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# Advancing Mental Health in Tamil Nadu

An Agenda for Action (2017-2020)

## Background

In recent years, mental health has gained prominence as a public health priority with mental disorders accounting for 13% of years lost due to disease worldwide.<sup>1</sup> The situation is particularly stark in low and medium income countries such as India with 90% of people with mental health issues not receiving interventions that they require to regain health.<sup>2</sup> For over thirty years, there has been a thrust on increasing access to mental health care through community based services. Yet in 2017, while there are an estimated 150 million Indians living with mental disorders,<sup>3</sup> less than 10% of people with common mental disorders and only 40-50% of people with schizophrenia are estimated to be accessing any form of care.<sup>4</sup> Despite commitment at the policy level, there continues to be a persistent deficit in substantively translating these intents on the ground presenting a know-do gap for implementation.

Large institutional tertiary care facilities, that bear the burden of a hegemonic colonial inheritance and large long stay populations, command a vast majority of funds allocated for advancing mental health care with limited resources being invested in mental health in primary care with a focus on social inclusion. Confined within a retrograde paradigm of curative care, the district mental health programmes offer limited access to proximal services and negligent targeted disorder specific early intervention packages. Further lack of convergence between health and social sectors within such a framework of delivery disregards concomitant social distress such as gender based violence, chronic pervasive poverty, homelessness and so on that deeply impact mental health. The issue is conflated with both a quantity and quality issue in human resources for mental health - the need for psychiatrists, social workers, psychologists, nurses and other professionals far outstrips the supply; and even among those who work in the sector there are familiar trappings of system reinforced medicalised orientation.

These limitations arising out of systemic barriers to resource infusions into community care contribute to inconsistent outcomes with limited meaning among people with mental illness. Chronicity, low work participation and high carer burnout foment pervasive negative notions of mental ill health and stigmatising attitudes that affect help seeking, to perpetuate a vicious cycle of delayed therapy and suboptimal gains among people living with mental health issues.

### **Emerging trends: Recovery, Progressive policy and legislation**

There is a large body of multidisciplinary evidence based interventions that have proven to be successful in influencing inspiring outcomes among people with mental illness. The concept of personal recovery

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

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

<sup>3</sup> Gururaj, G., et al. "National Mental Health Survey of India, 2015-16: Summary." *Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication* 128 (2016).

<sup>4</sup> Patel, Vikram, et al. "The magnitude of and health system responses to the mental health treatment gap in adults in India and China." *The Lancet* 388.10063 (2016): 3074-3084.

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with emphasis on people achieving the lives they want for themselves, despite presence or absence of symptoms and disability, has been emerging as a prominent perspective.<sup>5</sup> Mental health and promotion of well-being have been included as part of the Sustainable Development Goals (SDGs) indicating a global thrust on allocating resources to the sector as part of national development plans. Closer home, in February 2017 the Supreme Court of India has in an order in a case pertaining to issue of long stay at various hospitals in Uttar Pradesh directed the Centre to frame a policy for rehabilitation of people recovered yet living for long periods in these facilities. The Centre has recently also notified progressive laws in both disability and mental health, that attempt to be in consonance with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD), offer an emphasis on rights, social security, access to services and equitable living in society. At this juncture, these developments offer an unparalleled opportunity to sculpt systematic plans that can convert the stated moral imperatives into actual reality beyond written declarations, that otherwise risk becoming another recital of platitudes in the absence of action.

The recently concluded National Mental Health Survey 2015-16 notes some redeeming features in comparison to other states in India, such as the availability of 68% of essential psychotropic medication at Primary Health Center level, higher density of health workforce and highest number of institutes offering postgraduate studies in psychiatry.<sup>6</sup> Despite the strides Tamil Nadu has made on these indices, it scores poorly on intra and inter sectoral collaborations (4 out of 10) and in training of human resources (2 out of 10). Only 20 out of the 32 districts are covered by a monthly camp style district mental health programme.<sup>7</sup> The Institute of Mental Health (Chennai) is weighed down by, among many other issues, 733 of a total bed strength of 1800 being occupied by people who have been incarcerated for one year or more, of which 551 have lived for over five years inside the hospital.<sup>8</sup> Further, the state has recorded one of the highest suicide rates in the country for the last five years.<sup>9</sup>

The report also highlights that despite these lacunae, there are significant efforts being undertaken in the mental health sector, both by the Government and civil society organisations in Tamil Nadu. The State has 121 NGOs,<sup>10</sup> the highest number in the country, working within the mental health sector. It has effectively formed a State Mental Health Authority (SMHA), has seasoned professionals in leadership posts, and adequate financial resources for the DMHP and the nodal health centre. In light of these strengths, and the intent displayed by the State to be a pioneer in offering appropriate healthcare, the Government of Tamil Nadu (GoTN) is in a unique position to transform the State mental health care system into one that is responsive, user-centric, and inclusive, thus resulting in the creation of more healthy, resilient communities that embrace diversity.

## Agenda for Action in Tamil Nadu

To advance mental health in Tamil Nadu, there is need for committed and concerted effort to accelerate changes in systems statewide to enable conducive structures and environments that can spiritedly absorb and deliver comprehensive solutions based on a recovery perspective emphasising on

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<sup>5</sup> Slade, Mike, Michaela Amering, and Lindsay Oades. "Recovery: an international perspective." *Epidemiology and Psychiatric Sciences* 17.2 (2008): 128-137.

<sup>6</sup> Gururaj, G., et al. "National Mental Health Survey of India, 2015-16: Summary." *Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication* 128 (2016).

<sup>7</sup> Gururaj, G (2016)

<sup>8</sup> Murthy, P., et al. "Report of the Technical Committee on Mental Health 2016, pp.112. National Human Rights Commission. [http://nhrc.nic.in/Documents/Mental\\_Health\\_report\\_vol\\_I\\_10\\_06\\_2016.pdf](http://nhrc.nic.in/Documents/Mental_Health_report_vol_I_10_06_2016.pdf). Accessed on 28 June 2017.

<sup>9</sup> National Crime Records Bureau. *Crime in India 2015. Chapter 2-Suicides in India*. New Delhi:Ministry of Home Affairs. Available at <http://ncrb.nic.in/StatPublications/ADSI/ADSI2014/chapter-2%20suicides.pdf>. Accessed on 28 June 2017.

<sup>10</sup> Murthy, P (2016)

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meaningful, inclusive and satisfying lives for people with mental illness. The state mental health policy's stated vision is:

#### *Vision*

To promote mental health and ensure socio economic inclusion of persons affected by mental illnesses in Tamil Nadu; Continue to work in partnership with patients and their families to facilitate recovery and reintegration through the provision of affordable, accessible, comprehensive and community-based mental health services.

#### *Values and Principles*

We have identified cross cutting foundational values to assist in articulation of vision into practice:

1. **Person centered care:** Design and delivery of services will be centered around the priorities and needs for recovery that are expressed and directed by persons living with mental illness and their families. Services will endeavour to systematically onboard participation of and feedback from their primary constituencies, explicitly involve processes to nurture collaborative shared decision making with service users on all aspects of care.
2. **Focus on dignity, participation and experience of agency:** Services will enable participation of people with mental illness at home, work and community and assist them to express their will and determine their lives.
3. **Promote recovery and strengths based approaches:** Services will incorporate approaches that enable lives with engagement, hope and personal meaning, irrespective of diagnosis, disability levels, clinical prognosis and chronicity, acknowledging and building on strengths and opportunities present in all individuals and situations.
4. **Promote justice and social inclusion:** The Mental health system will take into cognisance social determinants such as extreme poverty, gender or caste based discrimination, poor housing, which deeply impact mental health. Particular marginalised groups are at greater risks of mental ill health and negative consequences of cascading into homelessness more than the general population. Services will acknowledge such socio-economic structural barriers, work with a positively biased focus with such populations and jointly deliver care plans that incorporate clinical and social recovery pathways to eliminate inequity and lift people out of extreme poverty.
5. **Build and federate service user, carer groups and restore power:** Service users and carers will be federated and incrementally empowered as advocacy groups to take leadership on their issues and drive necessary change in the mental health system.
6. **Recognise importance of tacit knowledge:** The mental health system will recognise the role of embodied knowledge, acquired through experience which cannot be expressed explicitly but is employed intuitively, in developing human resources with necessary skills to support a recovery focused, rights based, comprehensive continuum of care. Capacity building of human resources will incorporate a significant component of ongoing supervision to cultivate tacit knowledge.
7. **Cross sectoral, interdisciplinary approach to maximise gains:** Services across the continuum will adopt interdisciplinary care planning that incorporates interventions from diverse disciplines to drive the many goals of recovery from symptom reduction, return to work to reducing carer burden. Cross sectoral collaborations with the disability and social welfare departments and agencies are essential to comprehensive service delivery, enhanced outcomes and therefore decreased costs on account of ill health over a period of time.

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8. **Build responsiveness and accountability in the work force:** The mental health system will recognise the dependency on human resources in maintaining quality of care and will build a culture among staff to be responsive and accountable to service users.
  9. **Prevention and early intervention:** Prevention and early intervention have long ranging consequences for mental health by reducing mental ill-health and chronicity and thereby decreasing need for acute care and enhancing quality of life. Across the continuum of care, services will encapsulate prevention and early intervention efforts.
  10. **Use of diverse evidence modes to inform incremental policy and practice:** The Mental health system will establish accountability by measuring outcomes on a regular basis, incorporating scheduled monitoring and review mechanisms that offers continual feedback to services and re-calibrating strategy based on emerging lessons. Diverse modes of evidence will be employed to inform policy decisions and design of services, including service user perspectives, their narratives of ill-health and recovery, social audits through participatory research and repeated measures of key outcomes.

We recommend four priority areas for action in keeping with the vision of the State and the National Mental Health Policies, the Mental Healthcare Act 2017 and the emphasis on full participation and access to necessary supports for independent living in the United Nations Convention on Rights of Persons with Disability (UNCRPD).

## Priority 1: Bridge Treatment and Social Care Gap

Increasing appropriateness and efficacy of services

Nearly half of the homeless people with mental illness who have come in contact with The Banyan are from Tamil Nadu, over 30% from the city of Chennai which is relatively well resourced with availability of psychiatric consults and medication and have despite this cascaded into homelessness.<sup>11</sup> Availability of proximal psychiatric consults and medicines at urban or rural primary health centers is an important facet of increasing access to care. However in the absence of interventions that target social recovery goals such as return to work, decreasing household burden of care, regaining independence in day to day living, fostering adaptive caregiving patterns and so on, despite availability of evidence based therapy, treatment gap will persist with most people experiencing less than optimal outcomes and remaining out of care. Enhancing appropriateness of services to delivery early care and thereby achieve best possible gains is critical to lifting service performance to close the treatment gap.

This priority will focus on increasing appropriateness and efficacy of community mental health programmes in the state of Tamil Nadu over a five year period by enmeshing a wellness oriented, multi-dimensional care coordination framework of service delivery in select sites which can thereafter serve as capacity building hubs to diffuse this approach to community mental health to all districts of Tamil Nadu. In addition, the priority will view community mental health from a life course lens and offer services from childhood to old age with particular thrust on developing resiliency resources at individual, family and community levels.

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<sup>11</sup> Reintegration Data, Department of Monitoring and Evaluation, The Banyan

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## 1.1 Increase quick access to high quality, comprehensive interventions that fulfill psychological, physical and social needs of people with mental illness and their families in close to home settings

- *Establish state level guidelines for disorder specific high quality, accessible and comprehensive care packages combining clinical and social interventions:* We propose the development of detailed protocols outlining minimum service norms, care packages and process for people with mental illness demonstrating low, moderate and high needs based on combination of primary disorder and associated psychosocial issues. These will serve as the basis for ensuring fidelity to evidence based care across a multitude of mental disorders - those with high prevalence (depression and anxiety) and those with low prevalence but high severity (schizophrenia, bipolar and so on), early life and developmental disorders and disorders associated with old age.
- *Setting up Demonstration Sites:* Over a three year period, we propose that the state of Tamil Nadu incubate model community mental health programmes that offer comprehensive mental health care through distributed clinics anchored by multi disciplinary block mental health teams and supported by grassroots mobilisers who work across the public health (PHC) and social care (panchayat) system. In ten blocks (selected to represent diverse low, medium and high resource contexts) across Tamil Nadu, Year 1: 3 blocks, Year 2: 3 blocks, Year 3: 4 blocks. The demonstration sites will serve as resource and capacity building hubs and work with designated sub-sites in Year 4 and Year 5 to implement the same approach and scale up DMHP across Tamil Nadu.
- *Psychiatric Inpatient Care in District Hospitals:* We recommend that inpatient services of at least 30 bed capacity be set up as blocks within District Hospitals that serve as first referral units as part of the district's community mental health programme and offer both acute care and return to social living services.
- *Activation of Sub-Centers as first contact and follow up hubs:* We recommend that Sub-Centers, which are predominantly utilised to deliver maternal and child health interventions currently, be progressively developed to become hubs for social care assessments, joint delivery of health linked welfare entitlement i.e disability allowance in case of mental health linked to adherence to therapy, follow up center and home based services for those discharged from a higher level of care, lay counseling services and group based resilience and grit focused therapies. These centers will be staffed by Grassroots mobilisers (assigned to the Primary Health Centers) recruited to work as part of the District Mental Health Programme (DMHP).
- *Cadre of Grassroot Lay Workers:* We propose a rapid increase in availability of human resource through recruitment and skilling of grassroots cadre to work at Primary Health Centers and Sub-Centers and tie ups with poverty alleviation (Pudhu Vaazhvu Thittam (PVP) and Village Poverty Reduction Committees (VPRCs)) and disability sector volunteers for community based delivery of services.
- *Public Private Partnerships:* We propose a mapping of potential partners to assess value recovery orientation and capacities, and establishing collaborations to implement the block level mental health demonstration sites.

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- *Deaddiction Programme:* Within India there is an emerging body of evidence for lay health worker delivered care packages to address harmful alcohol use.<sup>12</sup> In the background of high prevalence of substance use, particularly alcohol use in Tamil Nadu, block mental health teams will require guidelines and capacity building to effectively screen for harmful use, offer primary level pharmacotherapy and harm reduction interventions at the primary level and escalate for inpatient care at district or state level tertiary care centers.
  - *Continuously monitor service readiness and quality levels* through staff capacity assessments and qualitative service audits monitoring of key indicators such as response time/reduced time to appropriate care, coverage of people using services receiving both clinical and social care and staff engagement/adherence to service guidelines.
  - *Collection and analysis of outcomes data* at client, household and community levels (decreased burden of disability on clients and their families, increased work participation and social inclusion, improved help seeking) beyond service output indicators.

## 1.2 Focus on Vulnerable Groups

- *Continuity in Care for people with complex needs*  
People discharged from tertiary care/inpatient settings, those with antecedents of homelessness and those running a chronic course with unremitting symptoms or absolute poverty require specific attention and consistent engagement to support their living in the community and reduce use of inpatient resources. We propose the initiation of a rigorous 12-18 month home based Continuity in care programme that supports development of independence in multiple domains necessary for social functioning ranging from care of self to participation in work and civic life through a matched community volunteer or health worker.
- *Early Intervention in Psychosis*  
Prognostic value of early intervention in psychotic disorders is well established in literature - length of untreated psychosis is associated with chronicity and poor outcomes,<sup>13,14</sup> while intervention at the critical early phase of onset predict social and vocational functioning.<sup>15</sup> Specialised early intervention services that run in liaison with primary care such as TIPS,<sup>16</sup> RAISE,<sup>17</sup> OPUS<sup>18</sup> and LEO<sup>19</sup> have demonstrated positive gains of better functioning, reduced inpatient care use and independent living. We propose the initiation of Early Intervention in Psychosis with active identification untreated psychosis and intensive specialist team

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<sup>12</sup> Nadkarni, Abhijit, et al. "The Systematic Development and Pilot Randomized Evaluation of Counselling for Alcohol Problems, a Lay Counselor-Delivered Psychological Treatment for Harmful Drinking in Primary Care in India: The PREMIUM Study." *Alcoholism: Clinical and Experimental Research* 39.3 (2015): 522-531.

<sup>13</sup> Marshall, Max, et al. "Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review." *Archives of general psychiatry* 62.9 (2005): 975-983.

<sup>14</sup> Perkins, Diana O., et al. "Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis." *American Journal of Psychiatry* 162.10 (2005): 1785-1804.

<sup>15</sup> Craig, Tom KJ, et al. "The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis." *Bmj* 329.7474 (2004): 1067.

<sup>16</sup> Johannessen, J. O., et al. "Early intervention in psychosis: the TIPS project, a multi-centre study in Scandinavia." *Psychosis: Psychological approaches and their effectiveness* (2000): 210-234.

<sup>17</sup> Rosenheck, Robert, et al. "Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program." *Schizophrenia bulletin* 42.4 (2016): 896-906.

<sup>18</sup> Petersen, Lone, et al. "A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness." *Bmj* 331.7517 (2005): 602.

<sup>19</sup> Craig, Tom KJ (2004)

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engagement with identified individuals in community care settings for a 2-5 year period followed by transfer to maintenance teams and appropriate escalation in event of loss of gains.

- *Homeless people with mental illness*

Transit Care Center and Shelter models implemented by various organisations in India such as The Banyan, Udavum Karangal and Anbagam in Chennai, Ashadeep in Guwahati, Iswar Sankalpa in Kolkata, that serve as restorative, safe spaces for homeless people with mental illness to access biopsychosocial interventions, pursue their capabilities and live a life that is meaningful and satisfying to them. Descriptive data from such organisations indicate that 80-90% of such people who are offered crisis intervention services journey back to their families of origin or choose independent living pathways into hostels or homes in urban/rural communities rented with their incomes. We recommend that each District psychiatric inpatient facility reserve a portion of beds and be trained to implement a rescue to reintegration protocol for people who are homeless with mental health issues. Under the disability sector's scheme for rehabilitation homes, most districts in Tamil Nadu have homes for homeless people with mental illness run in a public private partnership mode by locally identified not for profit organisation. National Urban Livelihood Mission (NULM) scheme of Shelters for homeless people includes special shelters for homeless people with mental illness. We recommend that community mental health teams identify, engage with and offer services and oversight for quality of care and adherence to minimum norms of care at such facilities.

- *Resilience focused Interventions for Children in Difficult Circumstances*

Self esteem and resilience have been demonstrated as important contributors to recovery among people with mental illness as well as reduce risks for developing mental illness.<sup>20,21,22</sup> A key focus for prevention and promotion in the mental health sector must therefore be on influence high risk pathways by increasing protective factors and diminishing risk factors. The existing District Mental Health Programme (DMHP) has life skills education in schools and colleges in its mandate. Translating this into a directed programme of intervention to serve objects of promotion and prevention will require:

- Systematic identification of children presenting with risk factors for mental ill-health (children living with parental mental illness, those experiencing social and economic discrimination, children in institutions, street children and so on ) through surveys and community mapping methods;
- Standardised group based engagement modules with children starting from pre-adolescence to their adolescent years that endeavour to cultivate mental wellbeing by fostering social support, adaptive coping, self esteem and resilience delivered in both school and non-school settings by grassroots mobilisers; both of which the Resource Center can develop from a broad range of existing interventions that have demonstrated success in low resource settings.

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<sup>20</sup> Torgalsbøen, Anne-Kari. "Sustaining full recovery in schizophrenia after 15 years: does resilience matter?." *Clinical schizophrenia & related psychoses* 5.4 (2011): 193-200.

<sup>21</sup> Deegan, Patricia E. "The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities." *Scandinavian Journal of Public Health* 33.66\_suppl (2005): 29-35.

<sup>22</sup> Mann, Michal Michelle, et al. "Self-esteem in a broad-spectrum approach for mental health promotion." *Health education research* 19.4 (2004): 357-372.

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- *Suicide Prevention*

Tamil Nadu has one of the highest suicide rates in India<sup>23</sup> making this an important focus for community mental health programmes in the state. Risks of suicide can be mitigated through a surveillance programme that targets high risk individuals and develops supportive, resiliency resources. We recommend that block mental health teams are trained to:

- Incorporate surveillance systems to document and record attempts and incidents of self harm and suicide
  - Identify, screen and persistently engage with high risk individuals in the community such as those with mental illness, farmers in debt, alcohol use, family or personal history of suicide and self harm, domestic violence, abject poverty and helplessness; and reduce access to lethal means:
  - Offer structured problem solving to those who attempt suicide or express suicidal ideations actively
  - Develop supportive networks of close contacts for people at high risk for suicide to reach out to in the community
  - Offer Dialectical Behaviour Therapy (DBT) in outpatient settings for those screened at high risk for suicide along with active problem solving and a buddy system
  - Offer protocol based escalations to District and state level specialist teams
  - Enable safe spaces for disclosure and support in sub centers
- *Management of Developmental Disorders*
- Developmental disorders present a high risk for mental disorders, with an estimated 40% of such individuals developing mental illness as adults.<sup>24</sup> We propose the following directions for management of developmental disorders:
- Screening, supportive interventions and referrals for maternal mental health issues by VHNs
  - Play based intervention delivered by VHNs in early childhood
  - School based teacher delivered intervention to strengthen healthy peer relationships, and address conduct issues
  - Screening for developmental challenges by VHNs and grassroots mobilisers and referral to block mental health teams for management interventions that target core functioning and caregiving skills and coordinate/link with education services

The Spastics Society of India, Tamil Nadu (SPASTN) may serve as the expert and capacity building partner to develop modules and train mental health teams to deliver these services.

- *Home Care for Elderly*

Tamil Nadu has a growing elderly population, the highest number living alone in the country.<sup>25</sup> An estimated 15% of the cohort of people over 60 years of age are affected by mental health issues such as dementia.<sup>26</sup> Grassroots mobilisers (lay staff of block mental health teams who work at the Primary Health Center level) may be trained to offer home based services that emphasise on enabling adaptations in the environment and family for cognitive challenges and skilling primary carers in dealing with daily tasks and challenges associated with such disorders.

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<sup>23</sup> National Crime Records Bureau. Crime in India 2015. Chapter 2-Suicides in India. New Delhi:Ministry of Home Affairs. Available at <http://ncrb.nic.in/StatPublications/ADSI/ADSI2014/chapter-2%20suicides.pdf>. Accessed on 28 June 2017.

<sup>24</sup> Cooper, Sally-Ann, et al. "Mental ill-health in adults with intellectual disabilities: prevalence and associated factors." *The British Journal of Psychiatry* 190.1 (2007): 27-35.

<sup>25</sup> Elderly in India, 2016, pp 89. Ministry of Statistics and Programme Implementation, Government of India. [http://mospi.nic.in/sites/default/files/publication\\_reports/ElderlyinIndia\\_2016.pdf](http://mospi.nic.in/sites/default/files/publication_reports/ElderlyinIndia_2016.pdf). Accessed on 28th June 2017.

<sup>26</sup> World Health Organisation. <http://www.who.int/mediacentre/factsheets/fs381/en>. Accessed on 28th June 2017.



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- *Address Gender based violence*  
Gender based violence, physical, sexual, emotional or financial, is associated with mental ill-health.<sup>27</sup> In a survey of women with mental illness using The Banyan's outpatient services, an association between experiencing issues in intimate relationships and homelessness was found. Primary Health Centers (PHCs) serve as first access points for such women to access health services, often for physical/somatic issues that originate in the violence, while the underlying issue itself may remain undisclosed. We recommend that PHC staff and block mental health teams be sensitised to screen for indications of violence and offer supportive individual engagements thereafter to enable necessary medical, social and legal help. International Foundation for Crime Prevention and Victim Care (PCVC) can serve as an expert and partner to implement modules to address gender based violence within community mental health programmes.
  
  - *Maternal Mental Health*  
In developing countries, over 15% of women during pregnancy and nearly 20% of women post birth period experience a mental disorder.<sup>28</sup> Maternal mental health is associated with child development and mental ill-health.<sup>29,30</sup> We recommend training of VHNs and ANMs for antenatal and postnatal screening for mental disorders, delivery of brief structured modules for mild issues and referrals of moderate to high needs cases to block mental health teams for management.
  
  - *Targeted and Culturally Resonant Approach for Socially Isolated and Marginalised populations*  
Socially isolated communities such as the Irulas, dalits, sexual minorities who continue to experience extreme exclusions, physical, social and economic, necessitate a biased focus for services outreach on account of their compound marginalisation that effectively keeps them excluded from resources available in the mainstream. We propose sensitisation of block mental health teams and building their capacities to engage with such fringe groups, understand their unique cultural narratives of mental health, and adapt service articulation.
  
  - *Support for Carers*  
Carers who are elderly and/or single wage-earners in the household supporting service users with serious and persistent mental illness represent an extremely vulnerable subset within the caregiving community with risks of both mental ill-health and social drift. We propose profiling of carers for high risk characteristics to offer group based and individual problem solving support.

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<sup>27</sup> Trevillion, Kylee, et al. "Experiences of domestic violence and mental disorders: a systematic review and meta-analysis." *PLOS one* 7.12 (2012): e51740.

<sup>28</sup> World Health Organisation. [http://www.who.int/mental\\_health/maternal-child/maternal\\_mental\\_health/en/](http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/). Accessed on 28 June 2017.

<sup>29</sup> Patel, Vikram, et al. "Effect of maternal mental health on infant growth in low income countries: new evidence from South Asia." *BMJ: British Medical Journal* 328.7443 (2004): 820.

<sup>30</sup> Cummings, E. Mark, and Patrick T. Davies. "Maternal depression and child development." *Journal of child psychology and psychiatry* 35.1 (1994): 73-122.

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## Priority 2:

### Social and Economic Inclusion

This priority will focus on building necessary resources in the environment to support social recovery of people with mental illness, alleviate accompanying distress, help them return to social roles and work and participate in the socioeconomic fabric of communities, and in this process create visible personal evidence of those with mental ill health pursuing lived experiences and influence negative perceptions associated with mental health.

#### **2.1 Establish inter sectoral linkages to enable delivery of social care interventions with particular focus on disability allowance, employment, housing and transport**

Convergence between health and social welfare mechanisms are essential to deliver comprehensive care that can mitigate both clinical symptoms and concomitant socio-economic issues. Schemes and interventions while delivered by different departments need to be delivered in a coordinated manner to jointly service variegated needs of users. We recommend that interagency/department agreements with the Disability sector be established to arrive at a consensus process for identification of disability in mental illness and to align the issuance of disability certificate and disability pension with the care process for people with mental illness. Similarly government departments and agencies for urban and rural housing need to be engaged for allocation of housing for those with long term care needs enrolled into Home Again; and agencies/departments involved in urban and rural livelihood rejuvenation must be engaged to allocate dedicated resources for increasing employment opportunities for people with mental illness. Grassroots mobilisers who play negotiator roles jointly delivering necessary health interventions with assistance to access social care will be mandated to work with a focus on the ultra poor households with a person with mental illness and mitigate risks of descending into homelessness. We further propose cross training of staff in the Disability department, mainly the District Differently Abled Welfare Officers and key functionaries in their offices, to sensitise on recognition of disability in mental illness and clarify agency roles. To further strengthen the integration, we propose State level sensitisation and training of leaders in urban local bodies and panchayats and building capacities of block level mental health teams to engage with and train local Village Poverty Reduction committees (VPRCs), self help groups and other such institutions.

#### **2.2 Incubate user led social enterprises with active public interfaces and increase service delivery through cadre of Peer service providers**

We recommend the creation of a state level Skills Development and Employment Cell with a dedicated focus to enhancing opportunities for work participation of people with mental illness. The Cell will assist districts and the tertiary care center to:

- Incubate service user led social enterprises with active public interfaces, such as Cafes, Tourism trails, Production and retail of indigenous arts and crafts, which engage with the public to challenge existing narratives of mental ill-health
- Build networks with employers, advocate for inclusive policies and offer supported employment translating into long term placements in the service sector industry - food service, housekeeping, security, gardening, data management and so on
- Recruit and skill a cadre of Peer service providers (service users as health care coaches, care coordinators etc)

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We recommend inviting as an expert partner the World Health Organisation (WHO) Training and Resource Centre in Trieste, (Italy) that has transformed institutional mental health care based on Dr.Franco Basaglia's care paradigms and set up several sustainable social cooperatives that employ people with mental illness.

### **Priority 3:**

#### **Influence Social Architecture of Tertiary Care**

Integrate community based inclusive living options for people with mental illness at Institute of Mental Health

Tamil Nadu has one of the highest number of people living long term in the state mental hospital - 551 with more than five years of stay.<sup>31</sup> By accommodating people beyond an acute phase, at whatever level of clinical recovery, hospitals seriously compromise their intended roles as specialist centers and the rights of people with mental illness to experience lives of their choosing. Integrating exit pathways for people with mental illness, while parallelly investing in supportive community care resources and eliminating long inpatient stays will assist in reducing the load on institutional care and enhance quality of tertiary care. This is a critical step towards refreshing mental health care systems in Tamil Nadu, improved mental health and wellbeing outcomes on a client level, reduce staff burnout, re-energise the environment, and make mental health sector an attractive career option. The recent Supreme Court order, in a public interest litigation on long stay population in Uttar Pradesh state mental health facilities, calls for a policy for people with to transition from large institutional spaces to other therapeutic options.

#### **3.1 Enable exit pathways out of institutionalised care for persons incarcerated over an extended period of time**

We propose that constitution of a clinical audit team to conduct comprehensive assessments of clients accessing care at the Institute of Mental Health (IMH), Chennai and categorise them according to possible options exit the facility:

- Reintegration to family: For those who are able to offer discernable details sufficient to trace an address and make the choice to return to family
- Hostels or Self rented homes as Independent living options: For those who have recovered but choose to live on their own
- Congregate Group Homes or Home Again: Housing with supportive services: For those with varying degrees of clinical recovery, where reintegration with family or independent living may not be possible immediately

We propose to pilot each of the these three approaches with a select sample of 200 people, and in the process build capacities within the state of Tamil Nadu to offer these services as part of the mental health system and incorporate at IMH these pathways to exit the facility.

#### **3.2 Influence Culture of Care to embrace Collaborative, Person Centered Approach**

Significant physical, social and philosophical barriers to recovery continue to persists in conventional institutional facilities in mental health which are encapsulated in vestiges of a colonial era as indicated by the National Human Rights Commission's report on mental hospitals across India. Modernising the Institute of Mental Health to embrace a contemporary mode of care, that is driven by service user needs and preferences for becoming well, will have far ranging consequences for mental health leadership and

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<sup>31</sup> Murthy, P (2016)

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human resources development in Tamil Nadu. We propose that the Government of Tamil Nadu onboard Prof Tom Burns of Oxford University as an expert to assist in developing IMH into a safe, therapeutic, community oriented and led space and build staff capacities to support this transition.

## Priority 4:

### Human Resource Development

#### Increasing Multidisciplinary Availability, Recovery Oriented Skilling and Cultivating Leadership

This priority will focus on human resources development that will support the execution of a continuum of care that is comprehensive by incorporating representation from multiple disciplines and at variegated levels of care, including grassroots mobilisers and peer advocates. Besides rationalising caseload ratios to deliver personalised care, attention needs to be paid to increasing availability of resources across disciplines of social work, nursing, psychology, occupational therapy, and direct care providers, assigning well defined roles that motivate coordinated action for service users' well being, and developing appropriate orientation and skills among the various cadres to deliver specialist interventions that can support the return to functioning, independence and high quality of life for people with mental illness.

#### **4.1 Establish statewide staffing norms and roles for mental health teams across the continuum of care from tertiary to primary care, with particular focus on enhancing availability of cadre to deliver psychosocial interventions**

There is increasing evidence from across the world that a wide variety of interventions may be successfully delivered with high fidelity by appropriately trained and supervised lay workers who do not necessarily possess professional qualifications in mental health.<sup>32</sup> Further, for services to take cognisance of social determinants of mental health and conscientiously deliver interventions to address these, roles of various disciplines other than psychiatry within the mental health system need to be invigorated to depart from a fallacious and often default physician assistant roles to that of specialists who offer inputs derived from their disciplines.

Establishing cross sectoral linkages with existing cadre of poverty alleviation and disability programmes to offer mental health care may be necessary to quickly increase availability of staffing for upscaling of services. Addition of negotiator roles at the grassroots level in both institutional and community settings to assist people in navigating care resources, both clinical and social, may become pertinent for achieving gains on the social justice front.

We propose an audit and analysis of existing staffing norms, their orientation and skills to support the vision of recovery oriented services across the continuum of care and use as a basis to prepare a Human Resource Plan that will by 2022 increase availability of grassroots cadre in community settings and improve representation of social workers, psychologists and occupational therapists across the spectrum.

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<sup>32</sup> Mutamba, Byamah Brian, et al. "Roles and effectiveness of lay community health workers in the prevention of mental, neurological and substance use disorders in low and middle income countries: a systematic review." *BMC health services research* 13.1 (2013): 412.

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#### 4.2 Deliver training modules with intensive supervision for mental health teams across the continuum of care

Low expectations of staff for service user recovery and inability to address multifactorial needs of people with mental illness are contributing factors for poor outcomes in mental health.<sup>33</sup> We propose that the Resource Center be tasked with delivering training modules to infuse mental health teams at tertiary and primary levels (Block mental health team - social workers, community health workers placed at PHCs and in community, psychiatrists, social workers, psychologists, nurses; Allied Primary Health Staff - PHC doctors, ANMs, VHNs) including grassroots cadre, with a personal recovery orientation and equip them with the necessary knowledge and skills to deliver highly attuned interventions that are able to ensure equitable outcomes for a diverse range of service users with low, moderate and high needs.

Such training will also focus on cultivating leadership across all cadres such that they develop the foresight and initiative to consistently push for better services and innovate in response to new emerging challenges in the sector. Particular attention needs to be paid to the building the lay worker cadre and the discipline of social work where roles are currently ill-defined and skilling inadequate to offer specific inputs towards recovery. We propose the institution of certificate and diploma courses in social work and community mental health for both non-specialist workers and social workers at tertiary to primary levels which will capacity build on the one hand on the other serve as motivation and growth pathways for people in the sector to further professional development, become leaders or social entrepreneurs in the sector.

### Highlights

1. **Facilitate Social Inclusion for persons living for long periods at the Institute of Mental Health (IMH), Chennai:** Address long stay related concerns through **Reintegration with Family where possible**, ensure continued care where required and make available other community based **Inclusive and Independent Living options**
2. **Activate Sub-Centers as Wellness Hubs:** Develop Sub-Centers into first contact and follow up hubs that jointly offer an array of **Mental Health and Social Care**, staffed by **Grassroot Mobilisers**
3. **Appropriate, comprehensive, cross sectoral community care:** Accelerate spread of community care, with a combined focus on mental health and poverty, across Tamil Nadu by setting up **Model blocks as Demonstration Sites** which will also serve as **Resource and Capacity Building Hubs**

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<sup>33</sup> Thornicroft, Graham, Diana Rose, and Aliya Kassam. "Discrimination in health care against people with mental illness." *International review of psychiatry* 19.2 (2007): 113-122.

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4. **Cohesive delivery of social care with health interventions:** Grassroots mobilisers assist in social care assessments and enable access to social entitlements (disability allowance, housing, transport subsidies, citizenship documents, entitlements to promote financial inclusion, poverty alleviation schemes) alongside health intervention delivery.
  5. **Service User Leadership and Participation:** Service users as peer advocates, service providers and federated groups in dictating momentum and changes necessary in the mental health system
  6. **Skills Development and Employment Cell** to coordinate a statewide agenda to enhance **Work participation and Social Inclusion** of people with mental illness
  7. **Targeted Programmes for Key Marginalised groups:** A positively biased focus on ultra poor, homeless, women and children in difficult circumstances, elderly, to diminish disparities, reduce disability and extreme poverty
  8. **Rapidly Increase Availability of Human Resources:** Particularly at the intersection of health and development disciplines, through cadre of lay Grassroots Mobilisers and reinvigorate staff through a continual training and supervision approach through **Diploma and Certificate Courses in Development Practice in Mental Health** that fosters leadership, enterprise, orientation, and skills necessary to deliver person centered services that can lift people out of extreme poverty

## The Banyan's Role

1. Undertake assessments of long stay population at the Institute of Mental Health and implement exit pathways of reintegration with family and Home Again/Independent Living for a cohort of 200 such people
2. Create a common approach for the model community care Demonstration Sites, identify, onboard and train implementation partners
3. Partner in audit of existing human resources, preparation of a Human Resources Plan for Mental Health in Tamil Nadu; and assist in capacity building and training of human resources across the continuum of care
4. Setup and coordinate a Resource Center for Homeless people with mental health issues to run direct services, develop guidelines and offer oversight for partners and other NGO run programmes for homeless people with mental illness in Tamil Nadu
5. Directly implement model community care programmes in 3 Demonstration sites - Thiruporur, Lalgudi, Kundrathur
6. Bring on board specific experts:
  - a. Tata Institute of Social Sciences for Diploma and Certificate Courses on Development Practice in Mental Health for Social Workers and Grassroots mobilisers
  - b. The Penn School of Nursing for Nurses and Direct Care Providers in institutional settings

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- c. Prof Tom Burns of Oxford University for expertise on cross sectoral integration and driving changes to transform the Institute of Mental Health (IMH)
  - d. The Trieste WHO Collaborating Center for expertise on social cooperatives for the Skills Development and Employment Hub

## Outcomes

Sustainable Development Goals target halving of mortality due to noncommunicable diseases and promotion of mental health and wellbeing and eradication of extreme poverty by 2030. We anticipate the following broad outcomes by 2022, consistent with incremental progress towards these SDGs:

1. Increased availability of appropriate service supports which offer an uplifting experience for end users across the continuum of care, from tertiary to primary, and across the life course, from childhood to old age
2. Decrease in treatment gap with more people with mental health needs accessing appropriate clinical and social care in primary to tertiary care settings, over the life course from childhood to old age
3. Increased availability of human resources, particularly development professionals such as social workers and direct care providers such as grassroots mobilisers, personal assistants in long term care options and health care workers in tertiary settings, with the orientation and skills to support a continuum of care delivered over a lifecourse to support clinical and social recovery
4. Increased work participation of people with mental illness through both enrolment and sustenance of formal employment/livelihood pursuits and return to social roles
5. Decreased burden of disability on service users and their families with enhanced social functioning, participation at home, work and community and reduced social and economic losses on account of caregiving
6. Decreased disparities in mental health outcomes, reduction in extreme poverty and diminished socioeconomic inequity among most marginalised groups in the population
7. Enhanced system performance and reduced costs of care with decreased bed strength in the tertiary center enabling use of investments to accelerate stepped, collaborative care with wider outreach of services
8. Reduced stigma and discrimination with increased personal evidence of positive recovery gains and diverse living choices exercised by people with mental illness
9. Enhanced social inclusion of people with mental illness with greater participation and opportunities for self direction in society and reduction of extreme poverty