OPERATIONAL GUIDELINES

MENTAL, NEUROLOGICAL AND SUBSTANCE USE (MNS) DISORDERS CARE

at HEALTH and WELLNESS CENTRES

A PART OF COMPREHENSIVE PRIMARY HEALTH CARE

NATIONAL HEALTH MISSION

OPERATIONAL GUIDELINES

MENTAL, NEUROLOGICAL AND SUBSTANCE USE (MNS) DISORDERS CARE AT HEALTH AND WELLNESS CENTRES

A PART OF COMPREHENSIVE PRIMARY HEALTH CARE

Table of Contents

Background and Rationale

- In India, the prevalence of any mental health condition is 10.6% (point prevalence) and 13.7% (lifetime prevalence), as per the recently completed National Mental Health Survey (NMHS)[1]. In terms of neurological disorders, it is estimated that there are more than 10 million Persons With Epilepsy (PWE) in India, with a prevalence of about 1%; and over 3.7 million people over 60 (2.1 million women and 1.5 million men) are affected by dementia. The number of Persons With Dementia (PWD) is expected to double by 2030[2].

- Recent national level studies have highlighted the growing contribution of Mental, Neurological and Substance Use (MNS) disorders/conditions to the overall disease burden in India. MNS conditions, suicide and interpersonal violence contributes to 12.3% of the total Disability Adjusted Life Years (DALYs) and 5.8% of the total deaths. Suicide is the third leading cause of Years of Lives Lost (YLL) in several states in India[3].

- The burden of Substance Use Disorders (SUDs), contributed mainly by alcohol and tobacco use, is more in middle aged (40-59) individuals

1 Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, Mehta RY, Ram D, Shibukumar TM, Kokane A *et al*: *National Mental Health Survey of India*, 2015-16: *Summary*. In., vol. Publication No. 128. Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS 2016

2 Shaji KS, Jotheeswaran AT, Girish N, Srikala B, Dias A, et al. (2000) Alzheimer's & Related Disorders Society of India, The Dementia India Report: prevalence, impact, costs and services for Dementia: Executive Summary. (Eds), ARDSI, New Delhi

3 Indian Council of Medical Research, Public Health Foundation of India, and Institute for Health Metrics and Evaluation, India: *Health of the Nation's States – The India State-level Disease Burden Initiative. New Delhi, India:* ICMR, PHFI and IHME;2017

(29%), males (35.67%); and rural areas (24.12%). However, other SUDs (illicit drugs) are more prevalent in urban metro areas.[4]In the context of the bidirectional relationship between mental health and SUDs and their demonstrated role as causative factors for non-communicable disorders, the high prevalence of SUDs in India, is of serious concern.

- MNS conditions contribute to significant morbidity, disability and even mortality among those affected and are associated with significant social and economic impact. The stigma and discrimination associated with mental health conditions, in addition to social exclusion, discourage health-seeking behaviour and compel those affected, to suffer in silence and lead a poor quality of life. In the worst cases, there are profound violations of human rights in the form of abuse, neglect and restrictions on their freedom (e.g. by being chained) in their homes, mental hospitals and in traditional healing centres.

- People with MNS conditions have poor access to care leading to a significant *treatment gap* (proportion of people with a mental health condition who do not receive any care for their condition). In the NMHS, except for epilepsy, all other MNS conditions had a treatment gap of more than 60%. The highest treatment gap was for alcohol use disorders (86.3%), followed by common mental disorders (CMDs) (85%) and severe mental disorders (SMDs) (73.6%).

- Three recent policy developments at the national level provide an opportunity for improving the delivery of mental health services. The new Mental Healthcare Act, 2017, enshrines access to mental health care as a statutory right and an entitlement, including its provision through primary healthcare. The National Mental Health Policy, 2014, envisages provision of universal access to mental health care and in the National Health Policy, 2017, mental health is recognized as one of the policy thrust areas.

- The District Mental Health Program (DMHP) has been in existence since 2003, and provides basic mental health care services for a range of facility and community-based interventions. These guidelines are intended to supplement and complement these efforts. States should consider initiation of this intervention in Health and Wellness Centres, in those

4 *Ibid.*

districts where the DMHP is established and operational and then scale up gradually based on learnings.

- The focus of these guidelines is on the provision of meaningful care for a set of delineated conditions. Over time and depending on state context, related to disease burden, maturity of health systems and the competencies of the primary health care teams, additional MNS conditions can be added.
- These operational guidelines are intended for state and district programme officers and service providers to integrate mental health into the delivery of comprehensive primary health care at Health and Wellness Centres.
- The guidelines are an adjunct to and build on the relevant recommendations of the DMHP guidelines. Thus details of roles and responsibilities of the MOs and staff nurses are not elucidated, since they are already covered in the DMHP Guidelines, Operational Guidelines and Operational Framework.
- These guidelines are part of a series of guidelines intended to support states to add other packages for delivery of Comprehensive Primary Health Care. Other companion documents include training manuals and standard treatment guidelines which would be updated and disseminated periodically.
- In urban areas, states would need to evolve strategies that combine effective outreach and facility based mental health services to serve as a platform for the delivery of this intervention. Prevention and management of mental, neurological and substance use conditions are expected to take place at the level of the Urban PHCs and the Urban CHCs. The range of health care facilities and outreach mechanisms vary widely between and within states, and local, context specific mechanisms would need to evolve through a process of piloting and study before being scaled up. Existing platforms and partnerships would be strengthened to implement the intervention so that assured mental health services are available for the urban population particularly those living in the slums and settled colonies.

Introduction

These guidelines provide an overall implementation framework to roll out incrementally services for the following six groups of MNS disorders and conditions:

i. **Common Mental Disorders (CMDs):** Depression, Anxiety/Panic Disorders, Somatisation/Psychosomatic Disorders

ii. **Severe Mental Disorders (SMDs):** Schizophrenia, Bipolar Disorder, Severe Depression

iii. **Child and Adolescent Mental Health Disorders (C&AMHDs):** conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder

iv. **Neurological Conditions:** Epilepsy and Dementia (including Alzheimer's)

v. **Substance Use Disorder (SUDs):** Tobacco, Alcohol and Drug Use Disorders

vi. Suicide Ideation/Behaviours

Table 1: Brief description of the common presentation of the mental health disorders covered under these guidelines

Table 1: Common Presentation of Mental Health Problems			
CMD	SMD	C&AMHD	SUDs
Multiple persistent physical symptoms with no	Marked behavioural changes	Problems with development, emotions or	Appearing affected by alcohol or other

CMD	SMD	C&AMHD	SUDs
clear cause, pain in multiple body parts Low energy, gets tired easily, sleep problems. Persistent sadness or depressed mood, anxiety. Loss of interest or pleasure in activities that are normally pleasurable. Excessive worrying about day to day activities Difficulty in concentrating Crying spells Getting angry at frivolous reasons	Neglecting usual responsibilities related to work, school, domestic or social activities. Reduced self-care Smiling/ laughing to self Reduced interaction/ isolating oneself Agitated, aggressive behavior, decreased or increased activity. Fixed false beliefs not shared by others in the person's culture. Hearing voices or seeing things that are not there. Lack of realization that one is having mental health problems.	behavior (e.g. inattention, over-activity, or repeated defiant, disobedient and aggressive behavior, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school). Difficulty keeping up with peers or carrying out daily activities considered normal for that particular age. Problems at school (e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work). Rule- or law-breaking behaviour, physical aggression at home or in the community.	substance (e.g. smell of alcohol, slurred speech, sedated, erratic behaviour). Signs and symptoms of acute behavioural effects, withdrawal features or effects of prolonged use. Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance). Emergency presentation due to substance withdrawal, overdose, or intoxication. Person may appear sedated, overstimulated, agitated, anxious or confused. Other problems e.g. recurrent requests for psychoactive medications such as diazepam (Calmpose), injuries, and infections associated with intravenous drug use (HIV/AIDS, Hepatitis C)

Note: Postnatal depression is a type of depression that many mothers (1 in 10) experience after having a baby. In addition to the symptoms described under CMD in Table 1, the mother might also have difficulty bonding with her baby and experience frightening thoughts (e.g. thoughts of hurting her baby).

Service Delivery Framework

A set of skills and competencies are required in different cadres of the Primary Health Care team (ASHA, MPW (F/M), CHO, Staff Nurses and Medical Officers) to effectively assess, diagnose, treat, support and refer people with mental disorders [Annexure E]. The level of skills required to undertake each of these functions depends on the roles and responsibilities of each cadre and is very different from the skills required of other more common disease conditions. Each cadre of worker needs to be trained appropriately.

A five pronged approach will be used to enable the integration of mental health care in primary health care:

i. Community level Health Promotion interventions and improving mental health literacy that enables an understanding of mental health, common symptoms, risk factors/causes of disorders, treatment, reduction of stigma and discrimination, and of techniques such as psychological first aid, and self-care.

ii. Early identification, referral to CHO for screening and home & community based follow up by frontline worker team and use of the Community Informant Decision Tool (CIDT) by MPW/ASHA Facilitators.

iii. Screening by Community Health Officer (CHO) through the use of a standard screening tool, psychosocial management and enabling referral.

iv. Diagnosis and initiation of treatment by the Medical Officer at the HWC-PHC/UPHC levels.

v. Reduction of treatment gap (psychosocial and pharmacological) by facilitating access to treatment by referral to higher level centres (PHC and other referral centres), initiation of treatment and ensuring regular supplies and treatment adherence.

Service Delivery

The general principles governing the service delivery processes for MNS disorders and conditions are given below. The specific service delivery processes for each of the four disorder groups are graphically represented in Figures in Annexures A (A.1 to A.5):

1. Awareness building and stigma and discrimination reduction activities through IEC and community mobilisation will be conducted by ASHA/ MPW in the community.

2. MPW (F/M) and ASHA facilitators will undertake case detection and identification of persons with potential MNS conditions in the community, as and when required, using the CIDT tool. They will provide relevant community-based intervention package (e.g. relaxation training, psychological first aid, basic guidance on self-care) to those who screen positive. They will also refer the person to HWC for psychosocial interventions and PHC for diagnosis and pharmacological interventions and continue to follow up with the person in the community.

3. At HWC, screening and the relevant intervention package will be delivered to persons referred, and also to those persons with MNS conditions who directly enter the system at this level.

    - CMDs – Persons with CMDs will be provided psychosocial interventions at the HWC by the CHO. Those who recover will be reviewed periodically and those under continuing care will be followed up at home or in the community. ASHA will follow-up at the house to provide treatment adherence support for ensuring compliance of medications and recognising complications/red flags that would need referral. Those who do not respond to the interventions delivered at the SHC-HWC will be referred to the PHC/ UPHC-HWC.

    - SMDs, SUDs and C&AMHDs – CHOs at SHC-HWC will provide basic interventions and will refer to PHC/UPHC or DMHP/STC, depending on expertise available, for diagnosis and initiation of treatment. Once treatment is started for these conditions, the PHC team at the SHC-HWC can undertake follow up for psychosocial interventions and treatment adherence support, with ASHA undertaking follow up activities in community.

- Epilepsy and Dementia – CHO will screen and refer to PHC for clinical diagnosis and pharmacological management. In urban areas, screening will be done at the UPHCs. Medicine dispensation and psychosocial interventions and community based follow up will be provided at HWC.

4. At the PHC/UPHC level, the relevant intervention package would be delivered to referred individuals and also to those who directly enter the system at this level. Those who recover will be discharged and those under continuing care will be followed up at same level, HWC or in the community, where the ASHA/MPW will also provide treatment adherence support.

    - CMDs – The MO will clinically diagnose and initiate pharmacological treatment (where required) for CMDs, including post partum depression, and refer back to HWC for psychosocial interventions.

    - SMDs, SUDs and C&AMHDs – The MO will screen, provide basic interventions and refer to psychiatrist, clinical psychologist at DMHP/STC; to Oral Substitution Treatment (OST) Centres for drug dependence treatment, whichever applicable. MO will provide follow up and discharge in consultation with psychiatrist at STC.

    - Epilepsy and Dementia – The MO will clinically diagnose and provide pharmacological management with adequate referrals to DH/STC, as required. MO will refer back to HWC for psychosocial interventions and drug refills, with ASHA providing follow up in the community.

Linking with RBSK and RKSK Programmes (For C&AMHD Disorders)

- Children with MNS disorders, up to 11years, to be referred to and managed by the RBSK team according to their management and referral processes.
- Adolescents with MNS disorders beyond 11 years and up to 18 years to be referred to and managed by the RKSK team at Adolescent Friendly Health Clinics (AFHC), according to their management and referral processes.
- CHO in HWC should be trained in follow up of such cases and ensure treatment compliance, complication identification, and appropriate referral.

Interventions for mental health at the primary health care level would be coordinated with a network of services at different levels of care and complemented by broader health system strengthening. Collaboration with other government non-health sectors, nongovernmental organizations, and

community level groups, including volunteers must be leveraged especially for community level care. They include:

a. NGOs for support group meetings, health promotional activities and MNS related services;

b. Government departments, such as: Social Justice and Empowerment, Women and Child Development, School Health, District Legal Services Authority, Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULBs) etc., to facilitate access to MNS services and entitlements/schemes/programs for the benefit of persons with MNS disorders. (e.g. obtaining disability certificates under Disabilities Act);

c. Referral and integrated/coordinated care linkages with other programs, such as School Health Program, RBSK, RKSK etc.;

d. Orientation of and referral linkages with faith healers to motivate early referral to government MNS services.

Programme managers should be cognizant that while there is evidence that shows that Primary Health Care workers can recognize a range of mental disorders and provide primary management for common problems such as anxiety, depression and hazardous alcohol use, to ensure implementation at scale in process, is likely to pose challenges initially. Access to service providers at higher facility levels through the use of teleconsultation facilities needs to be promoted.

Individual/Family/Community Level:

The Front-line workers – ASHA/ASHA Facilitators, Multi-Purpose Workers (MPW -F/M, Community Health Workers (CHW), where available, would provide care via community platforms. Interventions delivered at this level will include:

a. Awareness programmes about mental health conditions and stigma reduction generally – Targeted IEC and community mobilization for preventive and promotive messages; stigma reduction activities at the group level; providing information on services available at different platforms of care; general symptoms of common mental disorders and suicide ideation; awareness and advocacy about societal problems that act as risk factors for mental health conditions such as: gender-based violence (domestic violence, sexual violence etc.), child abuse (emotional, physical or sexual abuse), substance dependence etc.

b. Healthy lifestyle tips e.g. balanced diet, exercise, sleep hygiene, and stress management.

c. Case detection for MNS disorders using CIDT tool (by CHO/MPW/AF), and/or other checklist(s) as applicable, in the community and referral to HWC for screening and management.

d. Patient Health Questionnaires 2 (PHQ 2) to be included in the CBAC form for early identification of depression at the community level.

e. Improving psychosocial competencies at individual and family level e.g. through basic psychoeducation, psychological first aid, basic suicide risk assessment/management.

f. Follow up in the community and providing treatment adherence support, where applicable.

Health and Wellness Centre–Sub Health Centre Level:

Community Health Officers (CHO) will provide the primary level care at the Health and Wellness Centres, including screening and primary management, and will enable adherence to treatment protocols.

Interventions delivered at this level will include:

a. Awareness and stigma reduction activities at an individual level and psychoeducation for all groups of MNS conditions.

b. Promotion of mental health through family enrichment programs, school health programs, positive parenting, and physical activities initiative including yoga.

c. CMDs – Screening/identification, psychosocial interventions (basic counseling, psychological first aid, problem solving, behavioral activation, cognitive behavioral techniques, stress management, life-skills training, lifestyle modification, simple multimodal multisensory stimulation techniques for developmental disorders, sleep hygiene counseling), referral, and follow-up for CMDs, including for post-partum depression.

d. SMDs – Screening/Identification, referral to PHC and follow-up, community-based rehabilitation, family-based interventions, organising meetings of self-help groups.

e. C&AMHDs – Screening/Identification, referral to PHC and follow-up.

f. SUDs – Screening/Identification, brief intervention/management (including relapse prevention), harm reduction counselling, first aid response to overdose/intoxication, referral to PHC or addiction/ dependence treatment centres such as OST centres, and follow-up.

g. At the HWCs, CHOs would be administering Patient Health Questionnaire (PHQ) 9 and scoring the individuals for depression during the screening activity. Patients receiving interventions for MNS conditions would be provided with regular follow up and tracked for improvement in their PHQ 9 score.

h. Dispensing the already prescribed medications against prescriptions of the MO or psychiatrist at DH/MC.

i. Suicide risk assessment, suicide management by gatekeepers, referral, and follow-up for suicidal ideation and behaviors.

j. Screening and identification of seizures (indicating epilepsy) and dementia. Referrals to MO at PHC for clinical diagnosis of epilepsy and dementia for pharmacological intervention.

k. For Persons with Dementia (PWD) a comprehensive life plan should be developed and implemented, which would include – management of cognitive deficits including medication (once started by MO at PHC); strategies for preventing and managing behavioural and psychological symptoms, managing comorbidities, promoting general health and wellbeing, social engagement and quality of life; safety issues – driving, work, risk of falls; legal planning and advance care directive. Psychosocial support for both PWD and their care givers/family members.

l. Follow up for each of the disorders above will include activities such as continued psychosocial support, treatment counseling for adherence support, checking for side effects and toxicities for prescribed medications, monitoring for relapses and recurrences, checking for red flag signs, signs of abuse and neglect in patients with dementia and referral to appropriate higher centers as needed.

m. Establish linkages with – a) NGOs for support group meetings, health promotional activities and MNS related services; b) Government departments,

such as Department of Social Justice and Empowerment, Women and Child, District Legal Aid Authority, Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULB) etc. to facilitate access to entitlements/schemes/programs for the benefit of persons with MNS disorders (e.g. obtaining disability certificates under Disabilities Act); c) Referral linkages with faith healers to bring persons in the fold of government MNS services; d) referral and integrated/coordinated care linkages with other programs (school health program, elderly and palliative care, communicable diseases and NCDs program etc.)

Primary Health Centre/Urban Primary Health Centre (Health and Wellness Centre) Level:

Medical Officers (MO) will provide services and PHC/UPHC with requisite instructions to CHO/Primary Health Care team. Interventions delivered at this level will include:

a. Awareness and stigma reduction activities at the individual level, e.g. psychoeducation.

b. Identification/diagnosis, psychoeducation, pharmacological management, referral, and follow-up for CMDs, Epilepsy and Dementia (unless the MO feels the need to refer) and basic management of drug overdose/intoxication.

c. Identification/diagnosis and referral for confirmed diagnosis and initiation of treatment for SMDs, SUDs and C&AMHDs. Pharmacological management at PHC, once treatment initiated at DH/MC, in consultation with specialists at DH/MC.

d. Suicide risk assessment, basic suicide management, referral, follow-up, and emergency management of poisoning.

e. Follow up at every visit – including treatment counseling for adherence support, training patients on use of intra nasal midazolam to prevent onset of status epilepticus, assessing side effects/toxicities, assessing signs of abuse or neglect in patients with mental health conditions and dementia.

f. Emergency care for seizures to be administered either by intranasal or intramuscular midazolam[5]. To stabilize and then refer to STC.

5 To be introduced in the Sub Health Centre– HWC Essential List of Medicines after state consultation.

g. MO will be responsible for maintaining upward referrals with pediatrician/ physician at CHCs and neurologists at DMHP/STC for management support and downward referrals with CHO at HWC regarding patients and their follow up for drug refills/psychosocial support.

Note: The general principles of managing CMD, SMD, and SUDs in adolescents and older adults will remain the same, but with modifications needed to cater to the unique requirements of these discrete age groups. Similarly, the principles for managing CMD can be applied to management of post-partum/ maternal depression. However, if in doubt, refer to a specialist at DMHP/STC.

Secondary Level:

- Specialists (psychiatrist, neurologist, paediatrician, clinical psychologist, psychiatric social worker) will provide multidisciplinary care upon referral at the secondary level.
- Specialists will provide ongoing clinical support and supervision for continued management of persons with MNS conditions at the CHC/PHC/ UPHC/HWC levels, in an integrated and coordinated manner.

AYUSH Services:

Organizing AYUSH Services (Ayurveda) for Mental Health

- A list of commonly used drugs for mental health (and updated based on EDL) would be ensured from the lowest level where an ayurvedic doctor is posted.
- Usage of equivalent terms for identification/management/supplementing ongoing allopathic treatment would be available as part of Ayurvedic doctor's orientation programme.
- At Family level – a list of commonly used medicinal plants are given with usage, part used, preparation, dosage and drug interactions.
- Hospitals with facilities for admitting a patient under AYUSH would also deal with patients who would like to be weaned off allopathic drugs (e.g. chronic use of Clonazepam for insomnia).

Note: Ayush services for mental health conditions has been recommended in consultation with the Ministry of Ayush and experts in Ayurveda.

The type of medicines being prescribed by an AYUSH practitioner would depend on the type of specialty she/he belongs to. Accordingly, relevant medicines should also be made available.

Health Promotion including the Use of IEC for Behaviour Change Communication:

a. Mental Health Promotion refers to positive mental health, rather than mental ill health. It comprises consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills including 'Life Skills Education' which are conducive to individual and community health.

b. Community Mobilization in Mental Health will be facilitated by:

- IEC and mental health literacy and linking service delivery with existing community platforms/processes, for e.g. VHSNC/MAS, VHND/UHND, School Health Program and PRIs/ULBs.
- Mental health education and promotion messages propagated through whole community campaigns/group information sessions, peer-support approaches, or school-based interventions.
- Implementation of mental health education, prevention and promotion interventions goes beyond the traditional work of the health sector and thereby requires strong mechanisms for inter-sectoral coordination. For instance, advocacy to reduce risk factors for development of mental health disorders – gender based violence, child abuse, bullying in schools and colleges, substance dependence, work place stress management or and other forms of societal distress – will require collaboration with other government departments.

c. Primary Health Care team led by Community Health Officer should design and plan for community mobilization and ensure targeted IEC for:

- Stimulating community dialogue and remove myths, misconceptions and taboos and stigma related to mental health, epilepsy and dementia via group information sessions;
- Creating awareness about mental health disorders, risk factors and symptoms to watch out for;
- Empowering community with self care tips for promoting mental health and help individuals/family/community cope with difficult situations;

- Creating awareness about treatable conditions like Epilepsy;
- Connecting people with available mental health services;
- Creating awareness and sensitivity, through sustained advocacy, on social issues that are risk factors for developing distress/mental health conditions, especially in women and children.

d. Improved mental health literacy will help in early recognition, management or prevention of mental health conditions, encouraging positive lifestyle changes, generating empathy and support for distressful situations (individual or societal), reducing stigma and discrimination.

e. Through community awareness, service users and care providers would be empowered to increase the demand for and access to MNS services.

Referral and Treatment: Ensuring Continuity of Care:

a. Health care providers at all the levels should remain alert for situations that may require referral to Secondary and Tertiary care. It includes situation where there is non-response to treatment, serious side effects with pharmacological interventions, comorbid physical and/or mental health conditions, risk of self-harm/suicide etc.

b. Referral to secondary and tertiary care mental health services when indicated and available, should ideally be made by the Medical Officer, except in cases of acute emergencies such as high suicide risk.

c. Even in case of referrals for initial diagnosis and initiation of treatment by psychiatrist at secondary and tertiary level, follow up for psychosocial support and subsequent pharmacological management (where indicated) and follow up for treatment adherence and side effects etc will be provided by the Medical Officer at the PHC/UPHC, Community Health Officer at the HWC and front-line workers at the level of community.

d. The loop between the primary care medical provider and the specialist must be closed. This can be achieved when the specialists at district facility or higher are able to communicate to the medical officer of the adequacy of treatment, any change in treatment plans, and further referral action.

e. In order to expand access to services, and reach remote populations, Mobile Medical Units would enable an expansion of service delivery and serve the role of enabling the provision of care and serving to establish Continuum of care.

Referrals should be made to secondary or tertiary care mental health services, wherever a psychiatrist is available, for initial diagnosis and initiation of treatment in the following situations:

- Children with developmental health conditions e.g. Autism
- Children with mental health/developmental problems requiring medications e.g. Attention Deficit Hyperactivity Disorder (ADHD)
- Persons requiring initiation of Opioid Substitution Therapy (OST)*
- Persons with Severe Mental Health Conditions (SMDs)
- Mental health conditions comorbid with physical disorders e.g. Parkinson's disease with depression
- Multiple co-existing mental health conditions e.g. Depression with Obsessive Compulsive Disorder (OCD)
- High risk of self-harm/suicide
- High risk to others (violence)

Referrals from PHC to STC of patients whose treatment has been started at PHC, in following conditions:

- If the person does not respond to adequate dose and duration of more than one class of medication indicated for that disorder, using one medicine at a time
- If acute agitation does not subside despite appropriate treatment
- Serious side effects with pharmacological interventions after emergency management of acute side effects (only if warranted)

* OST services may be provided by MOs (after adequate training) at PHC/UPHC, in areas with high levels of opioid dependence (in keeping with the NDPS Act and Rules)

Epilepsy: Referrals should be made to STC, wherever specialists (Paediatrician, Neurologist) available, in the following situations:

- Red flags in patients with seizures
  - Fever

- Headache
- Vomiting
- Altered Sensorium
- Severe Giddiness
- Loss of function of body

- Progressive problem with new symptoms appearing rapidly
- History of recent injury
- Alcohol binge with symptoms appearing after the same. *
- Any other emergencies like 'status epilepticus' after stabilization
- If the person does not respond to adequate dose and duration of medication indicated for that disorder.
- Serious side effects with pharmacological interventions

* For Alcohol dependence, downward referral should also be made to the HWC for psychosocial management

Dementia: Referrals should be made to STC, wherever specialists (Physician/ Neurologist) available, in the following situations:

- Referral to higher centre equipped with Neurologist, trained or Psychiatrist if diagnosis could not be made/further work up is required
- Presence of certain Redflags (fever, headache, vomiting, focal deficits like one sided weakness or double vision, altered sensorium)
- Progressive problem with new symptoms occurring rapidly
- History of recent injury
- Alcohol binge*
- Increased aggression, violence (self-harm or directed at others)
- Not responding to adequate dose and duration of prescribed medications

* For alcohol dependence, downward referral to HWC for psychosocial management should also be made

Medicines and Diagnostics:

a. Medicines supply would be as per the state Essential Drug List (EDL), facility wise and buffer stocks would be maintained at all levels.

b. The Drugs and Vaccines Distribution System (DVDMS) linked with Comprehensive Primary Health Care – IT application should support regular supply and availability of required medicines and diagnostics.

c. Prescribing of medicines will be done by the Medical Officer at the level of PHC/UPHC.

d. Subsequent dispensing of medicines for patient who are being followed up in the community can be done at the level of the SHC–HWCs by the Community Health Officer on the recommendation of and in consultation with the MOs.

e. Medications recommended for use in Primary Care are given in Annexure B.

Human Resource and Capacity Building Plan:

A. Human Resource

The roles and responsibilities of the Primary Health Care team are as follows:

Service Provider	Role
ASHA/MPW/ASHA Facilitators	◗ Conduct community level awareness and stigma reduction programs ◗ Dispense information/knowledge about the myths related to MNS conditions ◗ Identify/detect MNS conditions using CIDT and other checklists, as may be applicable (MPW/AF) ◗ Deliver frontline basic psychosocial care ◗ Refer as appropriate (MPW) ◗ Provide treatment adherence support and follow-up care in the community

Service Provider	Role
CHO	◗ Conduct individual level awareness and stigma reduction activities ◗ Carry out identification/screening of MNS conditions ◗ Deliver psychosocial interventions ◗ Dispense medications that are already prescribed by PHC/DMHP ◗ Monitor for side effects and toxicity ◗ Provide emergency care for person experiencing seizure/ status epilepticus, to stabilise and then refer ◗ Refer as appropriate ◗ Provide follow up care ◗ Have linkages with other programs, departments and NGOs for referral services
MO	◗ Conduct individual level awareness and stigma reduction activities ◗ Carry out identification/screening/clinical diagnosis ◗ Treatment initiation ◗ Prescribe medications as appropriate ◗ Refer as appropriate ◗ Provide follow up care ◗ Emergency medical management of suicide attempts (including poisoning, self – immolation etc.) and status epilepticus

B. Capacity Building

- A sustainable and scalable model for capacity building would be the Training of Trainers model. The training module will substantiate the criteria for identification of training institutes, trainers etc.
- In every state, DMHP psychiatrists can play an important role in training of Medical Officers as Master trainers, while DMHP psychologists can play

a similar role for training Multi-Purpose Workers (MPWs)/Staff Nurses/ Community Health Officers as Master trainers.

- These trained Master trainers will train the identified workforce across the facilities.
- The state health department can identify and depute the MOs, MPWs, SNs, AYUSH staff for TOT programme.
- ASHAs will be trained in identifying symptoms of common MNS conditions, health promotion, stigma associated with MNS conditions, and services available at HWCs and referral centres. ASHA facilitators would also be trained for enabling better support to ASHAs in the extended package of services.
- Existing pool of State and District ASHA trainers would be trained to undertake training of ASHAs and ASHA Facilitators in a cascade manner.
- A one-day Orientation of Programme officers and BPM/DPM would be required so that they are in synergy with the programme features and understand the roles and responsibilities related to support (including availability of drugs and consumables), monitoring (reports, records) and supervision.

Budget

a. National Mental Health Programme provides funds to states/UTs for various activities defined under the program.

b. Besides their own resources, states/UTs are also free to propose for funding under National Health Mission.

Monitoring and Supervision:

a. The program and monitoring data for Mental Health services needs to be integrated and adopted in the present HMIS, operational under MoHFW. The following indicators would be used to monitor the programme:

   - Proportion of population reporting with MNS conditions.
   - Proportion of individuals screened for MNS conditions.

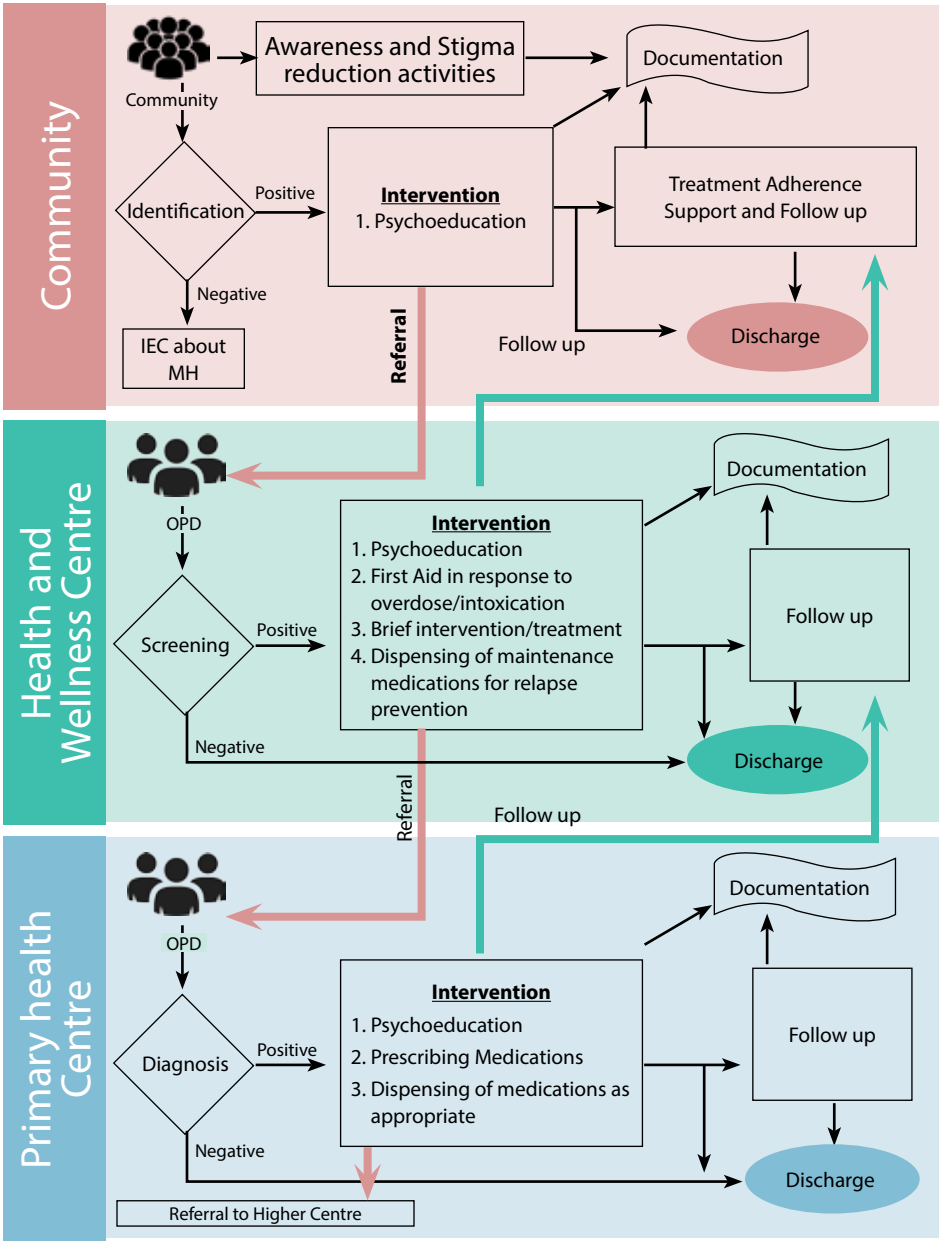
- Proportion of diagnosed individuals who are undergoing treatment.
- Proportion of individuals who need emergency care.
- Proportion of individuals diagnosed with epilepsy out of total screened.
- Proportion of individuals diagnosed with Common Mental Disorders (CMDs) out of total screened.
- Proportion of individuals diagnosed with Severe Mental Disorders (SMDs) out of total screened.
- Proportion of individuals diagnosed with Child and Adolescent Mental Health Disorders (C&AMHD) out of total screened.
- Proportion of individuals with Substance Use Disorder (SUDs) out of total screened.
- Proportion of individuals visited PHC/UPHC out of those referred by Community Health Officer.
- Number of psychoeducation sessions conducted at the HWC.
- Proportion of individuals who completed treatment for epilepsy out of those identified and referred from HWC.

ANNEXURES

ANNEXURE A: Service Delivery Process Map

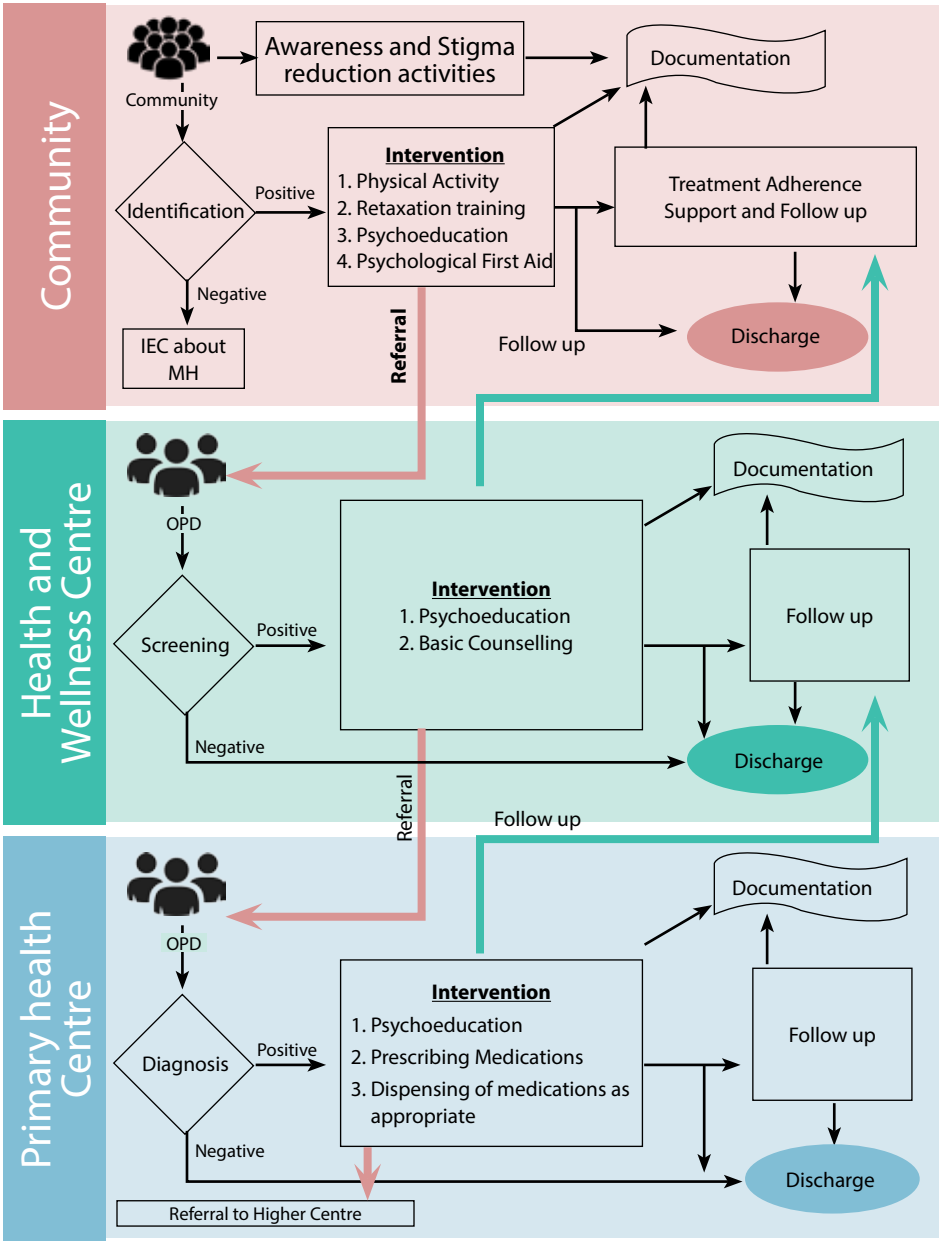
A.1

Service Delivery Processes for Substance Use Disorders



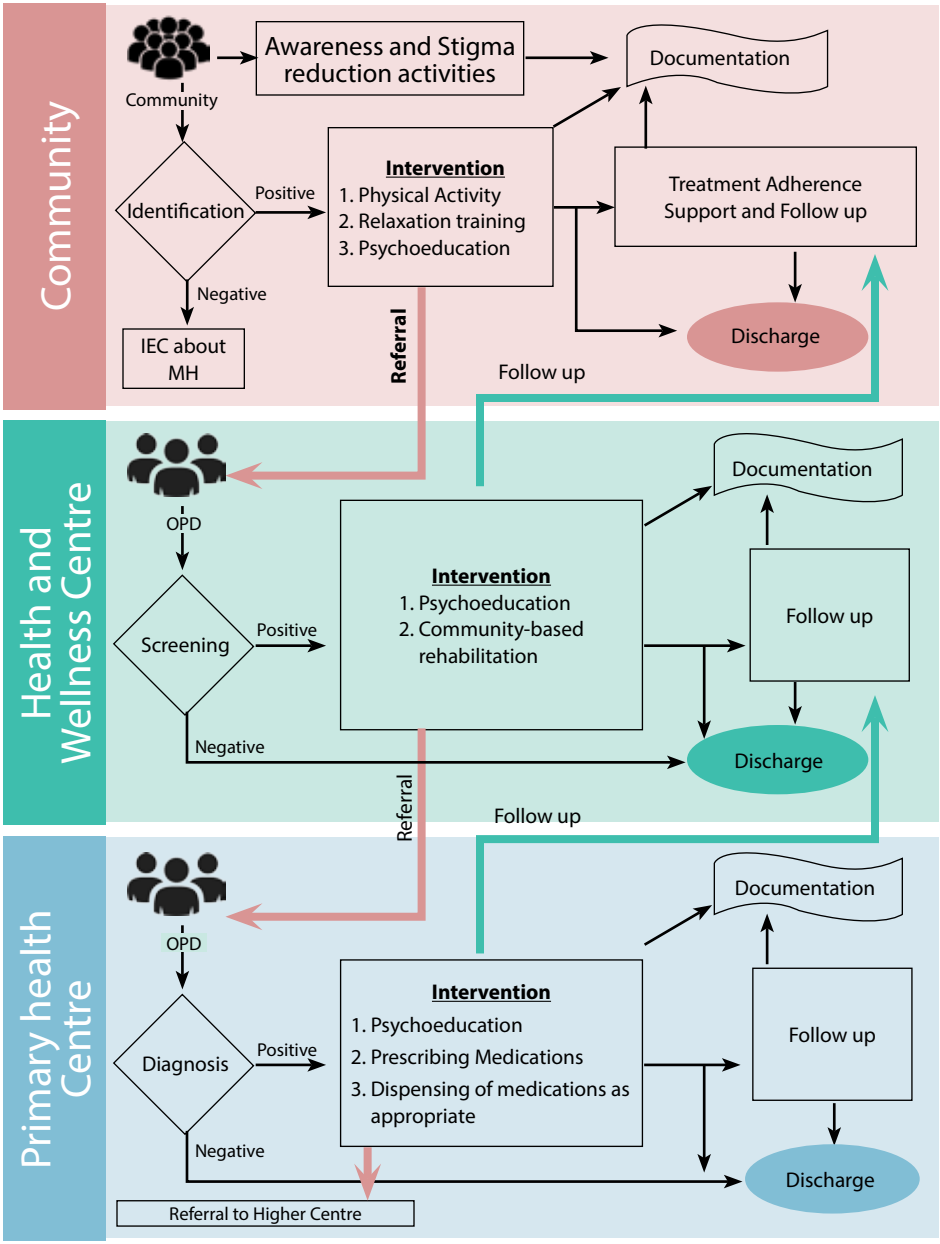
A.2

Service Delivery Processes for Common Mental Disorders



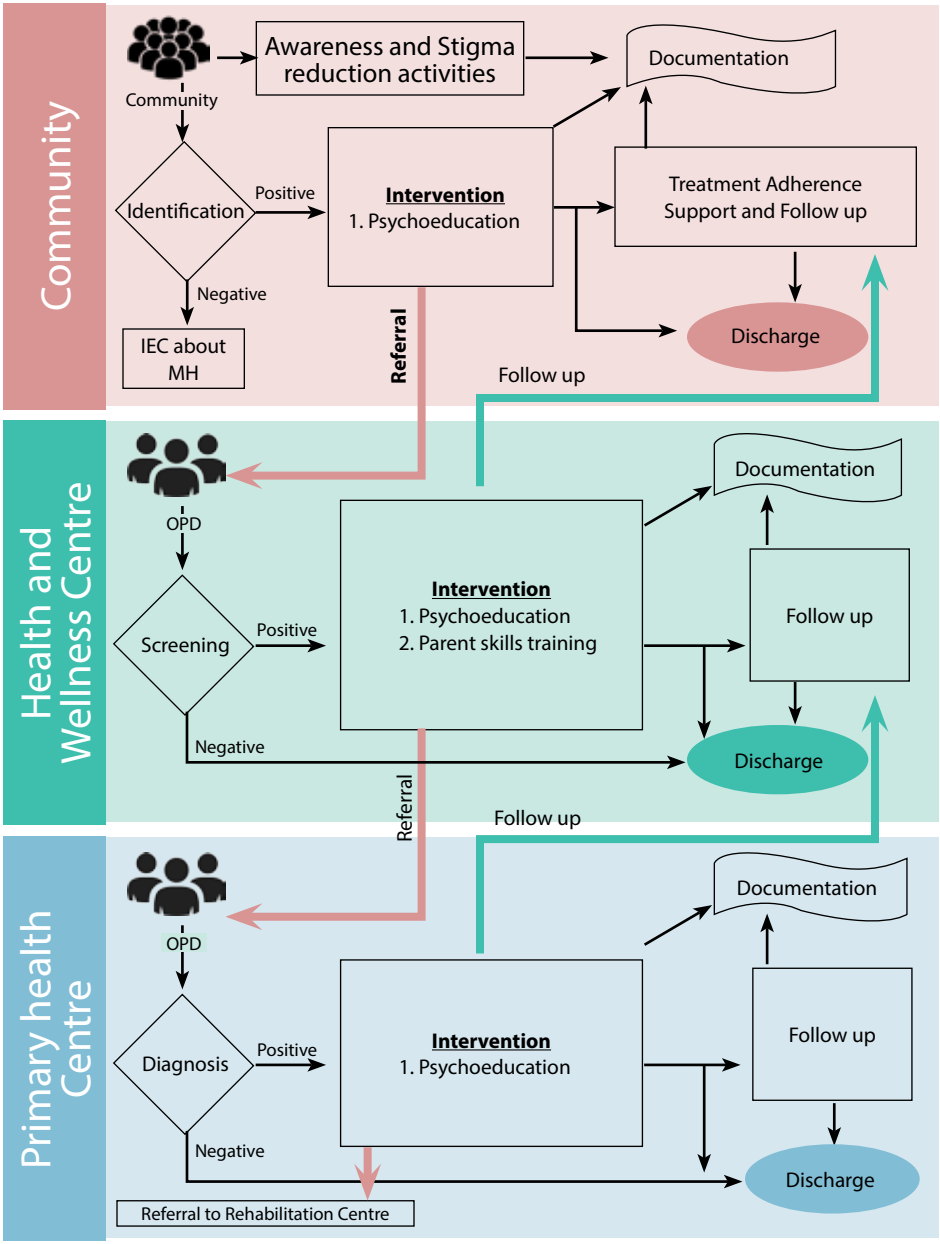
A.3

Service Delivery Processes for Severe Mental Disorders



A.4

Service Delivery Processes for Child Mental Disorders



ANNEXURE B: List of Medicines

S.No	Mental Health Condition	Suggested Medications**
1	Common Mental Disorders (CMD)	◗ Tab. Amitriptyline ◗ Cap. Escitalopram/Fluoxetine* ** Escitalopram is also recommended for depression in dementia, so this is better than Fluoxetine as it is common for both.*
2	Severe Mental Disorders (SMD)	◗ Tab. Risperidone ◗ Tab. Trihexyphenidyl
3	Substance Use Disorders (SUD)	◗ Tab. Diazepam/Tab Lorazepam ◗ Sublingual Buprenorphine/Methadone syrup* ◗ Injection Naloxone ◗ Tab. Naltrexone ◗ Tab. Thiamine/ Inj. Thiamine ** Could be made available in PHC/UPHCs if a State wishes to provide OST, in areas with high prevalence of opioid dependence [in conformity with training and other provisions of NDPS Act].*
4	Epilepsy	**Tab., Syrup and Injection –** ◗ Valproate ◗ Phenobarbitone ◗ Phenytoin ◗ Levetiracetam ◗ Midazolam **Tablets and Syrup –** ◗ Carbamazepine **Tablets –** ◗ Clobazam (mouth dissolving tab.) **Special formulation –** ◗ Intranasal and Intramuscular Midazolam* ◗ Folic acid ◗ Vitamin B12 supplements ◗ Calcium Supplements ** Could be made available in PHC/UPHCs if a State wishes to provide OST, in areas with high prevalence of opioid dependence [in conformity with training and other provisions of NDPS Act].*

S.No	Mental Health Condition	Suggested Medications**
5	Dementia	**For Cognition –** ◗ Donepezil ◗ Rivastigmine ◗ Memantine ◗ Galantamine **For Depression –** ◗ Escitalopram
6	For all disorders	Ayurvedic Medications/formulations for different mental health conditions should be made available at the Ayurvedic dispensaries. This will be specified in the training modules.

** To be kept at HWC for dispensation to such patients who have been prescribed these medicines (on a case to case basis) by a psychiatrist, or a trained medical officer.

ANNEXURE C: Brief Description of Psychosocial Interventions and Screening

Package	Summary
Psychoeducation	This include activities such as the following: 1. Mass awareness programs for larger dissemination of information and stimulating discussion within community, 2. Small group meetings to support focused discussion and resolving queries, 3. Family and one-to-one meetings to reinforce key messages of the program, query resolution at individual level.
Identification/ Screening	Community level detection can be done by ASHAs using pictorial check-lists such as the one used in VISHRAM or a validated check list like Community Identification and Detection Tool (CIDT). Confirmation of the diagnosis can be done at the healthcare facility level using validated screening tools such as Patient Health Questionnaire (PHQ-9) for depression and Alcohol Use Disorder Identification Test (AUDIT) for alcohol use disorders.
Psychological First Aid	Psychological first aid should be delivered to any individual who reports experiencing psychosocial distress. It consists of five essential steps: 1. Listening non-judgmentally 2. Assessing risk of harm to self or others 3. Giving reassurance and information 4. Encouraging the person to get appropriate help if needed 5. Encouraging self-help strategies
Relaxation Training	Breathing exercises as a practical and useful technique for relaxing the body and mind by controlling breathing, a technique that is also used in yoga and meditation. Demonstration of the exercise after explaining the steps outlined below: 1. Demonstration of how to breathe in the manner recommended 2. Take the patient through the steps 3. Allow the patient to practise

	4. Confirm that the patient has learnt the technique correctly 5. Encourage patient to practice regularly at home
Follow-up and Treatment Adherence Support	Follow up visits to : 1. Monitor clinical progress 2. Check for medication side-effects 3. Encourage adherence to psychosocial and/or pharmacological treatment
Suicide Risk Assessment	1. Identify risk factors– Note those that can be modified to reduce risk 2. Identify protective factors– Note those that can be enhanced 3. Conduct suicide risk assessment– Suicidal thoughts, plans, behavior and intent 4. Assess risk level and plan action– Determine risk, and choose appropriate action to address and reduce risk 5. Document assessment of risk, action taken and follow-up
Basic Suicide Management	**Low Risk** ◗ Counselling to reduce symptoms and address problems ◗ Give emergency contact numbers **Moderate risk** ◗ As above; and ◗ Early/frequent follow up **High risk** ◗ Contact supervisor urgently ◗ Inform family/significant other ◗ Take actions described in the manual
Basic Counselling (problem solving, behavioural activation)	People Centric Approach – Counselling services with Empathy, listening skills, reflection etc. Behavioural Activation (BA) – Behavioural assessment, activity monitoring, activity structuring and scheduling, activation of social networks Problem Solving – Define the problem, generate solutions, discuss advantages and disadvantages of the various solutions, choose solution that promises best results, apply the solution and assess outcome, and re-visit solutions if selected solution does not work

Community-based Rehabilitation	a) Clinical support (e.g. Structured needs assessments and clinical reviews to tailor treatment plans, individualized rehabilitation and adherence management strategies) and b) Psychosocial support (e.g. Psychoeducational information for both participants and caregivers, specific efforts to help participants and caregivers cope with stigma and discrimination)
First Aid Response to Overdose/ Intoxication	Response depending on type of substance
Brief Intervention/ Treatment	Brief Intervention for hazardous drinking: ◗ Assessment followed by personalised feedback ◗ Helping the patient to develop cognitive and behavioural skills and techniques (drink refusal skills, handling of peer pressure, problem-solving skills, and handling of difficult emotions), and ◗ Relapse management

ANNEXURE D: CIDT Screening Tool (Sample Screening and Diagnostic Tools for Adoption/Adaption by States)[6]

Name: Location:

DEPRESSION

Since the last Dashain festival Ram Bahadur looks really down and sad. It seemed to have started when his wife died. Nowadays, along with the loss of interest in his work he doesn't feel like doing anything, not even taking care of his baby son. These days, as he cannot fall asleep at night and has difficulty sleeping, he feels weak and fatigue. He has stalled to get angry and irritated with his family and friends even about trivial matters. As he feels easily tired and weak, he has started thinking that he cannot do anything in his life. Since past few days, he has started feeling that his future is dark because of which he does not want to live or feels that his life is useless. For 5 months he has hardly worked on the field anymore, he just sits at home all day.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION

QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } Finished
- Moderate match (person has significant features of this descriptions)..... 2
- Good match (description apply well)..... 3 Go to A2/A3
- Very good match (person exemplifies description, prototypical case)..... 4

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

6 CIDT: Jordans, Mark JD, et al. "Accuracy of proactive case finding for mental disorders by community informants in Nepal." The British Journal of Psychiatry 207.6 (2015): 501-506.

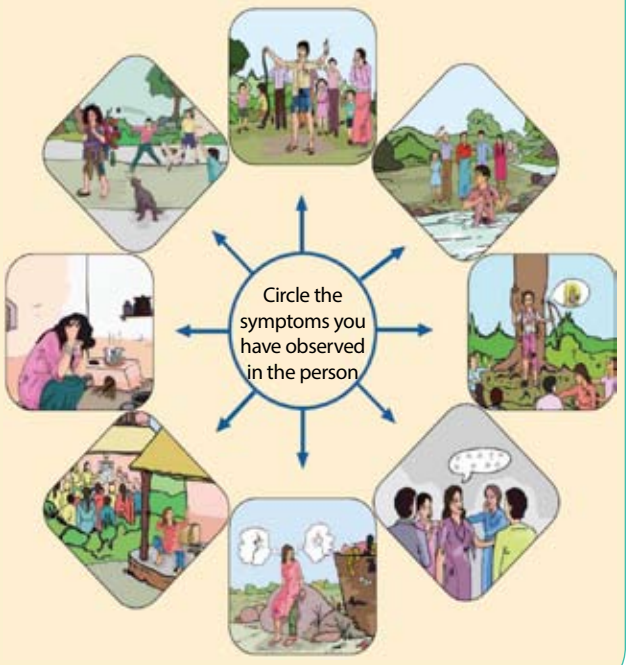
PSYCHOSIS

Since a few months, some changes can be seen in Prakash's behavior. He thinks of himself as a very powerful and superior being. He tells everyone that he can do things that others cannot do. He keeps talking weird things and monotonously and during such times, even if his family members or neighbors ask him to stop, he doesn't stop. He says that while he is sitting alone or when there is no one around him, he hears voices that are talking or calling to him. He has slowly stopped showing interest in the household and community activities that he is supposed to do. Due to such behavior, he had to stop the work he was doing. Often he just wanders around the town, not washed and looking very dirty. Prakash seems like a different person now.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION



QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } Finished
- Moderate match (person has significant features of this descriptions)..... 2
- Good match (description apply well)..... 3
- Very good match (person exemplifies description, prototypical case)..... 4

Go to A2/A3

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

EPILEPSY

One day when Rita was helping her mother in the kitchen, she suddenly got fits and fell off on the floor. Her whole body started to tremble. Since then this happens once in a while. In the same way, her body/ limbs starts making jerky movements and her mouth gets frothy and sometimes small blood drops starts coming out from her mouth. In few minutes, everything stops and she opens her eyes and feels tired so she sleeps for a very long time. After she wakes up, her mother asks her what had happened to her but in reply she says that she is completely unaware of what happened. She had this same problem three times last year. Once when she had fits, she urinated in her clothes. Because of her problem Rita finds it very difficult to go outside of her home.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION

QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) .....1 } Finished
- Moderate match (person has significant features of this descriptions).....2
- Good match (description apply well).....3
- Very good match (person exemplifies description, prototypical case).....4

Go to A2/A3

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

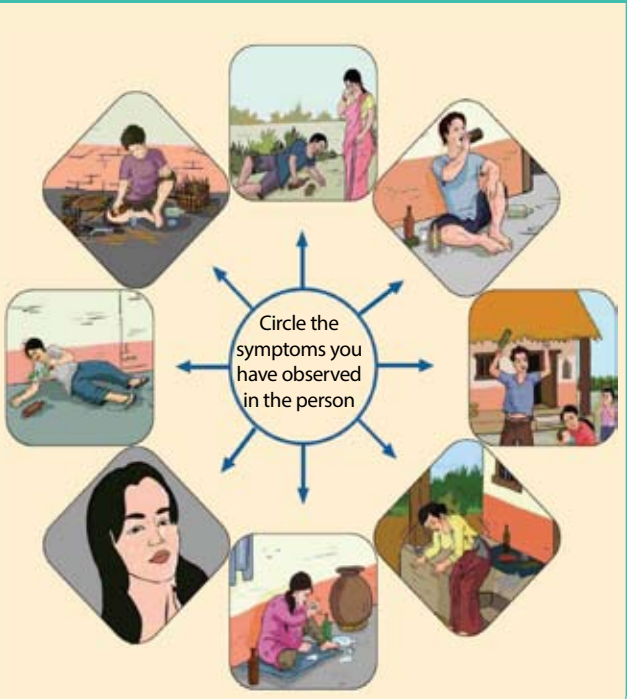
ALCOHOL USE DISORDER

Rajan drinks alcohol all the time, due to which, whenever someone goes near him, one can smell the strong stench of alcohol emanating from him. Because he always drinks alcohol, his speech is slurred and others find it very difficult to understand him. As he craves for alcohol everyday, he keeps consuming alcohol. After drinking alcohol, he speaks or does whatever he likes. Once he starts drinking alcohol, he cannot control himself and he always ends up drinking a lot. Due to heavy drinking, he has trembling limbs, sweats profusely, feels restless, and has increased palpitation. These days he no longer finds pleasure in activities he used to enjoy earlier, instead he has started to become engrossed in drinking alcohol. Due to such behavior, he is not able to complete his daily activities.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION



QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) .....1 } Finished
- Moderate match (person has significant features of this descriptions).....2
- Good match (description apply well).....3
- Very good match (person exemplifies description, prototypical case).....4

Go to A2/A3

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

BEHAVIORAL PROBLEM

Hari, an eleven year old boy currently studying in class five, is obstinate and does not obey his parents. He has always been a difficult boy. Not only does he vandalize his family's and neighbor's possessions, he also steals things and set fire to a barn before. He gets angry with his friends without any apparent reason, and is involved in physical fights with his peers. Often when he sees cattle, he chases them and beats them. He cannot concentrate on his studies and while going to school, he runs away and goes elsewhere. He often lies to his family and strolls around the village. At times he runs away and doesn't even return home al night or for a very long time. As a result of this, Hari is doing very badly in school and has no friends.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION

QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) .....1 } Finished
- Moderate match (person has significant features of this descriptions).....2
- Good match (description apply well).....3
- Very good match (person exemplifies description, prototypical case).....4

Go to A2/A3

A2 . Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

ANNEXURE E: Core Competencies of HR

Service Provider	Core Competencies
ASHA/MPW	◗ Basic principles of community engagement ◗ Basic knowledge of broad categories of MNS conditions/ disorders, symptoms etc. required for detection and/or referral for detection ◗ Basic knowledge of and competency to provide psychological first aid ◗ Knowledge about the myths related to MNS disorders, esp. epilepsy ◗ Capable of identifying status epilepticus ◗ Knowledge about when, how, where and whom to refer ◗ Patient engagement skills to provide treatment adherence support and follow-up care in the community ◗ Basic knowledge of psychotropic medications ◗ Capacity to identify red flags, which need immediate referral ◗ Knowledge about the rehabilitation measures for dementia ◗ Sensitization towards vulnerabilities, stigma, discrimination and rights violations associated with MNS disorders ◗ Ability to use health care technology as and when introduced
CHO	◗ Knowledge of and ability to use IEC materials appropriately ◗ Knowledge of categories of mental health problems ◗ Knowledge about the myths related to epilepsy and dementia ◗ Basic knowledge of seizures, epilepsy and dementia including its causes ◗ Basic knowledge of neurological disorders medications ◗ Knowledge of concerns relating to children and women ◗ Capable of identifying status epilepticus and providing first aid with Intranasal Midazolam ◗ Capable of providing medicines as per the direction/ prescription of Medical Officers/ Specialists

Service Provider	Core Competencies
	◗ General and specific counselling skills ◗ Ability to match counselling strategies to the needs of the patient ◗ Knowledge about when, how, where and whom to refer ◗ Capacity to identify red flags, which need immediate referral ◗ Patient engagement skills to provide treatment adherence support and follow-up care in the community ◗ Knowledge about the rehabilitation measures for dementia ◗ Sensitization towards vulnerabilities and stigma and discrimination faced by persons with epilepsy and dementia ◗ Sensitization towards vulnerabilities and rights violations associated with mental health disorders (legal, ethical issues) ◗ Ability to use health care technology
MO	◗ Knowledge of and ability to use IEC materials appropriately ◗ Knowledge of common psychotropic medications ◗ Knowledge of medications for epilepsy and dementia provided in these guidelines ◗ Knowledge of categories of mental health problems/ neurological health problem and ability to treat them. ◗ Knowledge of concerns relating to children and women ◗ Knowledge about emergency management of poisoning ◗ Capable of identifying status epilepticus and providing emergency medical intervention with I/M Midazolam ◗ Knowledge about when, how, where and whom to refer ◗ Knowledge about when to stop treatment or refer to higher center for same ◗ Capacity to identify red flags, which need immediate referral ◗ Sensitization towards vulnerabilities and rights violations associated with mental health disorders (legal ethical issues) ◗ Sensitization towards vulnerabilities and stigma and discrimination faced by persons with epilepsy and dementia ◗ Ability to use health care technology

ANNEXURE F: Detection/Screening Tool for Epilepsy[7]

Check List for Diagnosis of Seizure

- Was the patient completely unconscious during an episode?
- Did he/she pass urine or stool in his/her clothes during an episode?
- Did he/she ever injure himself/herself or have tongue/cheek bite during an episode?
- Was there any frothing from the mouth during an episode?
- Did he/she ever have such an episode while asleep?
- Has an episode ever occurred without preceding mental/emotionally stressful events?
- Any EPISODIC bizzare movements or behaviour, staring, blinking rapidly etc.

7 Anand K. Jain S., Paul E. Srivastava A., Sahariah SA, Kapoor S.K. Development of a validated clinical case definition of generalized tonic-clonic seizures for use by community based health care providers. Epilepsy. 2005 May;46(5):743-50. PubMed PMID:15857442

ANNEXURE G: Diagnostic Tool for Epilepsy to be Used by MOs (For Children & Adults)[8]

AIIMS Modified INDT-EPI tool for Primary Care Physicians

PERSONAL INFORMATION OF THE CHILD

1. **Name of the Child:**

2. **Age** (in completed months). ☐☐☐

3. **Sex:** (Male – 1, Female – 2) ☐

4. **Complete address of the child:**

5. **Informant:** 1 = Mother, 2 = Father, 3 = Guardian, 4 = Relative: ☐

1. Did your child ever have episodes of loss of consciousness associated with or wihout any of the following:

0: No **1:** Yes

- Up rolling of eyes
- Deviation of eyes to one side
- Tongue bite
- Frothing from mouth
- Passing urine/stool in clothes
- Jerky movement of all limbs
- Limbs becoming stiff
- Vacant stare
- Bluish discoloration around the mouth

2. Does your child have any of the following? **0** No **1** Yes (**for A**) ☐ (**for B**) ☐

A.

- Sudden backward or forward fall to the ground preceded by shock like contractions of the entire body
- Sudden head drops/inward or outward movement of the trunk, head and both upper limbs isolated or in clusters
- Sudden and unexplained episodes of falling to the ground and becoming very loose after that
- Brief episodes of (going blank)/losing contact with real time/ unresponsiveness to his/her surroundings
- Sudden unexplained paroxysmal episodes of altered emotions, like laughter, crying, getting agitated, inappropriate talking (after 2 years)

B.

- Stiffening of one half or one limb of body with or without loss of consciousness
- Jerky movement of one half or one limb of body with or without consciousness

8 Gulati S. Patel H, et al. Development and validation of AIIMS modified INCLEN diagnostic instrument for epilepsy in children aged 1 month – 18 years. Epilepsy. Res. 2017 Feb;130:64-68. Doi: 10.1016/j.eplepsyres.2017.01.008. Epub 2017 Jan 25. PubMed PMID: 28157600

3. HOW MANY SUCH EPISODES HAS THE CHILD HAD?

0: One **1:** More than one ☐

---

4. What was the duration between first and last episode/seizure?

0: Less than 24 hours

1: More than 24 hours ☐

9: Not Applicable

---

5. Did your child have these episodes always accompanied by fever?

(Ask only if the seizure occurred when the child was 6 months – 6 years of age)

0: No **1:** Yes **9:** Not Applicable

---

6. Did your child have these episodes only during brain infection (meningitis or encephalitis during active CHS infection/during hospitalisation)/head trauma (with 7 days)/or other infections (diarrhoea/ pneumonia) or any other cause as told to you by your doctor?

0: No **1:** Yes

(If answer is yes and parents know the cause mention here verbatim_____)

---

7. Did your child have these episodes only during the 1st month of life?

0: No **1:** Yes

---

8. In case of generalized stiffening with or without associated jerky movements and associated loss of consciousness with child turning blue or pale, is it always preceded by crying followed by cessation of breathing (mainly between 6 months to 60 months)

0: No **1:** Yes

---

9. Did your child has light headedness, giddiness/vertigo, blackening out of vision and/or associated with fall with prompt recovery specially after prolonged standing, skipping food or sudden change of posture?

0: No **1:** Yes

---

10. Anti Epileptic drug intake* (**0:** No **1:** Yes)

---

11. Final Diagnoses

0: No Epilepsy

1: Epilepsy

9: Indeterminate

* ***AED:*** *Anti Epileptic Drug*

*** To be rechecked for other associated NDDS from Summary assessment record of CAB and enter final diagnosis in point 11*

Epilepsy

- Response to questions 1 or 2 (A or B or both) and 3 & 4 is "1" AND **response to ALL of the questions 5–9 is "0"**

OR

- Response to Question 2 (B) is "1" and 3 and 4 is "0"

No Epilepsy

- Responses to **ALL questions 1,2 (A and B) "0"**

OR

- Response to **questions 1 is "1" AND 5 is "1"**

OR

- Response to **question 7, 8 or 9 is "1"**

Single Seizure

- R**esponse to question 1 is "1" or question 2(A) is "1" and question 3 is "0"**
- To be rechecked with presence of other associated NDD from summary Assessment record and regrouped for final diagnosis in point 11
- If any associated NDD classify as Epilepsy
- If no associated NDD check for Anti epileptic drug intake: If anti epileptic drug being used classified as indeterminate and if no anti epileptic drug being used classify as no epilepsy

Indeterminate

- Response to **questions 1 or 2(A) is "1" AND ANY of 6 or 10 is "1"**
- Child is on Anti Epileptic Drug he is indeterminate

ANNEXURE H: Detection/Screening Tool for Dementia to be Used by MPW/CHO

Everyday Abilities Scale for India

1. Does he/she ever forget that he/she has just eaten and ask for food again after he/she has just eaten?
2. Does he/she urinate in an appropriate place?
3. Do his/her clothes ever get dirty from urine or stools?

Tell me the following about his clothes:

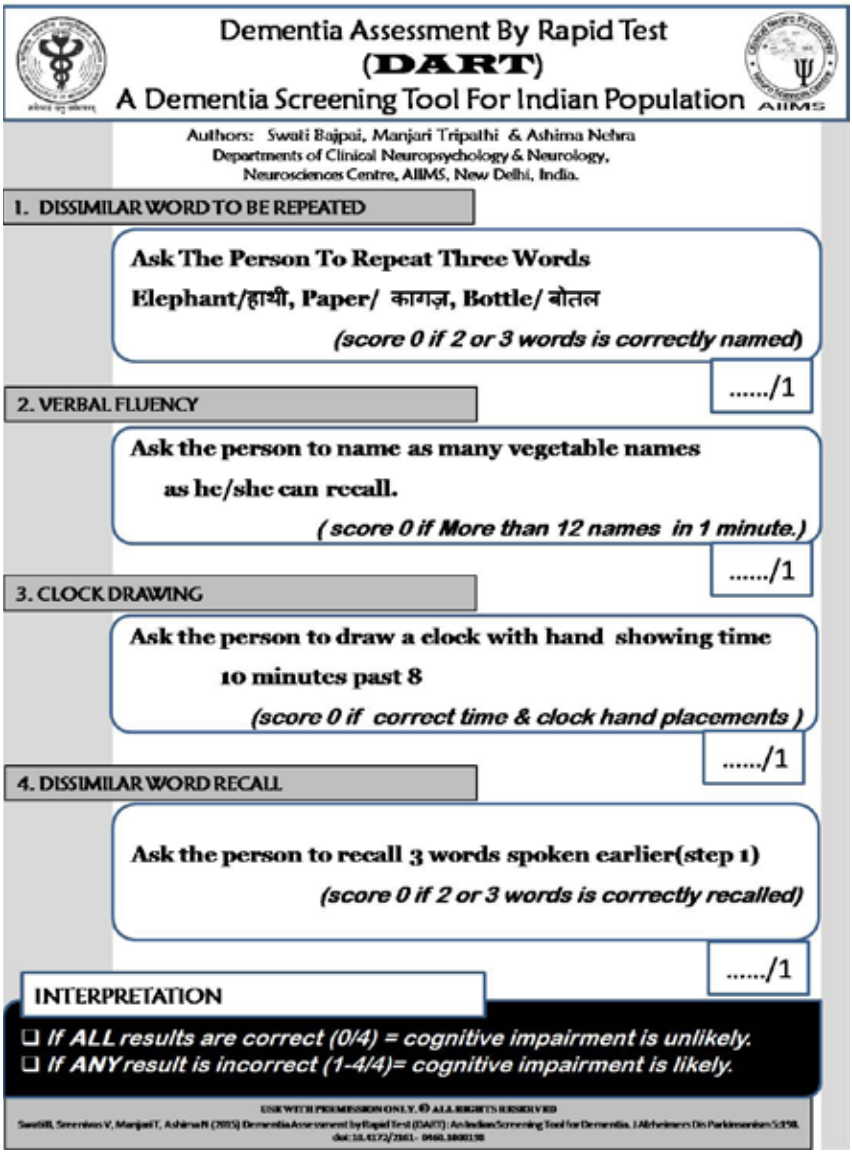
4. Is his/her shirt buttoned properly?
5. Is his/her dhoti/petticoat tied properly?
6. Is he/she able to work as a member of a team i.e. in a group activity which requires different roles from people will he/she be able to participate?
7. Does he/she express his/her opinion on important family matters, e.g., marriage?
8. If he/she is assigned or himself/herself decides to undertake an important task can he/she follow it through to completion?
9. Is he/she able to remember important festivals such as Holi, Diwali?
10. If he/she is asked to deliver a message does he/she remember to do so?
11. Does he/she discuss local/regional events such as marriages, disasters, politics appropriately?
12. Does he/she ever lose his/her way in the village?
13. Are they able to handle calculations and money?
14. Is there a change in behaviour or personality?
15. Is there new onset depression?

All questions are in Yes/No format. No is given 1-point. Scores >4 are to be evaluated further.

Points to keep in mind:

- **All these should be a new symptom or appearance not present in the individual few months or years before.**
- **History to be taken from a close caregiver, staying with person for longer than duration of appearance of symptoms.**

ANNEXURE I: Diagnostic Tool for Dementia to be Used by MO at PHC/UPHC[9]



Dementia Assessment By Rapid Test
(DART)
A Dementia Screening Tool For Indian Population

AIIMS

Authors: Swati Bajpai, Manjari Tripathi & Ashima Nehra
Departments of Clinical Neuropsychology & Neurology,
Neurosciences Centre, AIIMS, New Delhi, India.

1. DISSIMILAR WORD TO BE REPEATED

Ask The Person To Repeat Three Words
Elephant/हाथी, Paper/ कागज़, Bottle/ बोतल
(score 0 if 2 or 3 words is correctly named)

...../1

2. VERBAL FLUENCY

Ask the person to name as many vegetable names as he/she can recall.
(score 0 if More than 12 names in 1 minute.)

...../1

3. CLOCK DRAWING

Ask the person to draw a clock with hand showing time 10 minutes past 8
(score 0 if correct time & clock hand placements)

...../1

4. DISSIMILAR WORD RECALL

Ask the person to recall 3 words spoken earlier(step 1)
(score 0 if 2 or 3 words is correctly recalled)

...../1

INTERPRETATION

- ❑ *If ALL results are correct (0/4) = cognitive impairment is unlikely.*
- ❑ *If ANY result is incorrect (1-4/4)= cognitive impairment is likely.*

Swati B, Sreenivas V, Manjari T, Ashima N (2015) Dementia Assessment by Rapid Test (DART): An Indian Screening Tool for Dementia. J Alzheimers Dis Parkinsonism 5:198. doi: 10.4172/2161-0460.1000198

9. Swati B, Sreenivas V, Manjari T, Ashima N (2015) Dementia Assessment by Rapid Test (DART): An Indian Screening Tool for Dementia. J Alzheimers Dis Parkinsonism 5:198. doi: 10.4172/2161-0460.1000198

ANNEXURE J: Patient Health Questionnaire (PHQ-9)

Instructions — How to Score *the* PHQ-9

Major depressive disorder is suggested if:

- Of the 9 items, 5 or more are checked as at least 'more than half the days'
- Either item a. or b. is positive, that is, at least 'more than half the days'

Other depressive syndrome is suggested if:

- Of the 9 items, a., b. or c. is checked as at least 'more than half the days'
- Either item a. or b. is positive, that is, at least 'more than half the days'

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all–0, several days=1, more than half the days=2, and nearly everyday=3).Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below:

Guide for Interpreting PHQ-9 Scores

Score	Recommended Actions
0-4	Normal range or full remission. The score suggests the patient may not need depression treatment.
5-9	Minimal depressive symptoms. Support, educate, call if worse, return in 1 month.
10-14	Major depression, mild severity. Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment. Treat with antidepressant or psychotherapy.
15-19	Major depression, moderate severity. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 or higher	Major depression, severe severity. Warrants treatment *with* antidepressant and pychotherapy, especially if not improved on monotherapy; follow frequently.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home,

or relationships with other people. Patient responses can be one of four: Not difficult at all, Some what difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Patient Health Questionnaire (PHQ-9)

Patient name:_____Date:_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things	❐	❐	❐	❐
b. Feeling down, depressed, or hopeless	❐	❐	❐	❐
c. Trouble falling/staying asleep, sleeping too much	❐	❐	❐	❐
d. Feeling tired or having little energy	❐	❐	❐	❐
e. Poor appetite or overeating	❐	❐	❐	❐
f. Feeling bad about your self, or that you are a failure, or have let yourself or your family down	❐	❐	❐	❐
g. Trouble concentrating on things, such as reading the newspaper or watching TV	❐	❐	❐	❐
h. Moving or speaking so slowly that other people could have noticed Or the opposite; being so fidgety or restless that you have been moving around more than usual	❐	❐	❐	❐
i. Thoughts that you would be better off dead or of hurting yourself in someway	❐	❐	❐	❐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0	Not difficult at all	0	Somewhat difficult	0	Very difficult	0	Extremely difficult

TOTAL SCORE _____

List of Contributors

Members of the Task Force on Mental Health in CPHC

1. Dr. Sujeet Kumar Singh, Director, NCDC, MoHFW
2. Dr. Alok Mathur, Addl. DDG, DGHS, MoHFW
3. Dr. Indu Grewal, Addl. DDG, DGHS, MoHFW
4. Dr. Vijay K. Tewari, Health Education Officer, DGHS, MoHFW
5. Dr. Santosh K. Chaturvedi, Dean, Behavioural Sciences, NIHMANS (Chairperson)
6. Dr. Himanshu Bhushan, Advisor, Public Health Administration, NHSRC, (Member Secretary)
7. Prof. Suresh Bada Math, Chief of Community Psychiatry, NIMHANS
8. Dr. R. Thara, Director, Schizophrenia Research Foundation (SCARF)
9. Dr. Vikram Patel, Co-founder and Member of Managing Committee, Sangath
10. Dr. Abhijit Nadkarni, Director, Addictions Research Group, Sangath; Hon. Consultant Psychiatrist, South London & Maudsley NHS Foundation Trust, UK
11. Dr. Urvita Bhatia, Research Fellow and Consultant Psychologist, Sangath
12. Dr. Rahul Shidhaye, Associate Professor, PHFI
13. Mr. Vaibhav Murhar, Project Director (PRIME & ESSENCE), Sangath

14. Dr. Atul Ambekar, Prof. National Drug Dependence Treatment Centre (NDDTC), AIIMS
15. Dr. Manjari Tripathi, Prof. Neurology, AIIMS Delhi
16. Dr. Naveen Kumar, Addl. Prof. Psychiatry, Dept. of Psychiatry, NIMHANS
17. Dr. N Manjunatha, Asst. Prof. Psychiatry, Dept. of Psychiatry, NIMHANS
18. Dr. Shashidhara H.N, Specialist Grade Psychiatry, Dept. of Psychiatry, NIMHANS
19. Dr. Vinay B., Specialist Grade Psychiatrist, Dept. of Psychiatry, NIMHANS
20. Dr. Arvind Raj E., Associate. Prof. Psychiatric Social Work, Dept. of Psychiatric Social Work, NIMHANS
21. Dr. Aruna Rose Mary Kapanee, Assistant Professor of Clinical Psychology, Community Mental Health Unit, NIMHANS
22. Dr. Radha Krishnan, Assistant Professor of Nursing, Community Mental Health Unit, NIMHANS
23. Dr. Pallab K. Maulik, Deputy Director, George Institute of Global Health
24. Dr. Atreyi Ganguli, WHO
25. Prof. S.K. Deuri, Director, LGB Regional Institute of Mental Health
26. The Banyan, Chennai
27. Dr. H. Sudershan, Karuna Trust & VGKK
28. Dr. Rajesh Sagar, Prof. Psychiatry, AIIMS
29. Dr. Rajani Parthasarty, State Nodal Officer, Karnataka
30. Dr. Suneel Pandey, State Nodal Officer, Mental Health, UP
31. Dr. Ajay Chauhan, Programme Officer, Mental Health & Medical Services, Gujarat
32. Dr. Kiran P S, State Programme Manager, Kerala
33. Dr. Ranita Athokpam, State Nodal Officer, Mental Health, Manipur
34. Dr. Bimal Kumar, State Nodal Officer, Bihar

Sub Group on Epilepsy and Dementia

1. Dr. Manjari Tripathi, Prof. Neurology, AIIMS Delhi
2. Dr. P. Satish Chandra, Ex Director, NIMHANS
3. Dr. Suvasini Sharma, Incharge Pediatric Neurology, LHMC
4. Dr. Deepika Joshi, Prof & Head BHU, Neurology
5. Dr. Samhita Panda, AIIMS- Jodhpur Neurology
6. Dr. Pradeep Nair, HOD- Neurology JIPMER, Pondicherry
7. Dr. Nirendra Rai, AIIMS- Bhopal- Neurology

Sub Group on Ayurveda in Mental Health

1. Dr. D.C. Katoch, Advisor, AYUSH Dept., Ministry of Ayush
2. Dr. S.N. Ojha, Professor and Director, Ayurveda, J&K
3. Dr. Surinder Katoch, Ayurvedic Psycho-Counsellor
4. Dr. Parvatheey, Med. Superintendent. Govt. Ayurvedic Mental Hospital

Contributors from Ministry of Health and Family Welfare

1. Mr. Manoj Jhalani, Special Secretary and Mission Director
2. Ms. Vandana Gurnani, Additional Secretary and Mission Director (NHM)
3. Dr. Manohar Agnani, Joint Secretary (RCH), NHM
4. Mr. Vikas Sheel, Joint Secretary (Policy), NHM
5. Dr. N. Yuvaraj, Director, NHM-1, NHM
6. Dr. Rakshita Khanijou, Consultant, NHM

Contributors from NHSRC

1. Dr. Rajani Ved, ED, NHSRC
2. Dr. Garima Gupta, Sr. Consultant, CP CPHC Division
3. Ms. Shivangi Rai, Consultant, PHA Division

4. Mr. Prasanth K.S., Sr. Consultant PHA Division
5. Dr. Neha Dumka, Sr. Consultant, CP CPHC Division
6. Dr. Nisha Singh, Consultant, Public Health Planning Division
7. Mr. Ajit Singh, Consultant PHA Division
8. Dr. Aashima Bhatnagar, Consultant, PHA Division
9. Dr. Shuchi Soni, Consultant, PHA Division
10. Dr. Kalpana Pawalia, Consultant, PHA Division
11. Dr. Ishita Choudhary, Fellow, PHA Division
12. Dr. Sayali, Fellow, PHA Division
13. Ms. Akshita Singh, Fellow, PHA Division

Secretarial Support, NHSRC

1. Dr. Uddipan Dutta, PAO
2. Ms. Manju, Secretarial Assistant
3. Mr. Girish Kumar, Admin Assistant
4. Mr. Bhupal Ram, Support staff
5. Mr. Prakash Chemjung, Support staff
6. Mr. Ravi, Support staff

List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AYUSH	Ayurvedic, Unani, Sidha and Homeopathy
CMD	Common Mental Health Disorder
C&AMHD	Childhood & Adolescent Mental Health Disorder
DALYs	Disability Adjusted Life Years
DMHP	District Mental Health Program
IEC	Information, Education and Communication
MNS	Mental, Neurological and Substance Use
NMHP	National Mental Health Program
NMHS	National Mental Health Survey
OCD	Obsessive Compulsive Disorder
OST	Opioid Substitution Therapy
PWE	Person with Epilepsy
PWD	Person with Dementia
SMD	Severe Mental Health Disorder
STC	Secondary/ Tertiary Care Centers

SUD	Substance Use Disorder
TOT	Training of Trainers
UHND	Urban Health and Nutrition Day
VHND	Village Health Nutrition Day
YLL	Years of Lives Lost

Design & Layout: JS MEDIA (www.jsmedia.in)