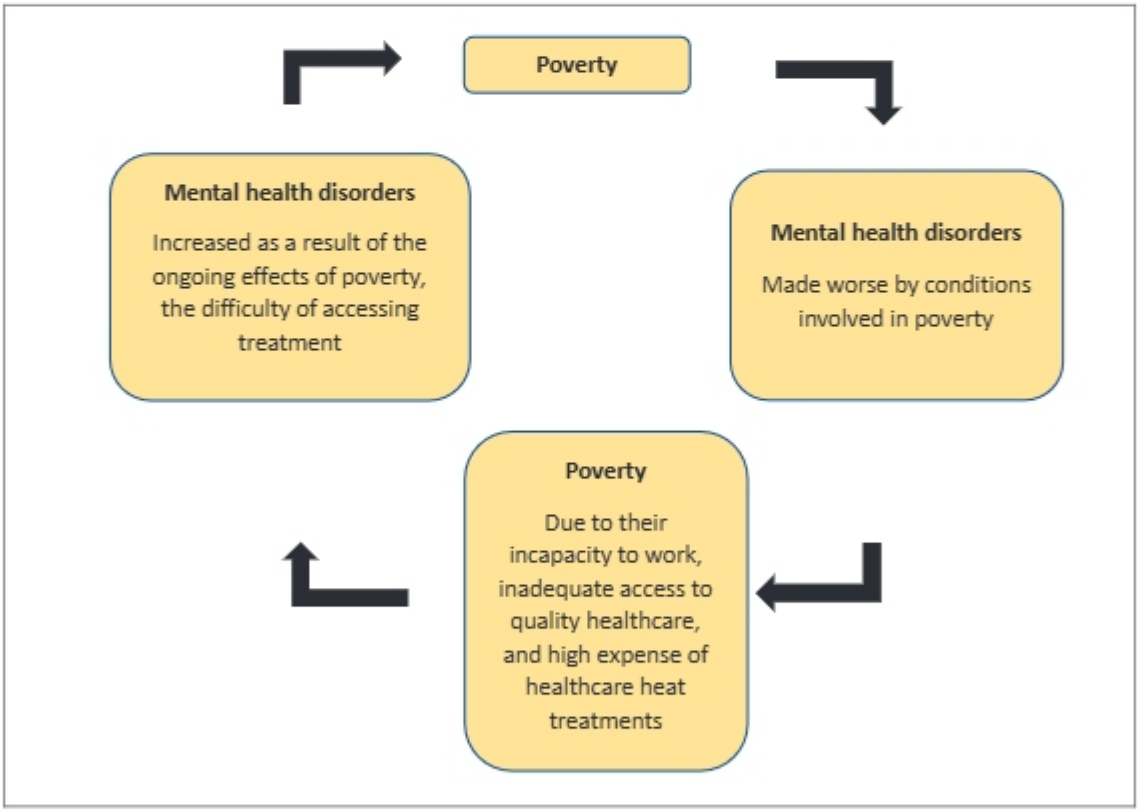


Figure 3: Poverty & Mental Health Disorders

TAKE HOME MESSAGE

Mental Health Promotion emphasises on positive mental health. The main focus on mental health promotion is 'factors causing good mental health and how they can be modified'.

Mental Health Promotion is thus a concept which places focus on factors which cause good health & wellness rather than disease.

The mental health promotive interventions can be either universal- targeting the general population or specific – targeting 'at risk' groups.

Educating the general public about mental illnesses, imparting life skills training, teaching stress relief activities like yoga, ensuring proper nutrition and reinforcing a healthy lifestyle are some of the important mental health promotion strategies.

It is important not only to manage mental illnesses but also to promote mental health.

References:

1. MNS care Training manual for CHO | National Health Systems Resource Centre [Internet]. [cited 2022 Aug 23]. https://nhsrcindia.org/mns-care-training-manual-cho

2. MNS care Training manual for MPW at HWC (Hindi) | National Health Systems Resource Centre [Internet]. [cited 2022 Aug 23]. https://nhsrcindia.org/mns-care-training-manual-mpw-hwc-hindi

3. MNS Care Training Manual for Medical Officer | National Health Systems Resource Centre [Internet]. [cited 2022 Aug 23]. https://nhsrcindia.org/mns-care-training-manual-medical-officer

4. Mental Health ATLAS 2017 [Internet]. [cited 2022 Aug 23]. https://www.who.int/publications-detail-redirect/9789241514019

5. Kumar D. Kumar, D. & Kishore, M. (2016). "Living Life positively: A facilitators' manual for conducting sensitization program in the domains of Life-skills education, stress management and suicide prevention" In collaboration with Director General of Health Services, National Institute of Health and Family Welfare and the country office of the World Health Organisation. 2016.

6.CORRIGAN PW, WATSON AC. Understanding the impact of stigma on people with mental illness. World Psychiatry. 2002 Feb; 1(1):16–20.

7. Shrivastava A, Johnston M, Bureau Y. Stigma of Mental Illness-1: Clinical reflections. Mens Sana Monogr. 2012; 10(1):70–84.

8.Kumar K, Chandrashekar CR, Gangadhar B, Bada Math S, Prabhash K, Thirthalli J, et al. Information Education and Communication Manual for Health Workers and the Community for Implementation of DMHP. In 2008.

9. Mn V, Mysore Narasimha V. Promotion of mental health and Wellbeing of Adolescents - A NIMHANS Model. 2015 Jan 1; 303.

10. Rajendra K, John | , Kommu JVS, Kumar N, Shetty V, Rajani | , et al. CHILD AND ADOLESCENT MENTAL HEALTH A MANUAL FOR MEDICAL OFFICERS TO PROVIDE CARE DURING AND AFTER COVID-19PANDEMIC 2020 Editors. 2020.

11. Bhargav H, Varambally S, Udupa K, G I, Arasappa R. Yoga-for-Mental-Health-Disorders -Research-and-Practice. In 2020. p. 179–98.

MODULE 19

Mental Health Issues Arising in The Context of Pandemics / Disasters

Objective of this module

What is a pandemic?
What are the m ental health issues caused by a pandemic?
Who are the vulnerable population?
Migrant population and pandemic, how to address psychological distress?
Addressing stress and stigma in frontline workers.
Psychological first aid in a pandemic
Dealing with the post pandemic mental issues.

INTRODUCTION:

A pandemic is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people".

In recent years, there have been several pandemics that are still on-going and have changed our world-view and how we lead our lives. The most notable among them, is the Novel Coronavirus Disease 19 (COVID-19), a viral infection which has affected millions of people all over the world. The World Health Organisation (WHO) declared COVID-19a pandemic, in early March 2020. This viral infection caused a range of respiratory syndromes from the mild common cold to Severe Acute Respiratory Infection (SARI). Numerous people were affected by the infection and many have lost lives.

Other viral infections like monkey pox virus, have also threatened lives and have recently been given a pandemic status. COVID-19pandemic, helped bring into focus, mental health issues, like never before, with most of us being limited to our rooms for days on end. Many individuals developed mental health issues and those with pre-existing illnesses had worsening of symptoms during this period.

Given that we now live in a post-pandemic era, with continual implications on our daily lives, we cannot ignore the importance of mental health issues developing as a consequence of pandemics.

This module helps the tele-counsellor understand some of these issues and be better prepared for addressing queries in the context of a disaster.

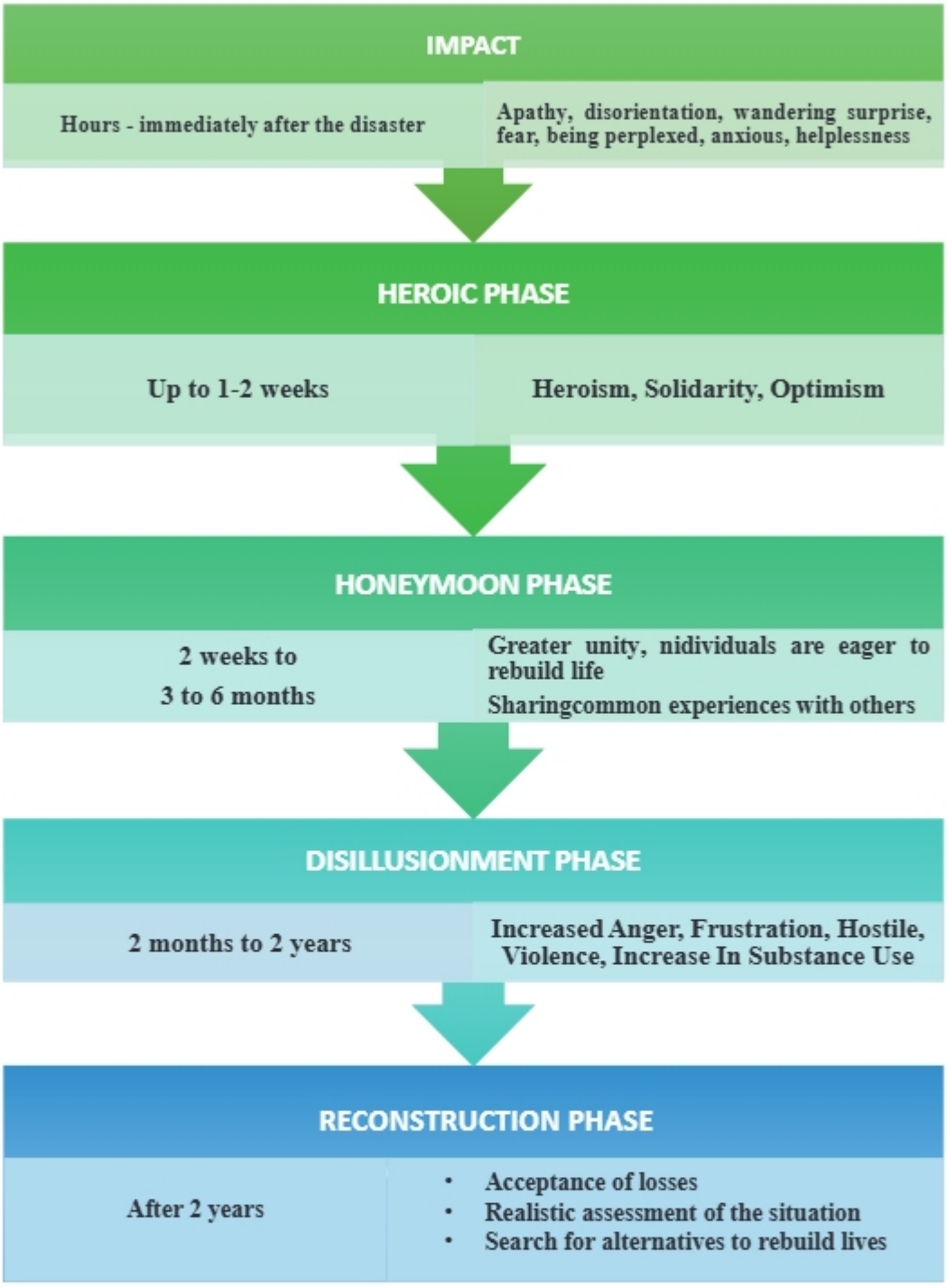
World Bank has predicted a steep global economic recession since decades following the COVID-19pandemic. Economic recession is associated with increases in the prevalence of psychological distress, anxiety, depression, substance abuse disorders, and suicide and suicidal behaviour. Unemployment, job insecurity, lower socio-economic status, and pre-existing psychiatric problems seem to be the determinants of post-economic recession mental health issues Unemployment following economic recession is a major risk factor for suicide and suicide rates had considerably increased following global economic crisis in 2008. Potential economic recession with rise in unemployment following Covid-19pandemic might have similar impact on suicide rate.

It is important to recognise the population-at-risk and identify the vulnerable groups:

General Public
People who are suspected to have the illness of the pandemic
People who have the illness
Children /adolescents / women
People with known psychiatric illness
Migrant worker population
And last but not the least
Frontline healthcare workers

The mental health issues and concerns depends on various factors. The reaction to a disaster depends on multiple factors. Reactions to a disaster change over a period of time. It is important to understand various psychological reactions in the various stages of disaster response among people in order to provide appropriate interventions.

Phases of emotional reaction to a disaster



In the Covid-19 pandemic we are now entering the phase of reconstruction, which could be a long and arduous path filled with potential to bring forth a number of mental health issues. Hence, as the first person of contact, it is important for the Tele-MANAS Counsellor to understand what kind of issues one may expect in the aftermath of a disaster?

Mental health issues in a pandemic:

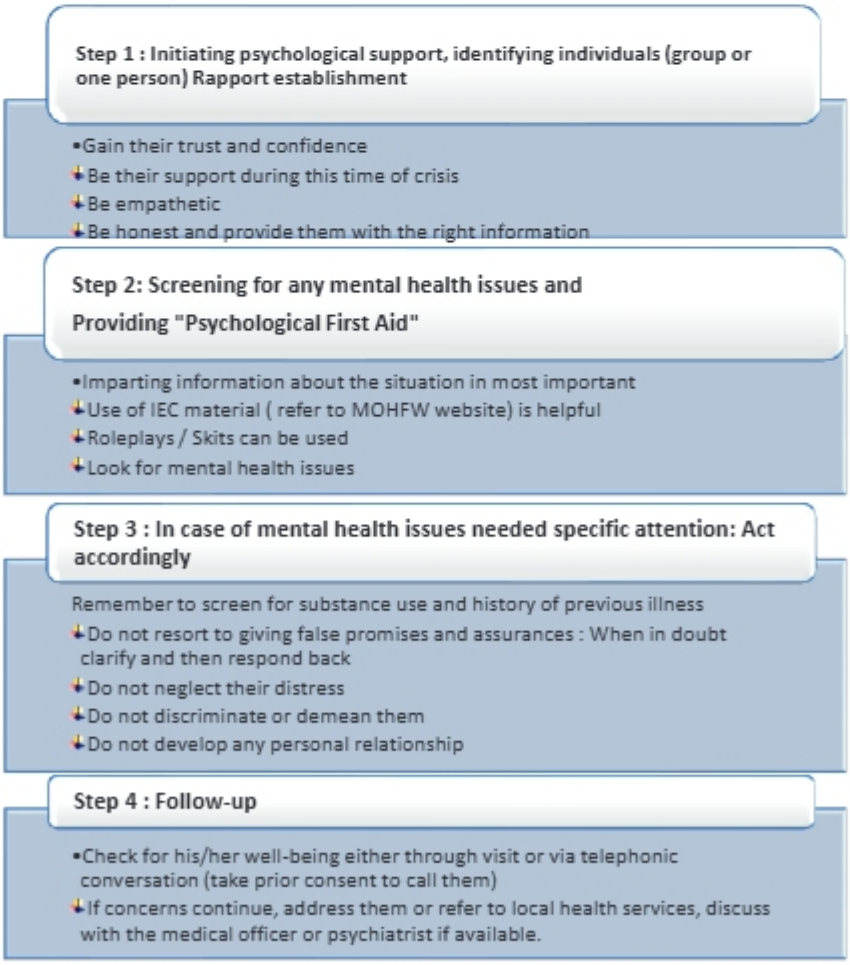
The psychological distress can manifest in many ways, the below list are common ones encountered. Emotional reactions such as panic, fear, and anxiety are normal reactions to a disaster situation like this, however, these should not be disregarded and should be addressed.

- Fear and panic of developing infection
- Worry about family and relatives
- Worry about caring for elderly and children, fear of them contracting the infection
- Difficulties in handling lockdown, boredom and loneliness
- Sleep disturbances
- New onset psychiatric symptoms which require treatment
- Worsening of pre-existing psychiatric illness
- Use of alcohol /tobacco and other substance use
- Managing children and adolescents – worry about school, dealing with boredom
- Women facing domestic violence
- Mental distress in individuals in isolation/quarantine
- Mental distress in individuals tested positive for the illness
- Migrant workers experiencing psychosocial issues
- Stress and well-being concerns among frontline healthcare providers
- Worsening of pre-existing psychiatric illness or medication related concerns
- Distress due to stigma

Migrant population and mental health in COVID-19 pandemic:

"I am a construction worker I have come all the way from Delhi getting fitness certificate. Why should I stay in the quarantine center, let me and my friends go. My family is waiting for me at my village."

How to address a concern of migrant?



Frontline Heath Worker - How to Deal with Stigma and Stress in Yourself or A Co lleague associated with the pandemic:

Providing right information

- Information and knowledge about the infection plays and important role in reducing stigma
- Educating people regarding the COVID-19 risk factors, incidence
- importance of measures such as social distancing, personal hygeine and use of protective measures such as mask - inform that following these steps will protect them from infection
- Encourage general public not to beleive and trust every little information provided in social media - beware of rumours
- Educating public through IEC materials

Action against those who discriminate

- Infrom general public that strict action will be taken against those who discriminate others based on the religious, occupation, and race
- Action against those who defy measures prescribed by the government

Support

- Be empathetic to those who have experienced stigma
- Extend support to them
- Report the matter if it has led to signoficant distress or the negative rection continue against the person

Psychological First Aid (PFA) in a Disaster:

We have discussed about mental health first aid in one of the previous modules.
Now let's see how PFA works when it comes to a disaster. For e.g.: A pandemic.
An approach is offered in "The Psychological First Aid Guide" for field workers commencing with

1. Establishing basic needs, such as access to adequate supplies of food and water, especially if access to shops and other resources is limited.

2. It is essential to link the individuals with new and pre-existing healthcare needs to the appropriate help available.

3. Ensure vulnerable sections of society are not overlooked, such as the infants, the elderly, the young and those with difficulties in mobility or communication who do not self-present.

Given that it is likely that, post-disaster, the individual may have many needs, it is necessary to prioritise most urgent needs first.

4. Individuals providing PFA will be reinforcing positive coping mechanisms and discouraging negative coping strategies. When possible, people should be connected with loved ones and means of contact made available because access to social support networks augments coping.

References/further reading:

1. Kathirvel N. Post COVID-19pandemic mental health challenges. Asian J Psychiatry. 2020 Oct;53:102430.
2. Marco C, Massima C, Alessandro T, Wen -Can J, Cheng Bin W, Sergio B , The COVID-19Pandemic, Critical Reviews in Clinical Laboratory Sciences 2020, 57:6, 365-388
3. Math SB, Nirmala MC, Moirangthem S, Kumar NC. Disaster Management: Mental Health Perspective. Indian J Psychol Med. 2015 Jul-Sep;37(3):261-71.
4. Betty P, Carol S. N , Mental Health and the COVID-19Pandemic, N Engl J Med 2020; 383: 510-512
5. Singh, Om Prakash 1,2,. The need for routine psychiatric assessment of COVID-19survivors. Indian Journal of Psychiatry: Sep–Oct 2020 - Volume 62 - Issue 5 - p 457-458
6. Lakshmi Nirisha P, Kumar NC, Math SB, Manjunatha N, Rakesh C, Manual for providing psychosocial support during COVID-19pandemic, 1st edition
7. World Health Organisation, War Trauma Foundation and World Vision International, 2011.

MODULE 20

MANOHITAM: Principles of Ayurveda and Yoga in Mental Health

Objectives of this module

To Know

What is Ayurveda and Yoga (A &Y)
What is the understanding of mental health according to A&Y
Principles of disease prevention and health promotion aspects of A&Y
Methods to modify of diet and lifestyle in enhancing mental health

Preface: Ancient indigenous systems like Yoga, Ayurveda etc. had a holistic approach towards health and considered mental health forms an integral component of the overall wellbeing of an individual. Yoga emphasis es on enhancing the person's state of mind in order to enhance his resilience and to prevent disease. Ayurveda focuses on prevention through life style modifications. Both disciplines have common fundamental principles. The overview of mental health related principles has been narrated in this chapter to help in both aspects: promotion of mental health as well as the prevention of mental illness. The chapter comprises of 2 sections viz., Section 1 - Concept of mental health in Ayurveda and Section 2 - Yoga for Mental well-being.

Section 1: Concept of mental health in Ayurveda

1.1.What is Ayurveda

Ayurveda is the traditional Indian indigenous system of medicine. Over 80% of the population has consulted an Ayurveda practitioner at one time or the other in their life. This science of life (*Ayu: veda*) adopts a holistic approach that focus on both preventive and curative aspect of disease. Ayurveda mainly incorporates life style modification involving Pathya (diet), Vyayama (Exercise), Nidra (Sleep), Sadvrutta (personal hygiene), Sadachara (social relationship), Brahmacharya (sexual hygiene) and so on for healthy living.

The fundamental principles of Ayurveda in understanding structure are based in the theory of panchamahabhootas (5 elements or i.e., prithvi (earth), *Ap (jala*/water), *Tejas* (fire), *Vayu* (air) and *Akasa* (space or ether)]. Whereas, the dosha theory explains normal functions as well as disease states. *Vata, pitta* and *kapha* are the doshas of shareera and *rajas* and *tamas* are considered as the doshas of manas (mind), As per Ayurveda the disharmony in the *doshas* results in disease and their equilibrium restore health.

Functions of *vata* analogous to nervous systems functions, locomotion, communication, conduction, etc. *pita* is responsible for transformation like in metabolism (example digestion) and *kapha* is responsible for maintaining structural integrity, lubrication etc. Among the man odoshas *Rajas* is responsible for actions, aggression etc. and *Tamas* causes inertia. Any imbalance in their function causes disease.

1.2 Which are the specialties of Ayurveda

There are 8 main branches or specialisation described in Ayurveda[5]

a. Kayachikitsa - General medicine
b. Balachikitsa - Paediatrics
c. Grihachikitsa - Psychiatry
d. Urdhwangachikitsa/Salakya - ENT and Ophthalmology
e. ShalyaTantra dealing with wounds and surgery
f. Damshtra/Vishachikitsa- Toxicology
g. Jarachikitsa - Geriatrics
h. Vrisha or vajikarana includes aphrodisiac / sexual medicine

1.3. Mental Health according to Ayurveda

According to Ayurveda, body and mind are considered as substrata of disease. There is a crosstalk between doshas of the body and the mind i.e., any disease that effects the body involves the mind and vice versa. Krodha (Anger), Shoka (sad), Harsha (happiness) etc. are considered as the normal emotions that have the tendency to overwhelm an individual if not regulated and therefore, are classified under Dharaniya Vega (normal human mental urges that need to be controlled). When they are not regulated they make the person vulnerable for mental illnesses.

Other manorogas are also mentioned. Psychotic and mood related disorders are explained under the broad spectrum of unmada[8]. Depressive symptoms (i.e., feeling sad, not interested in activities etc.) are correlated with Vishada. Chithodwega (anxiety) and graha etc are also mentioned in detail with treatment. All these come under the purview of Ayurveda Psychiatry

1.4.What are the causes of manasaroga according to Ayurveda

a. Aharavidhivarjana (due to unhealthy practices of diet, virudhahara etc.)
b. Satvrithaapalanam (defiance of moral code)
c. Asatmyendriyarthasamyogam (socio sensorial incompatibility)
d. Pranjaparadha (offences against wisdom)
e. Miscellaneous causes like genetic, hereditary, loss of beloved ones etc.

These are considered as some of the causes of Manasaroga. Anything that creates an imbalance in Sharirika and Manasikadoshas potentially acts as the causes for diseases.

1.5. How can mental illnesses be prevented

Not all the psychiatric diseases are preventable as such. But adapting a healthy lifestyle will help to keep a balance and also helps to reduce the intensity and frequency of episodes.

a. Wholesome diet and healthy diet pattern

Whatever food one takes in has the capacity to nourish the mind. Ayurveda explains certain rules that has to be followed while taking food i.e. Ashtaharavidhi[12].



Figure 1: Representation of ashtaharavidhi (rules in relation to food intake)

- Prakriti (the natural quality of food)

By nature, every food has certain quality. For example mudga (green gram) is laghu or very easy to digest whereas masha (black gram) is guru and is heavy to digest. So, while selecting food according to one's own digestive power this has to be remembered.

- Karana (samskara/processing the food)

Method of processing the food alters its natural quality. Example – roasting the grains before cooking will make the food lighter to digest.

Samyoga (The ingredients / combination)

When one or more ingredients are mixed together, the quality of combination will be totally different from that of components. Some combinations like honey and ghee in equal quantity has to be avoided.

- Rasi (Quantity)

Only conducive quantity has to be followed. The quantity of food is individual specific. While consuming food, it is important to remember that the stomach capacity can be divided into three sub-divisions. The first section for solid food, the second section for liquids and the third section should be left for vata, pitha, kapha. This is vital for health.

- Desha (Place where food is grown or cultivated) –

Desha covers the place where food is grown, the place to which they transport and the place where they utilised. One has to consider the property of Desha also while taking food

- Kala (Time of intake of food)

The term 'Kala' refers to time in the form of the day-night cycle, seasons and the states of individual. In a day proper time has to be maintained for intake of food. Consumption of seasonal food is significant for maintenance of good health.

Upayogasamstha (Rules of taking food)

- Eat hot and fresh food
- Eat proper quantity
- Eat after feeling hungry
- Eat in desired place with desired articles
- Neither eat in hurry nor very slow
- Eat with utmost concentration
- Avoid talking, laughing, watching TV or mobile while eating

Table 1: Example of rules of taking food

❖ Upayokta (The person who consumes the food)

Person should be wise enough to understand what food suits his body and should make efforts to avoid such food. For e.g., some sea foods are allergic to some people, some tubers cause gastric irritation to some others.

- Milk, green gram, butter, ghee, old rice etc. are considered as satvika ahara and are good for a healthy mind.
- Spicy food is considered as rajasika and stale & dry foods are Tamasika Ahara. Therefore one should be watchful about what he eats.
- Avoid Virudh a Ahara (incompatible foods)

It's a unique concept in Ayurveda. Virudhahara are the foods which are in wrong combination, underwent wrong processing or which consumed incorrect dose, in incorrect time etc.

AVOID:

Ghee and honey in equal quantity
Heating curd
Heating honey
Taking curd at night
Taking Excess sweet at night
Fish with milk etc

Table 2: Examples of Virudhahara

b. Achararasayana and Sadvrita (Moral code of conduct)

Sadvritas and Achararasayana are certain codes of conduct that one has to be followed in his personal and social life. The deviation is considered being a cause of psychiatric disease. Some of the key principles are as follows:

✓ Achararasayana are codes of social tenets. Accepted civilisational behaviour is helpful in avoiding stress, and incorporating moral values play a vital role in enhancing mental resilience and coping with stress. These codes help in optimistic thinking, improving patience, maintaining optimal personal and social relationships and personality development.

Some principles of Achararasayana are given below:

1. Satyavadinam – Always speak the truth
2. Akrodham – Do not be angry
3. Madya Nivrati – Do not indulge in alcoholic drinks
4. Maithuna Nivrati – Maintain sexual hygiene.
5. Ahimsa – Non-violence.
6. Anayasaka – Avoid over exertion.
7. Prashantam –Be calm and peaceful in mind.
8. Priyavadinam – Do not hurt others with your speech. Speak pleasantly.
9. Japa para – Always remember God / (Rhythmical repetition of some sound)
10. Anrashamsya – Do not be cruel to anyone.
11. Nitya karuna vedinah – Be merciful to all who are in need of help.
12. Sama Jagrana swapna – Maintain balance in waking and sleeping.
13. Yuktigya –Plan ahead to achieve goals
14. Anahamkari – Avoid super egotism
15. Upasitarah vriddhanam –Respect and serve elders
16. Shastra para – Continually study new sciences, advances etc.

Table 3: Examples of Achararasayana

❑ **Types of sadvritta:**

1. Vyavaharika sadvritta (Ethical codes of conduct).
2. Samajika sadvritta (Social codes of conduct).
3. Manasika sadvritta (Mental codes of conduct).
4. Dharmika sadvritta (Moral codes of conduct).
5. Sharirika Sadvritta (Physical codes of conduct).

- Don't consume food without washing hands, mouth, feet and face.
- Do not consume food in an improper place, a crowded place.
- One should not take food which is dirty.
- Curd is good for health. But intake of curd at night is strictly prohibited.
- Do not tend to any other work or activities while under the pressure of natural urges of the body.
- Don't postpone activities that need to finished at the proper time.
- Don't be quick to take any action without thinking it over well.
- Try to incorporate an oil massage on head, ears, nostrils and feet in your daily routine.
- Be friendly to all living beings, pacify anger, and console those who are frightened, be helpful to those in need, especially the poor, be truthful, peaceful, and try not to hurt others by your speech, deeds and thoughts.
- Keep a smile on your face and should begin the conversation first. Always be respectful to guests and display hospitality while tending to their needs. Be in the company of teachers, elderly persons and successful persons always (siddha and religious) and be respectful of them and serve them well.

Table 4: Examples of Sadvritta

c. Asatmyendriyarthasamyogavarjanam (Avoid socio-sensorial incompatibility)

Atiyoga (Overuse), ayoga (nonuse) and mithyayoga (improper usage) of sense faculties has to be avoided for a healthy life. (E.g.: exposure to loud sounds, extreme temperatures etc.). Staying in a stressful environment for a long time will create the chances of getting disease. Pranjaparadhavarjanam (crime against wisdom).

Due to ignorance or due to excessive desire (upadha), one will enter into some inappropriate indulgences (E.g.: using drugs alcohol addictions etc.) controlling craving to indulge is therefore, a virtue to be developed.

d. Rtucharya and Dinacharya

Seasonal regimes like rtusodhana (detoxification/purification) and daily regimes like oil massage, physical exercises, sleep hygiene etc. has to be followed for a healthy life.

1. Treatments mentioned in Ayurveda for these diseases

Treatment principles in Ayurveda can be broadly classified under three headings Daivavyapasraya, Yuktivyapasraya and Satvavajaya. Yuktivyapasraya is the use of medicines. The other two are non-pharmacological treatments viz., satvavajaya that involves using measures to restrain the mind from indulging unwholesome activities and daivavyapasraya is the spiritual method of healing using religious rituals like prayer. Depending upon the individuals' spiritual belief daivavyapasraya can be adopted.

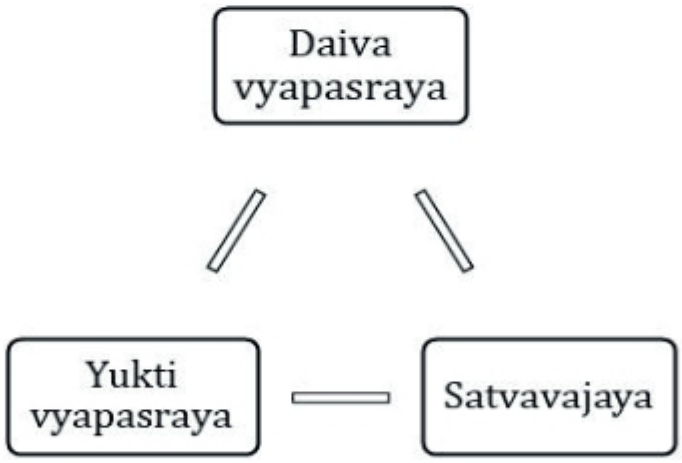


Figure 2: Trividha chikitsa

Non-Pharmacological management

Satvavajayachikitsa is an intervention to be performed on psychologically affected individuals in a stepwise manner. This includes Jnana (a knowledge of self), Vijnana (a scientific reasoning/skill developing), Dhairya (a determination or reassurance), Smrithi (an application of recollections or memory) and Samadhi (attaining a stable state of mind).

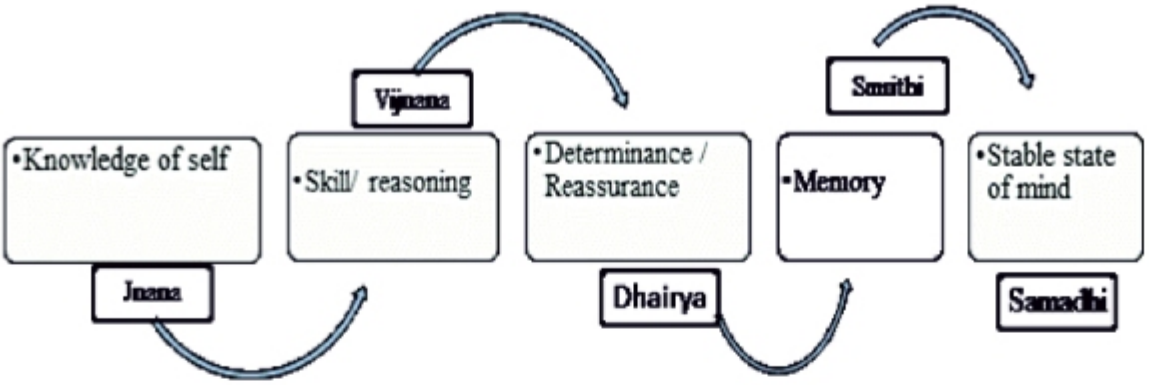


Figure 3: Satvavajaya Chikitsa

- Jnana (knowledge of self)
  - Awareness regarding the condition of one's own health, if the individual is taking any medication, it has to be continued without lapses.
  - Encourage the individual to follow a daily routine comprising of regular physical activities and hygiene to become responsible in maintaining their own health, follow healthy food habits, and maintain a healthy sleep pattern.
  - Understand their hobbies and encourage them to do so or engage in daily activities that would help relieve stress such as reading, breathing exercises or any other hobbies according to one's interest.
  - Create awareness regarding their strength and capabilities, positives etc. in them

- Vijnana (scientific knowledge or skill developing) i.e., awareness is created about the disease condition in a proper fashion.
  - Give proper knowledge to the individual about the occurrence of disease and its possible prevention based on sound theories.
  - Avoid believing myths/false/fake information.
  - Trust authentic data and information. Don't get misled by false information.
  - Interact with knowledgeable people and professionals.

- Dhairya (reassurance): Instil a sense of hope by reassurance
  - Reinforce the coping skills (if not possible by self, have the courage to seek help from professionals).
  - Focus on developing the will to maintain a positive healthy family atmosphere.

- Smrithi (memory enhancement)
  - Help them to recollect experiences from their own past where they had successfully overcome failures and such diseases
  - Highlight those who have had similar experiences and survived/had a successful /positive outcome.

- Samadhi (following Yoga)

Following yogic principles enhances the path to development of stable state of mind.

Section -2: Yoga for mental well being

2.1. What is yoga?

Yoga is a systematic way of gaining mastery over the fluctuations of the mind. The term 'Yoga' originally comes from the Sanskrit word "yuj" which translates to "connect or join". It includes a set of practices that aims at bringing about physical, psychosocial and spiritual wellbeing in an individual. It includes:

(a) practicing social and individual codes of conduct (Yama and Niyama)
(b) Physical postures (Asana)
(c) Techniques aimed at regulating breathing(Pranayama)
(d) The practice of meditation(Pratyahara, Dharana, Dhyana and Samadhi)

2.2. What is stress according to yoga?

Yoga philosophy understands excessive speed of thoughts in the mind as stress. According to Taittriya Upanishad, our existence can be understood in 5 different sheaths, namely, A nnamaya Kosha (Physical body), Pranamaya Kosha (sheath of energy), Manomaya Kosha (sheath of mental activity/emotions), Vijnanamaya Kosha (sheath of intellect) and Anandamaya Kosha (sheath of bliss) (see figure 1).

Yoga Vasishtha, another ancient yoga text, classifies Vyadhi/disease into two types based on the underlying cause:

a) Disease due to external factors (AnadhijaVyadhi): They are caused due to physical factors in the external environment (Annamaya Kosha) of an individual such as accidents, injuries, infections and poisoning.
b) Disease due to internal factors (AdhjijaVyadhi): They are due to imbalances in the Pranamaya and Manomaya Kosha of the individual.

Continued excessive speed of thoughts along with charged emotions accumulates in the Manomaya Kosha of the individual. This brings turbulence in the Manomaya kosha, further, penetrates down to Pranamaya Kosha and Annamaya Kosha. This is how mental stress can lead to a disease. The same path can be used to reverse a disease and bring wellness into the system.

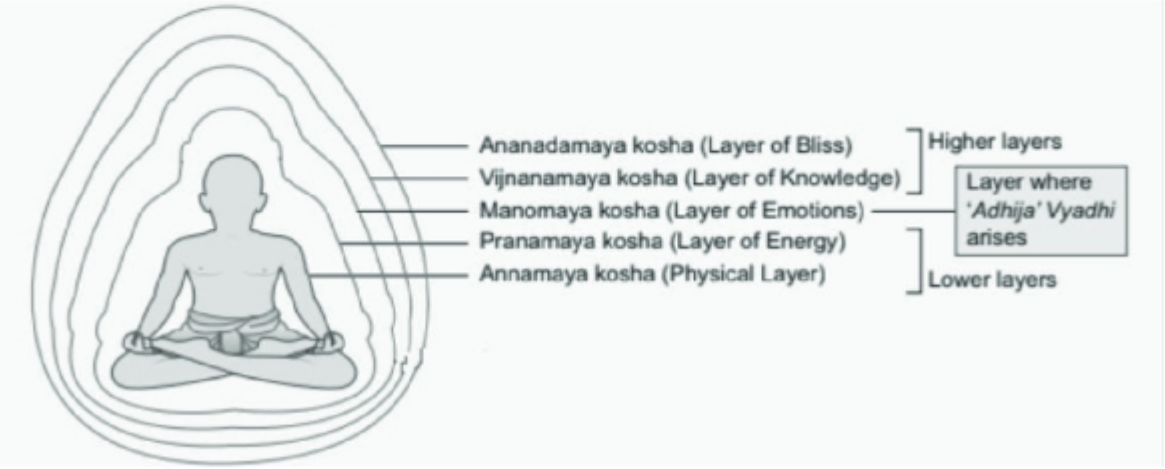


Figure 1: Representation of five layers of existence

2.3.How do you decide which path of yoga is suitable for a person?

There are four major paths of Yoga. They are:

a) Jnana Yoga (path of knowledge and wisdom),
b) Raja Yoga (path of will power and practice),
c) Bhakti Yoga (path of devotion) and
d) Karma Yoga (path of selfless action).

Yoga as therapy can be personalised according the nature of the mind and coping style that he/she adopts in stressful situations.

When asked a question about how an individual copes from a stressful situation, four major ways evolve. They are:

i. Contemplating on the problem and reading ancient scriptures or various literature for wisdom and solution (intellectually dominant personalities),
ii. Use of willpower to overcome the stressful situation (willpower dominant personality),
iii. Expression of the problem to the dear ones, crying and submitting oneself to higher force of existence (emotion dominant personality),
iv. Diverting the entire energy and focus on any action/service to the needy (action dominant personality).

Identifying the individual's most frequently used coping strategy; we can recommend a suitable path of yoga for their practice. The intellectually dominant personalities could be recommended to practice Jnana Yoga, willpower dominant personalities to practice Raja Yoga, emotion dominant personality to practice Bhakti Yoga, and action dominant personality to practice Karma Yoga (Refer figure 2).

2.4.If a person has "Intellectual" dominant personality, how do you channelise him on the path of "Jnana Yoga"?

Jnana yoga is a systematic way of understanding the real-self by contemplation of the knowledge from ancient traditional texts to discard ignorance from the mind. In order achieve this, the individual should be recommended to read texts that describe the nature of mind and also provide systematic methods to achieve stability of mind such as Patanjali Yoga Sutras, Chapter 2 of Bhagavad Gita. Also, reading texts such as autobiographies and biographies of enlightened beings is encouraged.

2.5.If a person has "Will power" dominant personality, how do you channelise him on the path of "Raja Yoga"?

Raja Yoga is the path to master the mind by the systematic practice of Ashtanga Yoga (8 limbs of yoga). Ashtanga yoga includes Yama, Niyama, Asana Pranayama, Pratyahara, D harana, Dhyana and Samadhi. This path requires willpower. The individual is advised to practice the eight limbs of yoga with perseverance for long duration, avoiding interruptions in the practice. Such practice brings stability at the mind.

2.6.If a person has "Emotion" dominant personality, how do you channelise him on the path of "Bhakti Yoga"?

Bhakti Yoga is the path of surrendering and engaging oneself in unconditional love towards any higher principle of life. This path best suited for emotion dominant personalities. They are encouraged to identify their Ishtadevata (higher principle of life) and connect to them emotionally by prayer, bhajans and offerings. They should be encouraged to perform their actions by surrendering their doership to this greater entity. They can be advised to read and further follow descriptions of Bhakti in Bhagavad Gita chapters 9, 10, 11 and 12.

2.7.If a person has "Action"" dominant personality, how do you channelise him on the path of "Karma Yoga"?

Karma Yoga is the path of performing action with utmost involvement but at the same time, detached from the fruits of action. This path is recommended for action dominant personalities. They should be advised to perform service-based activities. Especially, the service targeting the needy sections of the community. They should also be advised to refer to the Chapters 3,4,5 of Bhagavad Gita

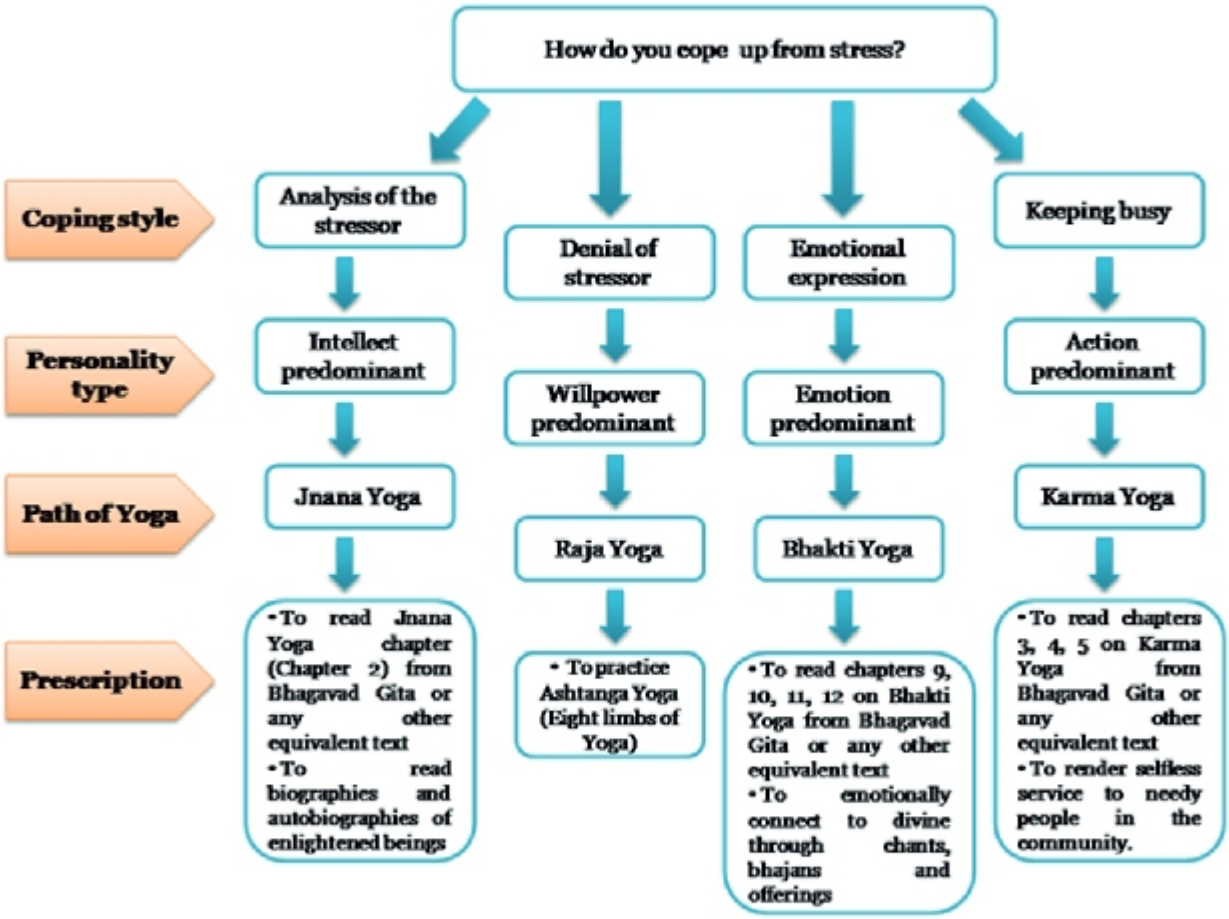


Figure 2: Recommendations on path of Yoga for different personalities

2.8. How does yoga classify different types of minds?

There are four types of minds according to the descriptions in Bhagavad Gita. They are: Sattva, Rajas, Tamas and Gunatita.

Sattva refers to the qualities of the mind such as self-control, virtuousness, and a sense of responsibility. *Rajas* is characterised by desire, passion, and attachment to material growth. Tamas is characterised by lethargy, false perception, and rigidity. Sattva, Rajas, and Tamas exist together. Whichever is the most dominant one, describes the individual's mental state. The ability to maintain equilibrium in extreme situations, untouched by likes-dislikes and good-bad, and performs all actions devoted to a higher principle of life describe the mental state of Gunatita. The practice of yoga aims at a systematic evolution of the mind from Tamas to Rajas, Rajas to Sattva, and Sattva to Gunatita (Refer to figure 3). Therefore, it is important to assess the mental attributes of an individual to plan a personalised yoga therapy module.

2.9.What type of lifestyle should be advised to shift a mind from the "Tamasik" trait to "Rajasik" trait?

A Tamas predominant personality is identified with low Rajas and Sattva. Hence, a gradual transition to Rajas and then to Sattva should be targeted.

Behavioural practices (Vihara): Yoga practices must include dynamic Suryanamaskaras (sun-salutations), Surya AnulomaViloma (right nostril breathing), Bhastrika (bellow's breath), and Kapalabhati (skull shining breath). Loud chanting of the sound AAA and Bhajans should also be included.

To encourage planning a schedule for organising the day.
To avoid excessive sleeping (not more than 6-7 hours/ day) and daytime sleep.
To encourage mobility and physical activity throughout the day. To avoid long -sitting

Dietary advice (Ahara): Rajasik diet with strong tastes (salty, sour, pungent, astringent, spicy) and invigorating spices (cloves, cardamom, black pepper, cinnamon, ginger, and garlic) is prescribed. Cheese, curd, fermented items, and canned and preserved foods should be avoided.

Mental attitudes (Vichara): Yogic counselling should aim at changing their state from procrastination and poverty of action to target-oriented action. Initially, encourage small task actions with reinforcement through fear or reward. Gradually, the complexity of the tasks can be aimed at.

2.10. What type of lifestyle should be advised to shift a mind from the "Rajasik" trait to "Saatvik" trait?

Behavioural practices (Vihara): Recommended to practice yoga module that starts with dynamic practices such as Suryanamaskaras (sun salutations) and is slowly graduated to slow practices such as maintenance in asana, Nadishuddi Pranayama (breathing through alternative nostrils), Bhramari Pranayama (humming bee sound), soothing chants and relaxation techniques with awareness on breath and mind as the main components. This will help to cut down the speed of their mind. Also, the practice of Laghushankhaprakshalana (systematically induced purgation) should be advised.

Dietary advice (Ahara): A Sattvik diet that includes fresh, juicy fruits and vegetables, whole grains, and legumes with pleasant taste is recommended. The food should be freshly cooked, least processed, and unctuous with natural oil. Avoid food items that are strong to taste (salty, sour, pungent, astringent, spicy)

Mental attitudes (Vichara): Yogic counselling should aim at changing their attitude towards action and associated results by broadening their perception of overall social wellbeing. This can be achieved by promoting the attitude of gratitude, being able to let go, and also performing simple acts of giving without expecting anything in return. To encourage being mindful about every action performed and being satisfied with the present.

2.11. What type of lifestyle should be advised to shift a mind from the "Sattvik" trait to "Gunatita" trait?

The shift from Sattva to Gunatita is a very challenging phase.

Behavioural practices (Vihara): Advanced asanas maintained with ease and stability, pranayama with longer and comfortable breath retention phases, and advanced meditative techniques are advised for a Sattvic personality to transcend to the Gunatita states.

Dietary advice (Ahara): The diet is not different from the Sattvic diet. However, it encompasses much deeper aspects like consuming food as an offering to the divine with an immense sense of gratitude. Offering prayer before consumption of the food is recommended. The individual should be able to accept any food given to them.

Mental attitudes (Vichara): The counselling programme should focus on creating awareness about attachment to the good, discussing the source of dualities (good and bad), and being mindful and non-judgemental. Doership should be fully given up and act as an instrument of the divine. Focus at flexibility in their perception of self, society and their interactions.

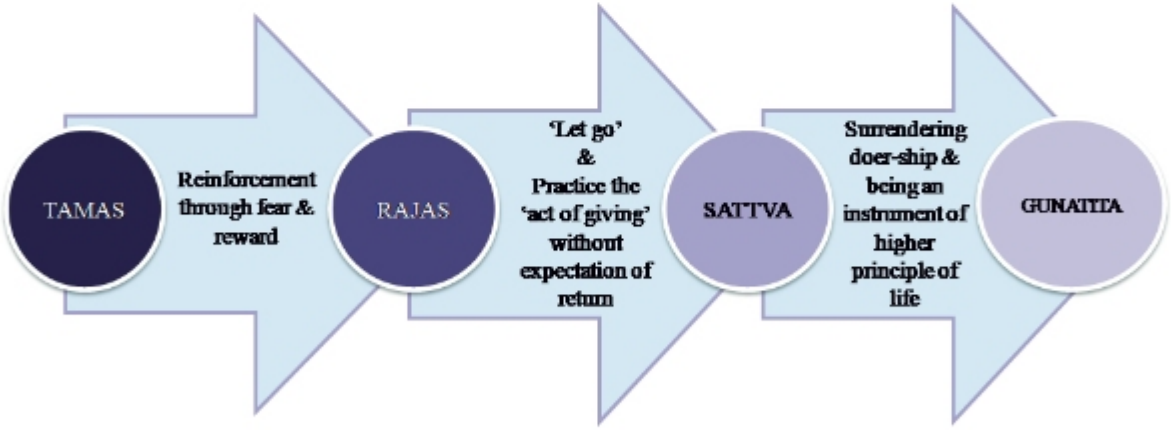


Figure 3: Systematic evolution of mind from Tamas to Gunatita

2.12. What are the precautions to be taken before practising Yoga?

Yoga should be practised on light stomach condition (only after three hours of taking a full meal and only after 2 hours of consuming a snack)

Perform your practises within your comfortable limit

Wear loose comfortable cotton clothing while performing yoga

Avoid consumption of tea, coffee or any other intoxicant before yoga practise (at least 2 hour)

REFERENCES:

1. CharakaSamhitha, Chikitsasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia; 1st/ 4th
2. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 5th chapter
3. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1/57th
4. *Ashtangahridayasutrasthana*(KRSreekanthamurthy, trans, eng): 4thed. Varanasi. ChowkhambhaKrishnadas Academy:1/5
5. *Ashtangahridayasutrasthana*(KRSreekanthamurthy, trans, eng): 4thed. Varanasi. ChowkhambhaKrishnadas Academy:1/4
6. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1/55
7. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 7/52
8. CharakaSamhitha, nidanasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 7th chapter
9. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 9/11
10. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 9/11
11. CharakaSamhitha, nidanasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 7th chapter
12. CharakaSamhithavimanasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1/21
13. CharakaSamhitha, sutrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 7/53
14. CharakaSamhitha, chikitsasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1-4/35
15. Achara rasayana-a behavioural therapy in Ayurveda to promote health and happiness. Internation al Journal of Ayurveda and Pharma Research,2018
16. Sadvritta (code of right conducts) in Ayurveda, World journal of pharmacy and pharmaceutical sciences, Bagde A. B, et. al, 2017
17. CharakaSamhitha, sutrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 8/15
18. CharakaSamhitha, vimanasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1/ 95
19. *Ashtangahridayasutrasthana*(KRSreekanthamurthy, trans, eng): 4thed. Varanasi. ChowkhambhaKrishnadas Academy:4/25
20. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 5th chapter
21. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 11/54
22. CharakaSamhitha, suthrasthana,Vaidyabhagavandas, (trans.)(eng.), Varanasi: ChaukambhaOrientalia 1/58

MODULE 21

Rehabilitation Services and Benefit Schemes in Mental Healthcare

Rehabilitation is helping the person with disability return to optimal level of functioning and achieve their life goals. Life goals differs based on person's life situation and aspirations. A person's goals can be getting a job, having friends, being respected by others or being independent. Thus, the concept of rehabilitation is diverse.

The strengths and abilities of the person with disability along with their family support can help restore the functioning ability.

Who can provide rehabilitation?

The treating and rehabilitation team can make a rehabilitation plan with the help of patient's family, friends and employers. Rehabilitation can be done as in-patient and out-patient services. A Rehabilitation team comprises of trained professionals from various disciplines like Psychiatry, Clinical Psychology, Psychiatric Social Work, Psy chiatric Nursing and Vocational instructors.

When and how long rehabilitation is needed?

Rehabilitation should start from beginning of the treatment to be most effective. Rehabilitation at an early stage helps people achieve their goals better and with less difficulty. Rehabilitation interventions can range from rehabilitation counselling to years of intensive interventions depending on the person's needs.

Why persons with a psychiatric illness need Rehabilitation Services?

Persons with psychiatric illness need rehabilitation for keeping oneself engaged, structuring day to day activities, promote or develop good work habits, rehabilitation counselling, assessing job potentials, help with studies and find a job, training to improve memory & concentration, improve social and communication skills, exercise, leisure activity.



Social welfare benefits and schemes for Person with Disability (PwD)

Rights of Person with Disability Act was enacted on 2016 (RPwD Act).

The Act was brought in as a means to ensure that the persons with disability (PwD) have a right to equality, lead their life with dignity, and respect for their own integrity at par with other members of the community. The Act also ensures protection of the PwD from all forms of abuse, violence, exploitation, inhuman, and degrading activities. Total 21 disabilities are included in the Act.

21 Disabilities included are:

Blindness	**Mental Illness**	Speech and Language disability
Low-vision	**Autism Spectrum Disorder**	Thalassemia
Leprosy cured persons	Cerebral Palsy	Hemophilia
Locomotor Disability	Muscular Dystrophy	Sickle Cell disease
Dwarfism	Chronic Neurological conditions	**Multiple Disabilities including deaf, blindness**
Intellectual Disability	**Specific Learning Disabilities**	Acid Attack victim
Hearing Impairment	Multiple Sclerosis	Parkinson's disease

According to RPwD Act:

- "**Person with disability**" means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others;
- **"Person with benchmark disability"** means a person with not less than 40 per cent. of a specified disability where specified disability has not been defined in measurable terms and includes a person with disability where specified disability has been defined in measurable terms, as certified by the certifying authority;

Disability Assessment Tools for Mental Disorders under RPWD 2016

Intellectual and Developmental Disabilities (IDD)	Vineland Social Maturity Scale (VSMS)
Mental Illness (MI)	Indian Disability Evaluation and Assessment Scale (IDEAS)
Autism Spectrum Disorder (ASD)	Indian Scale for Assessment of Autism (ISAA)

As per RPWD Act 2016, Unique Disability Identity Card (UDID) is an integrated system which includes 21 disabilities for Issuance of Universal ID and Disability Certificate for Persons with Disabilities with their identification and disability details.

Benefits of having UDID card

UDID will be a proof for disability all over India and card will have details like identity, disability details of the person with disability (PwD).

PwD will not have to carry and maintain multiple documents.

Various benefits by Government can be availed with UDID card.

Registration Process for UDID card for Person with Disabilities (PwD's)

Registration process for UDID card	**Registration process for UDID card who already have Disability Certificate**
Registration can be done by online mode: www.swavlambancard.gov.in.portal.	Registration can be done by online mode: www.swavlambancard.gov.in.portal.
Documents required during registration process :	**Documents required during registration process**
1. Personal details required – Scanned copy of passport size photo and signature/thumb impression	1. Personal details required – Scanned copy of passport size photo and signature/thumb impression
2. Address Proof- Scanned copy of Aadhaar Card / driving license / passport / ration	2. Address Proof- Scanned copy of Aadhaar Card / driving license / passport / ration
card/Voter Id / other (Domicile Certificate) Note: The entered Address proof should match with the uploaded copy of the address proof	card/Voter Id / other (Domicile Certificate) Note: The entered Address proof should match with the uploaded copy of the address proof
3. Identity Details- Scanned copy of Aadhaar card / driving license / pan card / ration card / voter ID.	3. Identity details- Scanned copy of Aadhaar card / driving license / pan card / ration card / voter ID
	4. Disability Certificate details Person already having valid disability certificate should upload the scanned copy of all the pages of Disability Certificate

How can a disability certificate help you?

Benefits	Schemes	Beneficiary
Disability pension	Disability pension varies based on percentage of disability. Example :40% to 75% disability ₹800/ month (Karnataka) ⩾75% disability ₹ 2000 / month(Karnataka) *Please verify in local district welfare office (DDWO) or nearest Revenue Office (Taluk Office) for the disability pension.	PwD
Travel benefits	Bus pass* (Rs 660 per year for KSRTC/BMTC (Karnataka). Please verify in respective state road transport	PwD
	corporation for registration / renewal amount.	
	Rail concessions (up to 75%)	PwD (ID) & 1 caregiver
Employment	1% reservation in government jobs. National career service portal	PwD due to IDD, ASD,SLD, Mental Illness(MI), and Multiple Disabilities
Education	5% reservation in government institutions Scholarships for PwD	All PwD, including those with ID, ASD,SLD, MI and Multiple disabilities SLD
	Exam concessions	SLD
IT Exemption	Under section 80U: ₹75,000/- for ⩾40% disability ₹1,25,000/- for ⩾80 % disability	PwD
	Under section 80DD: ₹75,000/- for ⩾40% disability ₹1,25,000/- for ⩾80 % disability	Caregiver of dependent PwD
Loans	Adhara (Karnataka) It is a loan scheme under the Department of Empowerment of Differently Abled and Senior Citizens(Govt of Karnataka). It can be availed by any person with more than 40% disability residing in Karnataka for more than 10 years.	PwD

Housing Scheme	Financial assistance for housing. Preferential site allotment (5% reservation)	PwD (except IDD and multiple disabilities)
Marriage allowance	₹50,000*(Karnataka) Please check with local district welfare officer	PwD
Pension transfer to PwD	Central Pension Accounting Office Ref. No. 1/27/2011-P&PW(E)	PwD
Exemption from routine transfers	No. 42011/3/2014-Estt.(Res.) dated June 6, 2014	Caregivers of PwD
Free legal aid services	All district courts.	PwD
National Trust Act schemes	As mentioned below	PwD covered under the National Trust Act1999

National Trust Act

	SCHEMES NAME	About the scheme	Beneficiary
1	NIRAMAYA	Health insurance scheme Insurance cover up to Rs1 lakh, on reimbursement basis. Treatment can be taken from any hospital. Facility for OPD treatment including the medicines, diagnostic tests, and transportation costs.	Persons with Intellectual Developmental Disorder (IDD), Autism Spectrum Disorder (ASD), Cerebral Palsy (CP) & multiple disabilities. Valid Disability Certificate is needed for applying the scheme.
2	VIKAAS	Day-care facilities for a duration of atleast 6 hours per day and activities enhancing interpersonal and vocational skills.	IDD, ASD, CP & Multiple disabilities. PwD should have a minimum age of 10 years. PwD should not be simultaneously enrolled under Samarth or Gharaunda scheme.
3	GHARAUNDA	Group Home for Adults. Vocational activities, pre-vocational activities. This also includes the provision of basic medical care from doctors and assistance for further training.	IDD, ASD, CP & Multiple disabilities. PwD should be more than 18 years of age

4	SAMARTH	Home providing respite for orphans or abandoned, families in crisis and also for PwDs from BPL & LIG families including destitutes.	IDD, ASD, CP & Multiple disabilities
5	SAHYOGI	Care associate training scheme. Aims to give training and make a skilled workforce of care associates, including parents. Provide two levels of courses primary and advanced. Parents or guardians may apply for this course.	Age group 18-45 years. 8th standard pass with regard to education No minimum qualification required for parents For advanced course they should have completed the primary training
6	BADHTE KADAM	Community awareness, community-level sensitisation, social integration and mainstreaming of PwDs.	Applicants should be registered with the National Trust Registered Organisation should not be blacklisted by the National Trust / any other government organisation
7	DISHA	Early Intervention and School Readiness Scheme Providing therapy, training and providing support to family members. Day-care facilities to PwD for at least 4 hours in a day.	Age group 0-10 years. With any one of the disability cover under National Trust Act. Should not have been registered under Samarth Scheme.
8	SAMBHAV	An additional information resource centre for providing information and easy access to aids, devices, appliances, software etc.	Must be Registered with the National Trust
9	PRERNA	The scheme is to create for sale of products and services produced by PwDs. 2. Providing funds to participate in events to sell the products made by PwDs. The scheme also provides an incentive to the Registered Organisation (RO).	51% of the working persons should be PwDs in the work centre. PwDs employed in the work centre should be above the age of 14 years.

Enrolment Process for these schemes:



Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY)

PM-JAY aims to reduce the financial burden on poor and vulnerable groups due to hospital admissions and ensuring access to quality health services.

1. Key features of PM-JAY

   No enrolment process is required.

   Provide hospitalisation covers upto Rs 5 lakh per family per year.

   Poor, deprived rural families and identified category of urban workers' families.

Details of rural and urban family categories that will be covered under PM-JAY are as follows:

For Rural:

Families targeted for PM-JAY should belong to one of the six criteria:

- Only one room with kuccha house.
- No adult member between age 16 – 59 yr
- Female headed house with no male member between age 16 – 59 yr
- Disabled member with no able-bodied adult member
- Scheduled Caste (SC)/Scheduled Tribe (ST) households
- Landless households whose major part of income come from manual casual labour

Families automatically included are:

- Households without shelter
- Destitute/ living on alms
- Manual scavenger families
- Primitive tribal groups
- Legally released bonded labour

For Urban:

The following occupational categories of workers are included:

- Rag picker
- Beggar
- Domestic worker
- Street vendor / Other service provider working on streets
- Construction worker/ Plumber/ Mason / Labour / Painter / Security guard
- Coolie and another head-load worker
- Sweeper/ Sanitation worker / Mali
- Home-based worker / Artisan / Handicrafts worker / Tailor
- Transport worker / Driver / Conductor/ Helper to drivers and conductors / Cart puller / Rickshaw puller
- Shop worker / Peon / Helper / Delivery assistant / Attendant
- Electrician / Mechanic/ Assembler / Repair worker
- Washerman / Chowkidar

The following beneficiaries are automatically excluded:

- Households having Kisan Credit Card with credit limit above Rs 50,000/=
- Household member is a government employee

- Households with non-agricultural enterprises registered with government
- Any member of household earning more than Rs 10,000/= per month
- Households paying income tax
- House with three or more rooms with pucca walls and roof
- Owns more than 2.5 acres of irrigated land with 1 irrigation equipment
- Owns 5 acres or more of irrigated land for two or more crop season
- Owning 7.5 acres of land or more with at least one irrigation equipment

Scheme is eligible for APL and BPL card holders
No cap on family size and age of members.
All members of family are eligible.
Free treatment available at all public and empanelled private hospitals.
Covers secondary and tertiary care hospitalisation
Cashless and paperless access to quality healthcare services.
1,350 medical packages covering surgery, medical and day care treatments, cost of medicines and diagnostics.
Beneficiaries of AB PM-JAY can use their PM-JAY card to access free treatments at ESIC empanelled hospitals

To check eligibility, beneficiaries can contact the helpline (14555/1800111565), visit nearest Common Service Centres (CSC) or log on to https://mera.pmjay.gov.in.
This can also be checked at empanelled hospitals.

Reference:

Department for Empowerment of Differently Abled and Senior Citizens, Govt of Karnataka, Bengaluru. www.dwdsc.kar.nic.in. (n.d.). Retrieved September 21, 2022, from https://www.dwdsc.kar.nic.in/

IEC Resources from the Psychiatric Rehabilitation Services, Department of Psychiatry, NIMHANS

National trust for welfare of Persons with Autism, Cerebral Palsy, Mental Retardation & Multiple Disabilities, www.thenationaltrust.in. (1999). Retrieved September 21, 2022, https://thenationaltrust.gov.in/upload/uploadfiles/files/National%20Trust%20Act%20-%20Englsih.pdf

The Rights of Persons with Disabilities (RPwD) Act, 2016. Department of Empowerment of Persons with Disabilities (Divyangjan), Government of India, Ministry of Social Justice & Empowerment. (n.d.). Retrieved September 21, 2022, from https://disabilityaffairs.gov.in/content/page/acts.php

Unique Disability ID, Department of Empowerment of Persons with Disabilities, Ministry of Social Justice & Empowerment, Govt. of India. (n.d.). Retrieved September 21, 2022, https://www.swavlambancard.gov.in/

Pradhan Mantri Jan Arogya Yojana (PM-JAY), National Health Authority, Government of India. (n.d.). Retrieved September 21, 2022, https://nha.gov.in/PM-JAY

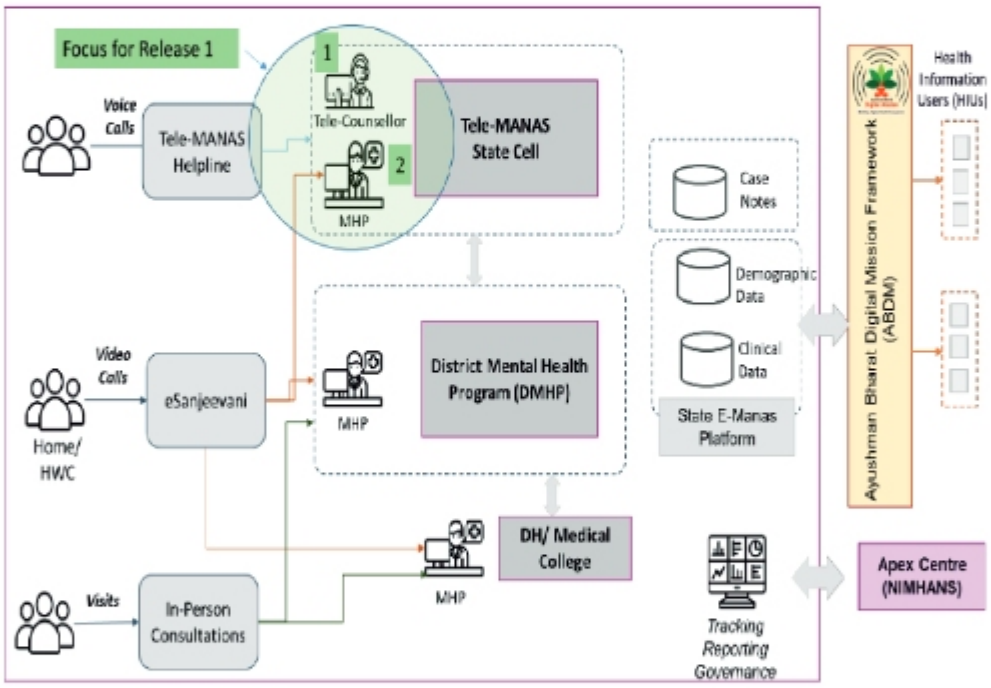
Narayan CL, John T. The Rights of Persons with Disabilities Act, 2016: Does it address the needs of the persons with mental illness and their families. Indian J Psychiatry. 2017 Jan-Mar;59 (1):17-20. doi: 10.4103/psychiatry.IndianJPsychiatry_75_17. PMID: 28529356; PMCID: PMC5419007.

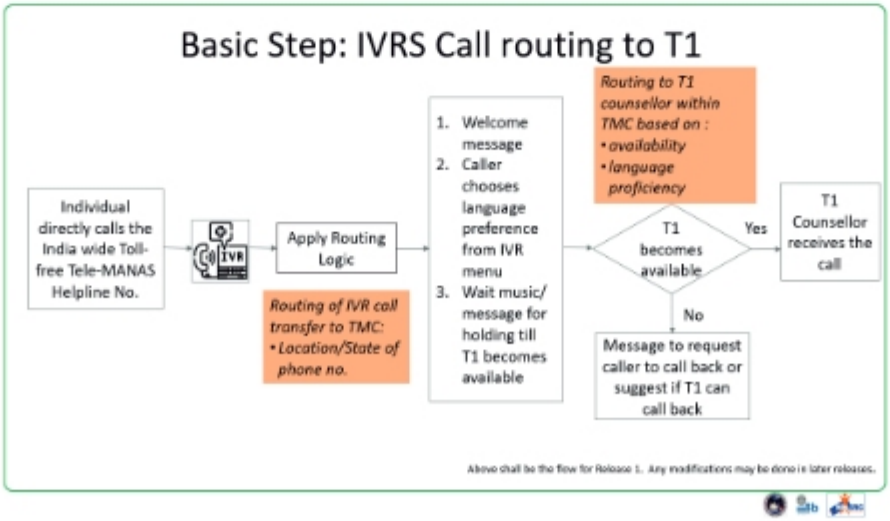
MODULE 22

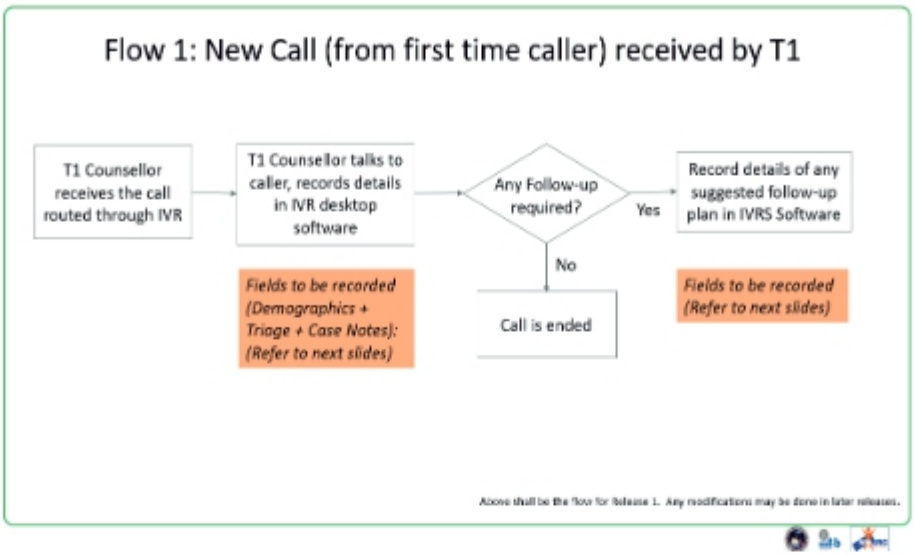
Technical Components Of Tele-MANAS : IVRS, FLOWS, Data Fields

Overview of Call Flow:

- Nationwide common 5-digit toll-free number setup
- Routing to State TMCs that are operational, based on caller's number
- Routing to T1 Counsellor depending on availability/language selected
- Counsellor receives a call on IVRS Desktop software, using a headset
- Counsellor records call details in IVRS software
- Feedback mechanism from Caller to be finalised

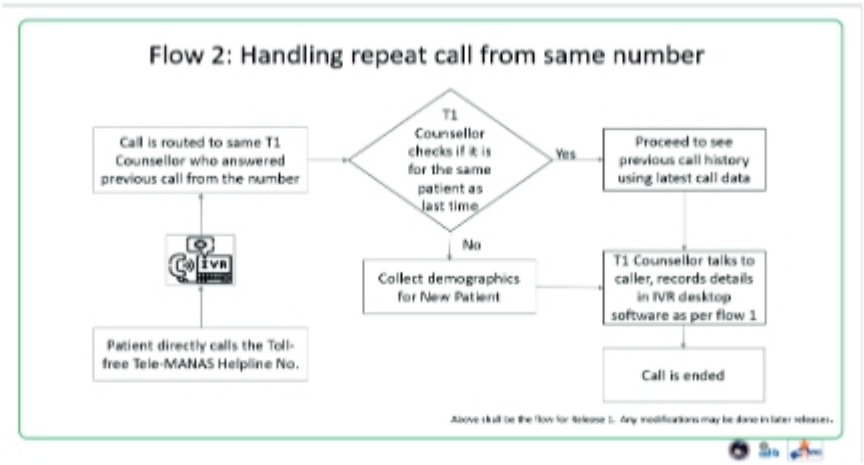


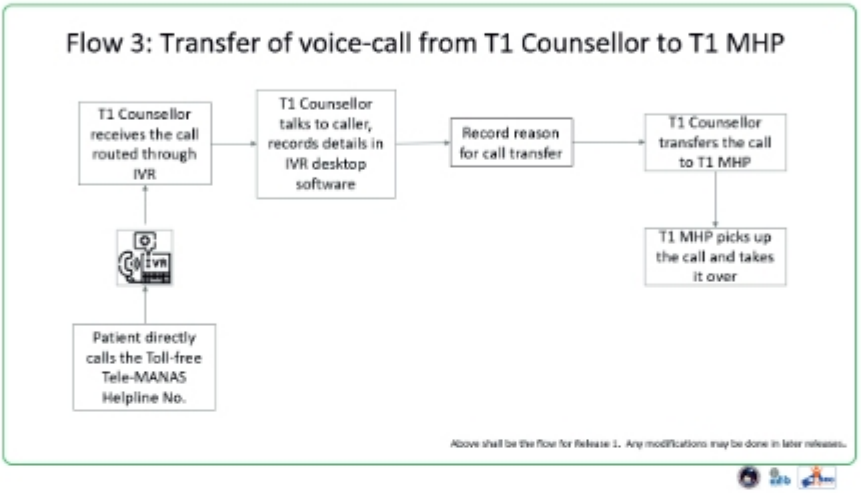




Fields to be captured by Counsellors

- Demographics of person in distress and/or caller
  - Name
  - Individual Calling (Patient / Caregiver / Others)
  - Age
  - Gender (Male/Female/Others/Prefer not to say)
  - District
  - State
- Triage
  - Emergency
  - Intermediate
  - Routine
  - Prank
- Case details
  - Presenting Complaints (Multiple options can be selected)
  - Brief Description of Complaints/ Reason for calling Helpline
- Details of Intervention provided mentioning
  - Plan for the Patient
  - Local Referral
  - Referral made to whom
  - Plan for follow-up
  - Plan for Callback
- Resolution of issue (Successful/Call dropped/Caller hung up)
- Date of Callback if needed + Mechanism for Reminder to Counsellor


Flow 2: Handling repeat call from same number
Call is routed to same T1 Counsellor who answered previous call from the number
T1 Counsellor checks if it is for the same patient as last time
Yes
Proceed to see previous call history using latest call data
No
Collect demographics for New Patient
T1 Counsellor talks to caller, records details in IVR desktop software as per flow 1
Call is ended
Patient directly calls the Toll-free Tele-MANAS Helpline No.
Above shall be the flow for Release 1. Any modifications may be done in later releases.


Flow 3: Transfer of voice-call from T1 Counsellor to T1 MHP
T1 Counsellor receives the call routed through IVR
T1 Counsellor talks to caller, records details in IVR desktop software
Record reason for call transfer
T1 Counsellor transfers the call to T1 MHP
T1 MHP picks up the call and takes it over
Patient directly calls the Toll-free Tele-MANAS Helpline No.
Above shall be the flow for Release 1. Any modifications may be done in later releases.

User Administration at TMC Level

- Coordinator/ Administrator will be identified at each TMC
- They will have access to IVR Administration Screen to
    - Add/update Counsellor data
    - Manage/Distribute counsellors in shifts

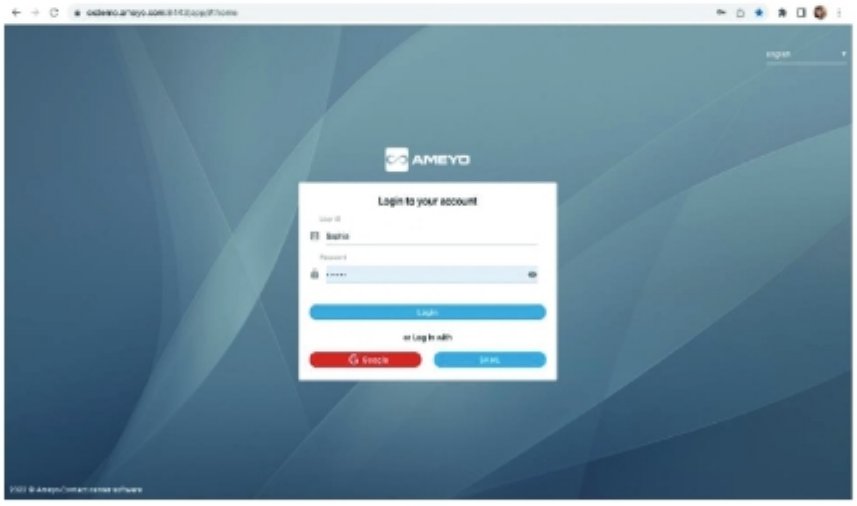
Setup of IVRS in State TMCs

- States need to procure required hardware
- States need to recruit and train human resources (Counsellors/ Mental Health Professionals/Admins/DEOs etc.,)
- States need to provide data through customised form / Google Form /E-mail
    - TMC Specific Data will be uploaded to IVR system by Administrator
        - Name/Address/Contact details of Tele Mental Health Cell
        - E-mail Address
        - Administrator in-charge in State Cell
        - Contact Details of Administrator etc.,
    - TMC Counsellor/ Mental Health Professional
        - Name of Counsellor
        - Educational Qualification
        - Date of Joining etc.,

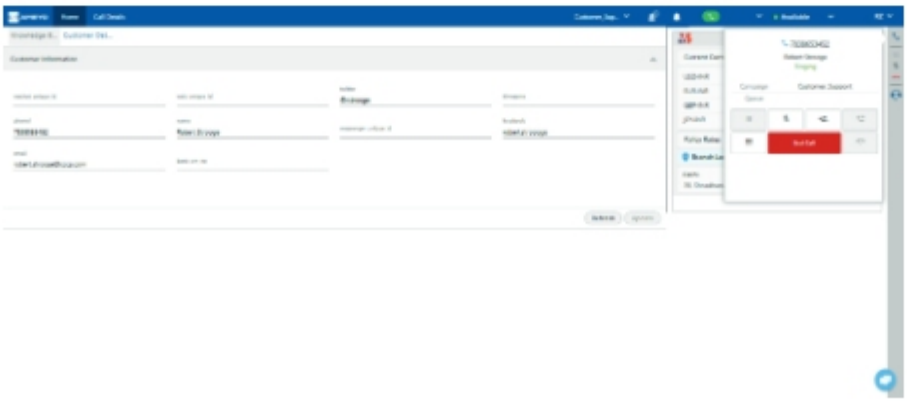
Accessing the IVR System

- Internet based access through Laptop/Desktop

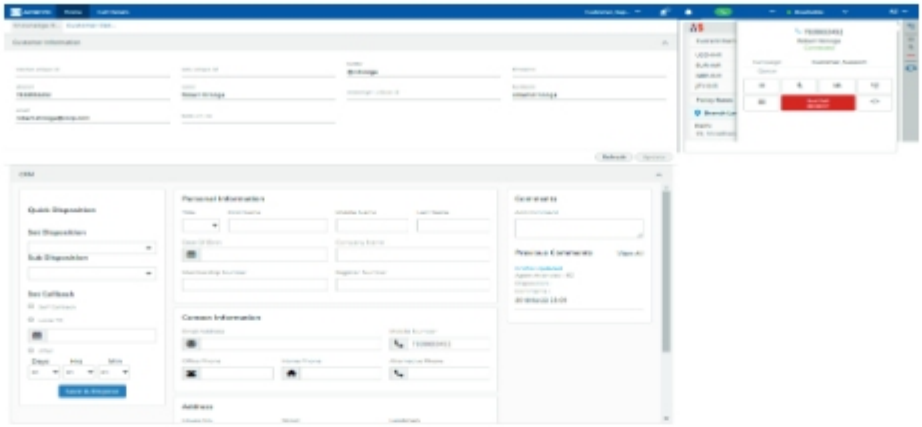
Access URL (Internet link), Username and password for the users to be shared separately



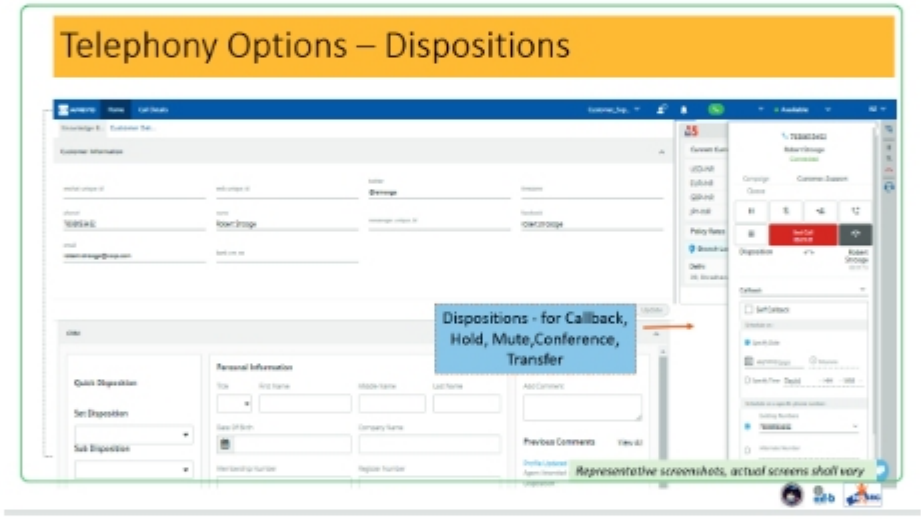
Caller Details Preview with CTI Pop Up



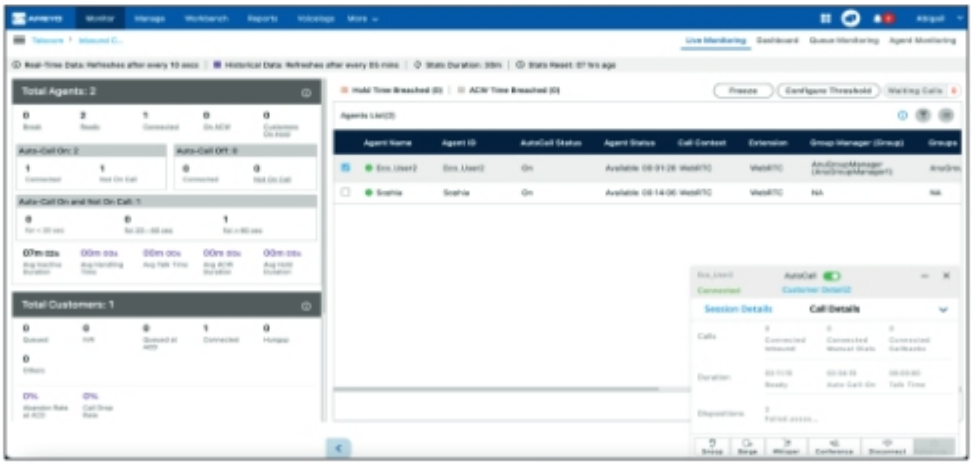
Recording Case Details



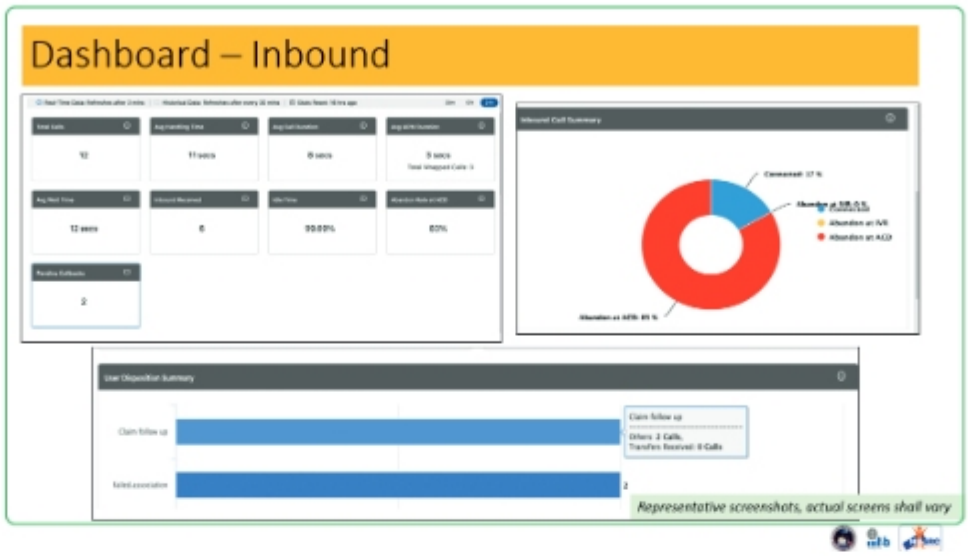
Telephony Options – Dispositions



Live Monitoring – Inbound



Dashboard – Inbound



ANNEXURE

List of State Tele-MANAS cells, mentoring institutes and the respective nominated representatives

S.No	States/ UTs	Nodal Officer/ Programme Coordinator	Nodal Person	Location of T-Manas Cell	Details of Mentoring Institutes
1	**Andhra Pradesh**	Principal Secy	Shri M.T. Krishana Babu	Siddharath Medical College, Vijaywada Dr P.S. Ajaykumar Asst Professor of Psychiatry Government Hospital for Mental Care, Peda Waltair, Visakhapatnam Dr N. Annapurna, MD, Asst Professor	All India Institute of Medical Science, Mangalagiri Contact: Dr Vijay Chandra Reddy HoD, Dept of Psychiatry
		MD, NHM Nodal officer	Shri J. Nivas, IAS		
		Programme Coordinator	Dr J. Narasinga Rao Programme Officer NMHP		
2	**Assam**	Principal Secretary	Shri Avinash Joshi	State Head Quarter, National Health Mission, Assam	LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor.
		MD,NHM Nodal officer	Dr. M.S.Lakshmi Priya, IAS		
		Designated Programme Coordinator	Dr Prakash Barman, Consultant NMHP		
3	**Arunachal Pradesh**	Principal Secy	Shri Vivek H.P	Mental Hospital, Midpu, Arunachal Pradesh	LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor.
		MD, NHM Nodal Officer	Liyon Borang (APCS)		
		Programme Coordinator	Dr Haniya Payee		
4	**Andman & Nicobar Islands**	Principal Secy	Shri Arjun Sharma	A & N Islands institute of Medical Sciences (ANIIMS), Port Blair	Jawaharlal Institute of Post Graduate Medical Education & Research (JIPMER) Puducherry
		MD, NHM Nodal Officer	Shri Arjun Sharma		
		Programme Coordinator	Dr Navin Govind		

S. No	States/ UTs	Nodal	Name of Nodal Person	T-manas	Location of T-Manas Cell	Details of Mentoring Institutes
5	Bihar	Principal Secy	Shri Pratyaya Amrit	03	Indra Gandhi Institute of Medical Sciences, Patna Bihar Institute of Mental Health & Allied Sciences, Koilwar , Bhopur Jawaharlal Nehru Medical College Hospital, Bhagalpur, Bihar	Indira Gandhi Institute of Medical Sciences, Patna (Contact : Dr Rajesh Kumar HoD, Psychiatry
		MD, NHM Nodal Officer	Shri Sanjay Kumar Singh, IAS			
		Programme Coordinator	Dr Sunil Kumar SPO, Mental Health			
6	Chandigarh	Principal Secy	Shri Yashpal Garg	01	Govt Medical College & Hospital (GMCH) Sector 32 in liason with GMCH Sector 16	PGIMER Chandigarh Prof. Debasish Basu, Dept of Psychiatry
		MD NHM Nodal Officer	Dr Suman Singh			
		Programme Coordinator	Dr Priti Arun HOD Psychiatry & Additional Director, Mental Health Institute,			
7	Chhattisgarh	Principal Secy	Dr Maninder Kaur Dwivedi	01	District Hospital, Raipur	AIIMS, Raipur. Contact : Dr Lokesh Sing HoD Psychiatry
		MD,NHM Nodal Person	Shri Bhoskar Vilas Sandipan			
		Programme Coordinator	Dr Sumi Jain SPC, NMHP			
8	Delhi	Principal Secy	Shri Amit Singla	01	Institute of Human Behaviour and Allied Sciences, Delhi	Institute of Human Behaviour and Allied Sciences, Delhi
		MD,NHM & Nodal Person	Shri V.S. Rawat 2 Dr R.K.Dhamija, Director IHBAS, Nodal Person			
		Programme Coordinator	Dr Om Prakash Professor of Psychiatry			
9	Dadar Nagar Haveli	Principal Secy	Dr A. Gopi Krishanan	01	2nd Floor, IT Cell/108 building, Shri Vinoba Bhave Civil Hospital, Silvassa, DNH Contact	Hospital for Mental Health, Ahemedabad Contact : Dr Dipti Bhatt,
		MD,NHM Nodal Person	Shri Suresh Chand Meena			
		Programme Coordinator	Dr Meghal Shah – SPO-NCD, CPHC,QA			
10	Goa	Principal Secy	Shri Arun Kumar Mishra	01	BSNL Head Quarter	Institute of Psychiatry and Human Behaviour, Goa (Contact : Dr Shilpa Waikar
		MD,NHM Nodal Person	Shri Arun Kumar Mishra			
		Programme Coordinator	Dr Rupa Nayak CMO, NCD & In-charge Mental Health Programme			
11	Gujarat	Principal Secy	Shri Manoj Agarwal, Add Chief Secretary	02	Hospital for Mental Health, Ahemedabad PDU Medical College, Rajkot	Hospital for Mental Health, Ahemedabad Contact : Dr Dipti Bhatt,
		MD NHM Nodal Officer	Remya Mohan			
		Programme Coordinator	Dr Ajay Chauhan Programme Officer, Mental Health, Medical Services, Gandhi Nagar			
12	Haryana	Principal Secy	Dr. G. Anupama Add Chief Secretary	01	Under finalisation Proposed at State HQ of State Health Department & NHM	PGIMER, Chandigarh Prof. Debasish Basu, Dept of Psychiatry
		MD NHM Nodal Officer	Shri Prabhjot Singh			
		Programme Coordinator	Dr Suvir Saxena, SPO, Mental Health & De-addiction Services			

13	Himachal Pradesh	Principal Secy	Shri Subhasish Panda	**01**	Dist Solan in 104 Call Center	IGMC Shimla,
		MD NHM Nodal Officer	Shri Hemraj Bairwa			
		Programme Coordinator	Dr Gopal Chauhan Spo, NHM			
14	Jharkhand	Principal Secy	Shri Arun Kumar Singh	01	CIP, Ranchi	CIP Ranchi
		MD NHM Nodal Officer	Dr Bhuvnesh Pratap Singh			
		Programme Coordinator	Dr Lalit Ranjan Pathak , SNO,NMHP			

S.No	States/ UTs	Nodal	Name of Nodal Person	T-Manas	Location of T-Manas Cell	Details of Mentoring Institutes
15	Jammu & Kashmir	Principal Secy	Shri Manoj Kumar Dwived	01	IMHANS, Kashmir	Psychiatry Disease Hospital, Srinagar
		MD, NHM Nodal officer	Choudhary Mohammad Yasin			
		Coordinator	Dr Qazi Haroon Programme Manager NMHP			
16	Karnataka	Principal Secy	Shri T.K. Anil Kumar	02	NIMHANS DIMHANS	NIMHANS, Bengaluru
		MD, NHM Nodal Officer	Dr Arundhati Chandrashekhar			
		Programme Coordinator	Dr Rajani P, DD Mental Health			
17	Kerala	Principal Secy	Smt. Tinku Biswal	01	State Mental Health Programme office, Mental Health Center campus, Peroorkada, Thiruvananthapuram	The Institute of Mental Health & Neuro Sciences (IMHANS), Govt Medical College Campus, Kozhikode
		MD, NHM Nodal Officer	Dr Rathan U Kelkar, IAS			
		Programme Coordinator	Dr. Kiran P.S State Nodal Officer			
18	Lakshwadeep	Principal Secy	Shri Amit Satija	01	Govt Indira Gandhi Hospital, Kavaratti Contact :Dr Salih Komalam (Medical Superintendent) Dr Jhoncy James, Psychiatrist, IGH Kavaratt	IMHANS Kozhikode Contact : Dr P. Krishna Kumar, Director
		Nodal Officer	Shri K.Shamsudheen			
		Programme Coordinator	Dr Sabitha F Hassan Nodal Officer NMHP Kavaratti			

S. No	States/UTs	Nodal person /Programme Coordinator	Name of Nodal Person	T-Manas	Location of T-Manas Cell	Details of Mentoring Institutes
19	Ladakh	Principal Secy	Dr. Pawan Kotwal	01	MD office, Continental building, Skara Leh	PGI MER, Chandigarh Prof. Debasish Basu, Dept of Psychiatry
		MD, NHM Nodal Officer	Dr Iftakhar Ahmed Chowdhry (IRS)			
		Programme Coordinator	1. Dr Padma Angmo SNO, NMHP 2.Dr Fatima Nissa DNO,Kargil			
20	Maharashtra	Principal Secy	Dr. Pradeep Vyas	03	Regional Mental Hospital, Thane Regional Mental Hospital, Pune Geriatric Health & Mental Illness Center, Ambejogai, Beed or DH, Osmanabad	AIIMS, Nagpur (Dr Sujog Jaiswal)
		MD, NHM Nodal Officer	Dr. Ramaswami N			
		Programme Coordinator	Dr Swaonil Lale			
21	Madhya Pradesh	Principal Secy	Mohammad Suleman, Additional Chief Secretary	02	MGM Medical College, Indore Gwalior Mental Hospital, Gwalior	AIIMS, Bhopal Contact : Dr Vijendra Singh, HoD, Dept of Psychiatry, AIIMS
		MD, NHM Nodal Officer	Ms Priyanka Das			
		Programme Coordinator	Dr Sharad Tiwari, SPO Mental Health			
22	Manipur	Principal Secy	Shri V. Vumlunmang	01	Department of Psychiatry complex, RIMS, Imphal, Manipur	LGBTIMH, Tezpur Contact Dr Vijay Gogoi Associate Professor.
		MD NHM Nodal Officer	Dr Ningombam Somor			
		Programme Coordinator	Dr Athokpam Ranita Devi SNO, NHMP,			
23	Meghalaya	Principal Secy	Shri Sampath Kumar	01		LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor.
		MD NHM Nodal Officer	Shri Ram Kumar .S			
		Programme Coordinator				

S. No	States/ UTs	Nodal person /Programme Coordinator	Name of Nodal Person	T-manas	Location of T-Manas Cell	Details of Mentoring Institutes
24	Mizoram	Principal Secy	Ms. Esther Lalruatkim	01	Directorate Hospital & Medical Education, MINECO,Khatla, Aizwal	LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor
		MD, NHM Nodal Officer	Dr Eric Zomawia			
		Programme Coordinator	Dr Robert L Khawlhring SNO, NMHP			
25	Nagaland	Principal Secy	Shri Imokba Jamir Commissioner Secretary	01	State Mental Health Institute (SMHI) Kohima Contact : Dr Nuvotso Khesoh	LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor
		MD, NHM Nodal Officer	Dr.Thorhusiekatiry			
		Programme Coordinator	Dr Chikrozho Kezo SPO, NMHP			
26	Odisha	Principal Secy	Ms.Shalini Pandit	02	Mental Health Institute SCB MCH, Cuttack Prof Dr Ajay Mishra, Director cum Superintendent DMHP, De-Addiction Centre (DAC) unit of MKCG MCH Campus Berhampur, Ganjam Dr Bibhu Kumar Sahu, Asst Professor cum Joint Director	Mental Health Institute , SCB MCH, Cuttack Prof Dr Ajay Mishra, Director cum Superintendent
		MD, NHM Nodal Officer	Dr Brundha D, IAS			
		Programme Coordinator	Dr Prameela Barar, Add Director, Mental Health, SPO			
27	Punjab	Principal Secy	Shri Ajoy Sharma	01	Institute of Mental Health, Amritsar	PGI Chandigarh
		Nodal Officer	Abhinav Trikha			
		Principal Secy	Shri Ajoy Sharma			
		Programme Coordinator	1Dr Sandeep, Asst Director Mental Health 2 Ms Harsuchetun Kaur, State Coordinator,MH			

S. No	States/UTs	Nodal person /Programme Coordinator	Name of Nodal Person	T Manas	Location of T-Manas Cell	Details of Mentoring Institutes
28	Puducherry	Principal Secy	Shri C. Uday Kuma	01	Indira Gandhi Medical college & Research Institute, Kadirkamam	JIPMER (Contact : Director)
		MD, NHM Nodal Officer	Dr. G. Sriramulu			
		Programme Coordinator	Dr K. Balan Ponmani Stephen, Nodal officer			
29	Rajasthan	Principal Secy	Dr. Prithv	02	SMS Medical College, Jaipur Mental Hospital, Shastri Nagar, Jodhpur	
		MD, NHM Nodal Officer	Shri Sudhir Sharma			
		Programme Coordinator				
30	Sikkim	Principal Secy	Shri D. Ananda Commissioner cum Secretary	01		LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor.
		MD, NHM Nodal Officer	Dr. Raj Prabha Moktan			
		Programme Coordinator	Dr M.M.Dhakal Joint Director & SPO Mental Health			
31	Tamil Nadu	Principal Secy	Dr. P. Senthil Kumar	02	104 Helpline, The Director of Medical & Rural Health Services, Chennai-6	Institute of Mental Health, Chennai
		MD, NHM Nodal Officer	Ms.TMT. Shilpa Prabhakar, IAS			
		Programme Coordinator	Dr Venkatesh Mathan ,SNO, Mental Health			
32	Telangana	Principal Secy	Shri S.A.M RIZV	01	Institute of Mental Health, Hyderabad Contact :Dr Uma Shankar, Superintendent;	Institute of Mental Health,, Hyderabad Contact: Dr PhaniKanth Associate Professor
		Noda[Officer	Ms Swetha Mohanty, IAS			
		Programme Coordinator	Dr K Anusha			

S. No	States/UTs	Nodal person /Programme Coordinator	Name of Nodal Person	T-Manas	Location of T-Manas Cell	Details of Mentoring Institutes
33	Tripura	Principal Secy	Dr. Devasish Basu	01	Modern Psychiatric Hospital, Nasirgarh	LGBRIMH, Tezpur Contact: Dr Vijay Gogoi Associate Professor.
		MD, NHM Nodal Officer	Shri Subasish Das, TSG, SSG			
		Programme Coordinator	Dr Chaitali Malakar, Psychiatrist,Modern Psychiatric Hospital, Narsingarh			
34	Uttar Pradesh	Principal Secy	Shri Amit Mohan Prasad, Add Chief Secretary	04	BRD Medical College, Gorakhpur Mental Health Institute & Hospital, Agra Mental Health Hospital, Varanasi Mental Health Hospital, Bareilly	King George's Medical University, Lucknow (KGMU) Contact: Dr Vivek Agrawal
		MD, NHM Nodal Officer	Smt. Aparna U			
		Programme Coordinator	Dr Sunil Pandey, Directorate of Medical Health			
35	Uttara-khand	Principal Secy	Mrs. Radhika Jha	01	Mental Health Institute, Selaqui, Uttarakhand Contact : Dr Abhishek Gupta	AIIMS, Rishikesh, Uttarakhand Contact: Dr Vikram Singh Rawat
		MD, NHM Nodal Officer	Dr. R. Rajesh Kumar			
		Programme Coordinator	Dr Archana Ojha, Nodal officer, NMHP			
36	West Bengal	Principal Secy	Shri Narayan Swaroop Nigam	02	Tele-Counselling Cell, Swasthya Bhawan campus, Swasthya Sathi Building, 3rd Floor, Bidhan Nagar, Sector V Kolkota 700091 Pavlov Hospital & CoE on Mental Health 18, Gobra Road, Sea Lane, Beniapukur, Kolkota 700046	Institute of Psychiatry 7, Debendra Lal Khan Road, Bhowanipore, Kolkata 700020 Contact: Dr Surjit Sarkhel, Associate Professor, Dept of Psychiatry Pavlov Hospital & CoE on Mental Health 18, Gobra Road, Sea Lane, Beniapukur, Kolkota 700046 Contact: Prof Dr.Srijit Ghosh, HoD Psychiatry, Pavlov Hospital and CNMCH
		MD, NHM Nodal Officer	Shri Shubhanjan Das			
		Programme Coordinator	Dr Debasish Halder DDHS, NCD II			

Regional Coordination Center (RCC):

S.No	Name of the RCC	Director of RCC	Name of Nodal Person of T-Manas	Designation
1	CIP Ranchi	Dr B Das	Dr Surjit Prasad	Associate Professor, Psychiatry
2	LGBRIMH Tezpur	Dr S K Deori	Dr Vijay Gogoi	Associate Professor, Psychiatry
3	PGI, Chandigarh	Dr Vivek Lal	Dr Debasish Basu	Professor & Head, Psychiatry
4	IHBAS, Delhi	Dr R K Dhamija	Dr R K Dhamija	Director, IHBAS
5	NIMHANS, Bengaluru	Dr Pratima Murthy	Dr Naveen Kumar C	Professor, Dept. of Psychiatry

Apex Institute:

S.No	Name of the Apex Institutes	Director/ Head of the Institute	Name of Nodal Person of T-Manas	Designation
1	Ministry of Health & Family Welfare, Govt of India, New Delhi		Ms Noorin Bux,	Deputy Secretary, Mental Health
2	NIMHANS, Bengaluru	Dr Pratima Murthy	Dr Naveen Kumar C	Professor, Psychiatry
3	IIIT Bengaluru	Prof T K Srikanth	Ms Vandhana Venkatesan	Project and Operations Lead
4	NHSRC	Prof (Major General) Atul Kotwal	Dr Neha Dumka	Lead Consultant, KMD


सत्यमेव जयते


NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES


NHSRC


iit·b
ज्ञानमुत्तमम्