KERALA STATE MENTAL HEALTH POLICY

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Preamble

The journey of mental healthcare in our society represents one of the most profound evolutionary arcs in the history of public health. It is a transition from an era of silent institutional custody to a vibrant, rights-based movement that places human dignity, autonomy, and community integration at its absolute core. To understand the depth of our current mission and the magnitude of our future vision, one must first look back at the historical foundations upon which our existing frameworks were built. Long before national independence, early evaluations of the health sector laid bare a startling reality. The colonial government's Bhore Committee, appointed in 1943 and submitting its monumental report in 1946, unveiled a sprawling subcontinent possessing a mere fraction of the psychiatric infrastructure required. At a time when the ratio of bed allotment in England stood at one for every three hundred people, Indian institutions could only offer slightly above ten thousand beds across the entire country, translating to a dismal ratio of one bed for every forty thousand individuals. The Bhore Committee rightfully observed that no individual should be deprived of medical assistance due to an inability to afford it, advocating strongly for a paradigm shift toward preventive healthcare and the urgent expansion of medical aid to rural populations. It was during this period that the conceptual seed of the Primary Health Centre was planted, envisioned as the active network through which future doctors—imbued with a deep sense of social responsibility—could guide the public toward healthier, more fulfilling lives. This early vision underscored the necessity of modernizing mental

hospitals and integrating mental health departments into premier national institutes, setting the stage for decades of gradual reform.

Building upon these early foundations, subsequent decades witnessed a series of critical evaluations that incrementally shifted the narrative from isolated psychiatric asylums to comprehensive community health integration. This holistic perspective was further amplified internationally during the Alma-Ata Conference of 1978, which championed the rallying cry of "Health for All" and firmly embedded mental health as one of the eight core components of primary healthcare schemes globally. In tandem, India's own National Health Policy of 1983 and the National Mental Health Programme of 1982 catalyzed efforts to dissolve the boundaries between general health programs and mental health initiatives. Recommendations flowed emphasizing the integration of mental health into primary health centers, the establishment of regional community centers, and the profound realization that the promotion of mental well-being is just as critical as the clinical curing of illness.

Yet, the most seismic philosophical earthquake in the realm of psychiatric care occurred at the dawn of the twenty-first century, fundamentally rewriting the relationship between the state, the medical establishment, and the individual. The adoption of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006 marked a definitive departure from the archaic medical and charity models of disability. Prior to this, individuals experiencing mental illnesses were predominantly treated as passive objects of welfare, medical experimentation, or societal pity. The UNCRPD established a social, rights-based model, asserting that persons with disabilities are active subjects possessing inherent legal agency, dignity, and the inalienable right to full inclusion in society. It demanded an end to

substitute decision-making, advocating instead for supported decision-making and equality of opportunity. This global mandate compelled a massive structural realignment of our domestic legislative landscape, paving the way for the National Mental Health Policy of 2014. This policy championed a pro-poor orientation, recognizing the destructive, bidirectional cycle of poverty and mental illness, and sought to deliver last-mile service provisions to marginalized rural populations who had historically been denied access to essential psychiatric care.

The culmination of this rights-based evolution was the landmark Mental Healthcare Act (MHCA) of 2017, a transformative piece of legislation that repealed outdated, custodial frameworks and codified the human rights of patients into undeniable statutory guarantees. The MHCA fundamentally dismantled the paternalistic, doctor-controlled asylum model, replacing it with a legal architecture that guarantees the right to access affordable, quality healthcare devoid of discrimination based on gender, sexual orientation, caste, or socio-economic status. It strictly prohibited cruel and degrading practices, championed the right to strict medical confidentiality, and emphasized that every individual has the right to live within their community rather than facing forced, indefinite institutionalization. Perhaps most profoundly, the Act effectively decriminalized attempted suicide, recognizing that individuals driven to such extremes are suffering from severe stress and require compassionate medical care, treatment, and rehabilitation rather than punitive criminal prosecution. This monumental shift mandated the creation of robust oversight mechanisms, including Mental Health Review Boards, to serve as vigilant watchdogs protecting patient autonomy, ensuring that principles like Advance Directives and Nominated Representatives are rigorously honored in everyday clinical practice.

While these international conventions and national legislative milestones established an impeccable theoretical framework, translating these mandates into the complex, dynamic socio-demographic reality of our state presents a myriad of unique situational challenges. Our state faces profound epidemiological burdens that require localized, highly nuanced interventions. Current evaluations indicate that severe mental illnesses affect a substantial segment of our population, while a broad spectrum of acute, chronic, and neurodevelopmental disorders continuously strain our public health infrastructure. We are currently navigating a demographic transition characterized by increased life expectancy and massive outward youth migration, phenomena that have birthed an acute geriatric care crisis. The resulting "empty nest" paradigm leaves vast numbers of elderly citizens living in profound isolation, rendering them highly vulnerable to late-life depressive disorders, neurocognitive declines such as Alzheimer's and vascular dementia, and late-onset anxiety. The traditional joint-family support structures that historically absorbed the burden of eldercare are rapidly eroding, generating an urgent demand for specialized psychogeriatric nursing, home-based care networks, and community-led palliative interventions.

Concurrently, our society is locked in a fierce battle against escalating waves of substance use and behavioral addictions that threaten to derail the potential of our younger generations. The state carries a disproportionately heavy burden of alcohol-related disorders, characterized by a lowering age of initiation and staggering rates of severe alcohol dependence that fracture families, deplete household finances, and induce severe psychiatric and cognitive conditions ranging from depressive disorders to alcohol-related dementia. Even more alarming is the explosive surge in the use of high-potency synthetic drugs, such as methamphetamines and MDMA, among adolescent and college cohorts.

Compounding this chemical epidemic is the silent, pervasive spread of behavioral addictions. Driven by rapid digital penetration, problematic smartphone overuse, internet gaming disorders, and social media addiction are systematically disrupting sleep architectures, destroying academic focus, and triggering severe emotional volatility among children. Furthermore, a massive hidden burden of psychosexual disorders, heavily clouded by deep socio-cultural taboos, continues to cascade into chronic depression and marital dissolution, remaining largely unaddressed outside specialized clinical corridors.

To systematically confront these escalating demographic and epidemiological crises, our forward-looking policy and planning frameworks must be anchored in an unwavering mission defined by three foundational principles: Democratization (Jnakeeyavalkaranam), Equity (Samathwam), and Ethical Awareness (Naithika Bodham).

Democratization demands that our policy programs do not emerge from isolated bureaucratic chambers, but rather from active, continuous dialogue involving public health workers, patients, families, and grassroots administrators. It is through this deep public participation and decentralization of power that we can guide our communities toward genuine self-reliance. Equity dictates that our available resource wealth must be distributed justly, meticulously tailored to the unique vulnerabilities and needs of different geographic regions and marginalized populations, ensuring that no individual is left behind due to the lottery of their birth or location. Ethical Awareness must permeate every facet of our medical education, clinical practice, and societal conduct, fostering a public health service driven by profound empathy, dedication, and an uncompromising commitment to human dignity. By embedding these principles into our operational DNA, we ensure that the benefits of modern

scientific and technological advancements bypass urban monopolies and reach the most remote rural doorsteps.

Driven by this mission, our strategic vision for the future architecture of mental health services necessitates a complete reimagining of our physical and digital infrastructure. We must systematically pivot away from the antiquated model of centralized, long-term institutional confinement. The future lies in maximizing community-based facilities through the establishment of expansive networks of day-care centers, transitional halfway homes, and supported accommodation facilities. These environments are critically designed to help individuals stabilize, engage in therapeutic skill training, and step safely back into daily society while preserving their independence. For the urban marginalized, the creation of Integrated Day-Respite Urban Hubs—operating through dynamic public-private partnerships—will provide vital vocational training and transitional employment placement. Furthermore, to truly bridge the geographic divide, we must heavily invest in digital scale-up. The seamless integration and expansion of Tele-MANAS will serve as a continuous digital triage system, providing instantaneous psychological first aid and seamlessly routing patients to localized physical care teams. By integrating language-specific, AI-driven pre-screening tools directly into our primary Health and Wellness Centers, grassroots public health workers will be uniquely empowered to identify early markers of psychosis and clinical depression, truly universalizing the right to access care.

The realization of this expansive vision fundamentally relies on transforming how our allied agencies and state apparatus interact with individuals experiencing psychological distress. Historically, the intersection of mental illness and law enforcement has been fraught with

misunderstanding, criminalization, and trauma. Moving forward, our vision champions the complete eradication of punitive responses to mental health crises. We propose the full implementation of a Compassionate Co-Responder emergency model, wherein trained psychiatric social workers deploy alongside emergency responders and law enforcement to manage crises humanely in the field. This approach ensures that wandering homeless individuals or those rescued from suicide attempts are met with therapeutic support rather than lock-ups and judicial apathy. By continuously sensitizing police departments, legal aid providers, and judicial officers, we aim to build an invisible, yet impenetrable, wall of legal and psychological protection around the most vulnerable, ensuring that the decriminalization of suicide and the right to community living are realized not just in statute, but in everyday practice.

Crucially, our vision recognizes that reactive clinical care is entirely insufficient to stem the tide of modern psychological distress; we must aggressively pivot toward preventive and promotive frameworks targeting the foundational environments of our youth and workforce. Recognizing that the vast majority of psychiatric disorders precipitate during adolescence, we propose the massive expansion of protective school-based initiatives like the Our Responsibility to Children (ORC) program. By training teachers as nodal first-responders and establishing specialized referral matrices, we can divert vulnerable youth away from punitive systems and toward psychological reintegration. This must be coupled with the formal integration of evidence-based Life Skills Education directly into academic curricula, equipping our youth with the critical thinking, emotional regulation, and interpersonal assertiveness required to navigate modern stressors, resist peer pressure, and prevent the onset of behavioral and substance addictions. Complementary programs, such

as the Vimukthi mission, will aggressively work to secure drug-free campuses by channeling the energies of at-risk youth into highly structured creative and physical pursuits, engineering healthy psychosocial environments through positive reinforcement.

This commitment to stress reduction and proactive care must extend beyond the classroom and into the realities of the modern workplace and the sacred duty of eldercare. We propose the institution of mandatory structural stress audits across high-pressure government and private employment sectors, coupled with the establishment of confidential employee assistance programs and peer-support networks like the Santhwanam initiative utilized by our police forces. For our rapidly expanding elderly demographic, our vision promises a comprehensive Care Economy that honors their contributions through dignified, accessible support. By heavily funding and expanding dementia-friendly initiatives like Ormathoni, comprehensive home-based palliative care, and localized day-care centers through the Vayomithram scheme, we will combat the profound loneliness and cognitive decline that threatens our seniors, ensuring that their later years are defined by comfort, community, and respect.

Ultimately, the architecture of this policy is governed by a singular, overarching philosophy: the State Mental Health Policy must never be viewed as a static, immovable edict. Rather, it must function as a dynamic, living document—a responsive framework that continuously breathes, evolves, and adapts to the shifting contours of scientific evidence, technological advancement, and societal transformation. We commit to a culture of relentless self-evaluation through continuous, rigorous epidemiological research, building upon the foundations of the National Mental Health Survey to meticulously track emerging

morbidities, shifting demographics, and the evolving treatment gaps within our communities. By perpetually engaging with stakeholders, refining our strategies, and holding our institutions accountable to the highest standards of human rights, we ensure that this policy remains a powerful, living instrument of change. It is through this unwavering commitment to continuous evolution, equitable access, and deeply democratized care that we will forge a society where mental well-being is not a privilege afforded to the few, but an undeniable, universal reality for all.

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Mental Health Care Sector: A Historical Overview

Activities and initiatives in the mental health sector had begun even before national independence.

2.1 Bhore Committee Report (1946)

The colonial government appointed a Health Survey and Development Committee in 1943. Sir Joseph Bhore chaired the committee. In 1946, the Bhore Committee submitted a report to the government recommending revolutionary programs to replace the treatment systems in place at the time. The factors that prompted the committee to make these recommendations are as follows:

1. No individual should be deprived of medical assistance due to an inability to afford it.
2. In health programs, top priority must be given to disease prevention activities (preventive healthcare).
3. Medical aid and disease prevention activities must urgently reach the rural population. They currently receive only a very minimal level of medical services. When famines and epidemics sweep across the land, it is this section of the population that bears the heaviest burden.

4. Doctors of the future must possess a sense of social responsibility. They should be capable of attracting, connecting with, and guiding people toward leading a healthier

and more satisfying life. A suitable service network for this purpose needs to be developed at the rural level. The focal point of these active networks must be the Primary Health Centre. These were the primary recommendations of the Bhore Committee.

The observations and recommendations of this committee regarding mental health are as follows: "According to the existing system, the total number of beds allocated for mental health patients across the country is only slightly above 10,000. In Indian mental hospitals, the ratio of bed allotment is approximately one bed for every 40,000 people. Whereas in England, this ratio stands at one bed for every 300 people." The committee's directives regarding mental health treatment are as follows:

a) A Mental Health Organisation should be formed under the centralized administration of the Director General of Health Services. Below him, there should be Health Service Directors in the states.

b) The 17 mental hospitals across the country must be modernized. Within the first 5 years, two mental health training and educational institutions should be established at the national level, and an additional five such institutions should be established within the subsequent five years.

c) Necessary training facilities must be available in these institutions for doctors and other categories of mental health workers from both within and outside India.

d) A mental health department should also be included in the All India Institute of Medical Sciences (AIIMS).

2.2 Mudaliar Committee Report (1962)

Reviewing the progress made in the field of mental health activities during the decade following the Bhore Committee Report, the Mudaliar Committee stated:

"No reliable statistical data regarding the prevalence of mental illnesses is available. There is reason to believe that a vast number of mental patients require treatment. Currently, there are only 1,500 beds available across India for such individuals. No health education programs related to mental illness have been established. Furthermore, facilities for treating psychosomatic (mental-origin physical) illnesses in general hospitals are inadequate."

The recommendations of this committee primarily focused on three key areas:

B. Training

The main requirements related to this are as follows:

1. Necessary training must be provided to all categories of workers associated with mental health activities.
2. Necessary mental health knowledge and training must be provided to pediatricians, teachers, nurses, and individuals holding administrative responsibilities in various fields of health, tailored to their respective domains.
3. Mental health education must be imparted to everyone working in connection with medical science.

4. There is a shortage of specialists in the field of psychiatric treatment; to address this shortage, the existing mental hospital should be upgraded into a training institute equipped with all facilities, in addition to the All India Institute of Mental Health.
5. In order to resolve the shortage of specialists and achieve self-sufficiency, if individual states are unable to do so on their own, it should at least be achieved at the regional institutional level.

C. Research

2.3 Sri Shrivastava Committee (1974)

This committee did not provide specific directives necessary for implementing mental health programs. However, a major recommendation was to utilize the services of a category of workers called Community Health Workers (C.H.W). The subject of mental health was also included in the training program for these health workers.

One chapter in this manual, which consists of a total of 12 chapters, is about mental health. It explains how to manage mental health problems and emergency situations.

2.4 Alma-Ata Conference (1978)

This was an international conference in which India actively participated. This conference proved useful in creating a turning point in the structure and system of the public health department. Following this conference, several reform activities took place in the field of public health on a global scale, focusing on the slogan "Health for All." The component of mental health also became a part of public health programs. Accordingly, it is also

noteworthy that the mental health program became one of the eight core components of the primary healthcare scheme.

"Existing public health problems—methods to identify them, health education programs, disease control and prevention, improving the distribution of food substances including nutritional values, supply of pure water, environmental sanitation, maternal and child healthcare including family planning methods, immunization against infectious diseases—control of locally endemic diseases, appropriate treatment for diseases and injuries, promotion of mental health and essential drugs..."

These are the eight components that are now part of our primary health programs.

2.5 National Health Policy (1983)

Our National Health Policy went a step further in analyzing mental health care. Mental, physical, and socio-biological rehabilitation facilities must also be made available to those with disabilities, the deaf and mute, the elderly, and those with intellectual disabilities.

2.6 Sixth Five-Year Plan

Regarding the goal to be achieved within the next 20 years to identify those affected by mental illnesses and to deliver urgent treatment to those who need it, the Sixth Five-Year Plan states as follows:

"In matters of mental health, facilities must be made available to 20% of the population. By 1990, these facilities should be accessible to 50% of the people, and by 2000 A.D., to 75% of

the people. This reference specifically pertains to the aspects of identifying patients and providing treatment."

2.7 National Mental Health Programme (1982)

The Government of India's National Mental Health Programme took shape in 1982 as a result of various activities aimed at raising the standard of physical and mental health of the people through diverse channels. The Central Council of Health and Family Welfare recommended the following matters:

1. The mental health programme must be an integral component of the general health programme. The importance of mental health should be enhanced by incorporating it into the operational frameworks of all programmes, including education and social welfare.
2. Necessary steps must be taken to include this subject in the curricula of medical education courses at various levels to make the learning effective.

To implement the National Mental Health Programme, a committee was formed under the chairmanship of Sri Narayan Reddy, the Director of the National Institute of Mental Health and Neurosciences (NIMHANS). This committee formulated and submitted a programme concerning the implementation of the project. Its primary recommendations are as follows:

1. Mental health activities must be included within the scope of functioning of the primary health centres operating in states and union territories.
2. Regional centres must be established targeting community mental health.
3. A national advisory committee must be formed to handle mental health matters.

4. A dedicated workforce with a sense of commitment must be developed.
5. Along with treating and curing mental illnesses, mental health must also be promoted.
6. Integrate various multipurpose health training schools with the National Mental Health Programme.
7. The services of voluntary organizations should also be included in the mental health programme.
8. The subject of mental health must be made compulsory in degree-level education.
9. Community mental health programmes must be evaluated periodically.
10. Records and manuals must be designed.
11. Special training programmes must be formulated for the staff working in connection with mental hospitals.

As a result of all these recommendations, a government order was issued on September 22, 1987. This order clarifies the central assistance provided to the states for incorporating and implementing national mental health programmes during the Seventh Five-Year Plan period.

In accordance with the government order GO(Rt) 4196/86/H&D dt. 27.11.96, the National Mental Health Programme was started in Kerala in 1986. Following this, training in basic subjects related to mental health was provided to several doctors and paramedical workers functioning in primary health centres.

2.8 Other Developments

The 'Drug Dependence Control Programme' (Drug Dependence Control System) developed after 1988 is a major milestone associated with this field. The enactment of the Narcotic

Drugs and Psychotropic Substances (N.D.P.S) Act, 1985, along with the increasing misuse of dangerous substances like 'Heroin', led to the creation of such a law. The features of this programme are as follows:

1. Establishing de-addiction centres (substance abuse treatment clinics).
2. Training programmes at various levels.
3. Providing necessary assistance to voluntary organizations working in the field of addiction treatment.
4. Implementing value-based regulations on drug usage across the nation; for this purpose, special centres were established in places like Delhi, Chandigarh, Bangalore, and Pondicherry.

Care and protection programmes for individuals with intellectual disabilities gradually moved away from the scope of the mental health programme. Individuals with intellectual disabilities were also excluded from the purview of the Mental Health Act of 1987. A national institute was established in 1984 for those affected by intellectual disabilities. Its objectives included providing training to teachers in service, developing learning materials required for training and education, and arranging necessary protection, including legal aid, for individuals with intellectual disabilities matters are included in this central policy. In 1995, the Persons with Disabilities Act came into force.

Until then, the Indian Lunacy Act of 1912 was in place for the protection and care of mental patients. In its place, a much more effective legal code, the Mental Health Act of 1987, was brought into existence. This act came into effect in 1993. Subsequently, several prominent developmental initiatives have emerged in this sector. Activities such as identifying and

helping those prone to mental illnesses due to social disasters and other factors, forming self-help groups, suicide prevention, interventions, community-based care centers like day homes, mental health education involving media personnel, special programmes for school and college students, and the Health Formulations from July to October 1994, have all contributed to the growth of the mental health sector.

2.9 Pai Committee Report (1979)

The Pai Committee Report emphasizes that the facilities in the three existing mental hospitals in the state must be increased.

"Urbanization, which is growing as a part of modern life, the anxieties and philosophy of intense competition, and the resulting stress, mental health problems, and illnesses are on the rise. The knowledge about such diseases and their treatment methods have advanced significantly during this period... The standard of mental hospitals must be elevated from merely being treatment institutions to research training centers level. Facilities for inpatient and outpatient departments to function must be available in the psychiatry department of all district hospitals." The Pai Committee also recommended that there should be a ward with 15 beds in district hospitals, five beds in taluk hospitals, and a treatment room with special facilities.

2.10 Krishnamoorthy Commission Report

On March 15, 1983, the government appointed Sri. V. Krishnamoorthy to study and evaluate the functioning of mental hospitals in Kerala. He observed that revolutionary changes are taking place in perspective and operational methods in the field of psychiatric treatment.

Understanding the changing new perspectives and trends, our policy programmes that seek solutions to mental health problems must be timely restructured. The existing mental health institutions, treatment methods, and the benefits derived from them must be reviewed. It is certain that strong resistance can arise against any transformation. Because – "Institutions always tend to deviate from the circumstances of the time they were formed and from their aims and objectives, and habitually try to institutionalize completely different things... Decisions often end up not being for the patients, and they reach a state where the institutions simply continue without change" – the observation made by Leonard J. Duhl and Robert L. Leopold in the book "Mental Health and Social Problems: A Contemporary Approach" still holds true today resistance against change, which is nowadays referred to as "institutional sclerosis" and is institutionalized in nature, exists. It must be overcome. All matters related to problem-solving must be analyzed in one's own way, and one must move forward dynamically to take up responsibilities. The belief that there is only a hospital-centered method for psychiatric treatment must be discarded right at the outset. Instead, a three-tier institutional system framework must be brought into existence.

a) Temporary treatment units b) Intermediate treatment units c) Long-term treatment centers

Regarding the practical implementation of this scheme, Sri. V. Krishnamoorthy opined that the psychiatric treatment system should be developed in a decentralized manner and expanded across the state. The newly formed operational network system should be utilized for community-based rehabilitation and follow-up care of patients who have completed their hospital treatment. If that is done, the number of patients requiring inpatient hospitalization

will decrease. Through effective field work and health education programmes, mental health workers will be able to secure social acceptance for those who have recovered from illness. Therefore, this scheme must be comprehensively implemented across the state. He suggests that when doing so, the following recommendations should also be taken into consideration.

1. The names and details of those identified as patients, as well as those discharged from hospitals after treatment, must be registered and maintained at each primary health centre. They must be provided with identity cards. For those holding the card whose annual income is less than 2,500 rupees, necessary medicines must be provided free of cost. A moderate price should be charged from those with higher incomes. If primary health centres face delays in executing this procedure, district and taluk hospitals themselves must take over and conduct this free distribution of medicines.
2. Psychiatric treatment departments must function in connection with district hospitals. Patients discharged from the hospital must be examined periodically, and follow-up treatment must be provided to those who require it.
3. Field workers associated with the national mental health programme must be entrusted with the responsibility of preparing comprehensive statistical charts regarding the existing mental health problems in the state and reporting them in a timely manner. Arrangements must be made to collect and analyze state-level statistical data and publish them in due time.

2.11 Narendra Commission Report (1987)

An expert committee was appointed under the leadership of Justice Narendra to study and report on the functioning of mental hospitals in Kerala. The commission's report highlights

the necessity of reintegrating those who have completed their treatment into their families and society. Most of these individuals belong to vulnerable sections of society. They are also individuals unable to sustain themselves independently. It is the responsibility of the government to arrange accommodation facilities and rehabilitation projects for them. Opportunities must be provided to engage those in this category who are capable of performing relatively minor tasks in some form of constructive activity.

Instead of the confinement-style treatment method in the existing mental health centers, a comprehensive mental health program must be developed. Countries like Great Britain, Japan, and America have achieved great progress through this approach. The environment and facilities helpful for implementing a program of this kind are present in Kerala. They are listed below:

a) The required psychiatric specialists are currently available.

b) A well-organized health department equipped with service delivery frameworks is operational.

c) Social awareness, political commitment, and high literacy levels are all present in Kerala.

It is the view of the commission that all these factors should be utilized effectively and medical services should be delivered right to the doorsteps of everyone who needs them. Steps must also be taken to develop facilities at primary health centers, as well as taluk and district hospitals, to provide necessary primary treatments to mental patients and to equip them with the arrangements required to manage them. The existing mental hospitals, on the other hand, shall exist solely as regional 'referral' institutions. If this state is to be achieved,

district hospital shape must be given to activities that are collaborative. By utilizing the existing public health service system itself, it is possible to implement an exemplary policy program of this nature."

2.12 Directives of the Hon. Kerala High Court (1997)

In the judgment delivered by the Hon. Supreme Court (Crl. 237/89) on a petition filed by Sheela Barse against the Union Government, the shortcomings observed in the state's mental hospitals were referred to. The Hon. Supreme Court opined that a Mental Health Authority with statutory powers is absolutely essential to effectively implement the Mental Health Act and its rules in their true sense and with proper intent. On the basis of this directive, considering public interest litigation, a judgment was passed by the Hon. Kerala High Court (O.P. No. 1667 of 1996-S). The said High Court judgment further states that the formation of a Mental Health Authority is necessary to evaluate and elevate the standard and environmental facilities of mental hospitals and nursing homes, as part of the welfare measures for suffering mental patients in the state.

2.13 Kerala State Mental Health Authority

In 1993, the Government of Kerala constituted the State Mental Health Authority. The formation of the Authority took place in accordance with Section 4, sub-section 1 of the Mental Health Act of 1987, and Section 3 of the Mental Health Rules of 1990. The responsibility for coordination, regulation, and development of the mental health service sector under the state government, related institutions, and all types of activities that come under its consideration and fall within the purview of the Mental Health Act, is vested in the

Mental Health Authority. The responsibility to inspect psychiatric hospitals, nursing homes, and all other institutions operating in the field of mental health (including all types of institutions meant for housing mental patients) belongs to the Mental Health Authority. The responsibility to advise the government on all matters related to mental health is also vested in the Mental Health Authority. Furthermore, the responsibility to undertake and implement all tasks directed by the government related to mental health remains vested in the Mental Health Authority.

2.14 Ninth, Tenth, and Eleventh Five-Year Plans

(a) District Mental Health Programme

As part of the Ninth Five-Year Plan, the Central Government implemented the District Mental Health Programme in Thiruvananthapuram and Thrissur districts. The objective of this scheme is to ensure necessary mental health care for all sections of the public experiencing mental health problems in the community. This includes conducting pre-scheduled mental health clinics every month without fail in rural/interior areas. It also aims to provide all types of psychiatric treatments, including free distribution of medicines, to the patients attending these clinics, and to conduct mental health awareness programs for people from various walks of life in the community organizing awareness programmes, and providing training to everyone—including doctors and paramedical staff working in the fields of psychiatric treatment and public healthcare—to identify and treat mental illnesses right at the initial stage. These are the objectives of this scheme.

As part of the Tenth Five-Year Plan, the District Mental Health Programme was implemented in Idukki, Kannur, and Wayanad districts under the auspices of the Central Government.

(b) Manpower Development Scheme

As part of the Eleventh Five-Year Plan, the Central Government implemented the Manpower Development Scheme to address the shortage of trained psychiatric treatment specialists that exists today. As part of this, the Central Government has provided the necessary financial assistance to upgrade the Institute of Mental Health and Neurosciences (IMHANS) functioning in Kozhikode into a center of excellence. Financial aid has also been made available to expand the psychiatry department at the Thiruvananthapuram Medical College to start new courses required to train various types of specialists in the field of psychiatric treatment, and to increase the intake/number of students who can be admitted to existing courses.

2.15 National Rural Health Mission

As part of ensuring psychiatric treatment for everyone who requires it, the District Mental Health Programme implemented by the Central Government following its model, the community mental health programme was implemented in Kasaragod, Kozhikode, and Malappuram districts as part of the National Rural Health Mission. Furthermore, it was decided to implement this programme in Pathanamthitta, Ernakulam, Palakkad, and Kottayam districts during the 2012-2013 financial year.

2.16 State Government Mental Health Programme

Under the auspices of the state government, it was decided to implement the mental health programme in Kollam and Alappuzha districts during the 2012-2013 financial year, following the model of the district mental health programme.

Since the crystallization of the **Kerala State Mental Health Policy in 2013**, the structural integration between the **National Rural Health Mission (NRHM)**—now operating under the broader **National Health Mission (NHM)** framework—and the **District Mental Health Programme (DMHP)** has positioned Kerala as a pioneering model for community-based mental healthcare in India.

The operational synergy and evolution of NRHM-DMHP coordination in Kerala since 2013 focuses on decentralized, grassroots delivery:

2.17. United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006)

The **Convention on the Rights of Persons with Disabilities (CRPD)** and its **Optional Protocol** were adopted by the United Nations in December 2006, marking a monumental paradigm shift in global human rights law.

Before the CRPD, disability was predominantly viewed through a "medical" or "charity" lens—treating individuals as passive objects of medical treatment, welfare, or pity. The CRPD fundamentally rewrote this approach, establishing a **social, rights-based model** that treats

persons with disabilities as active subjects with human rights, legal agency, and the right to full inclusion in society.

1. Core Principles of the CRPD (Article 3)

The entire convention is anchored by eight foundational principles that states must uphold:

- **Dignity and Autonomy:** Respect for inherent dignity, individual autonomy, and the freedom to make one's own choices.
- **Non-discrimination:** Absolute prohibition of discrimination on the basis of disability.
- **Full Participation:** Effective and complete inclusion and participation in society.
- **Respect for Difference:** Acceptance of persons with disabilities as part of human diversity and humanity.
- **Equality of Opportunity:** Levelling the playing field across all sectors of life.
- **Accessibility:** Removing physical, environmental, transportation, technological, and informational barriers.
- **Equality between Men and Women:** Addressing the double discrimination faced by women and girls with disabilities.
- **Respect for Children:** Respecting the evolving capacities of children with disabilities and preserving their identities.

2. Key Rights and State Obligations

The CRPD spans 50 articles detailing civil, political, economic, social, and cultural rights. Some of the most transformative provisions include:

Article 12: Equal Recognition Before the Law

Arguably the most revolutionary article, it asserts that persons with disabilities enjoy **legal capacity on an equal basis with others in all aspects of life**.

- **The Shift:** It requires governments to move away from *substitute decision-making* (such as absolute guardianship or conservatorships) and move toward *supported decision-making*, where individuals are given the help they need to make their own legally binding choices.

Article 19: Living Independently and Being Included in the Community

This article recognizes the equal right of all persons with disabilities to live in the community, with choices equal to others.

- **The Shift:** States must ensure that individuals have access to a range of in-home, residential, and community support services (including personal assistance) to prevent isolation or forced institutionalization.

Article 9 & 21: Accessibility and Freedom of Expression

- **Physical and Digital Environments:** States must enable individuals to live independently by ensuring access to the physical environment, transportation, information, and communication technologies (including the internet).
- **Communication Choice:** Sign languages, Braille, augmentative/alternative communication, and all other accessible mass media forms must be officially recognized and promoted.

Articles 24 & 27: Education and Employment

- **Inclusive Education:** Governments are obligated to provide an inclusive education system at all levels, meaning children with disabilities should learn alongside their peers in mainstream schools with appropriate support.
- **Right to Work:** Prohibits discrimination in employment, mandates reasonable accommodations in the workplace, and promotes opportunities for open, inclusive, and accessible labor markets.

3. The Optional Protocol: The Enforcement Mechanism

The **Optional Protocol** is a separate, side-treaty to the CRPD. When a country ratifies the Optional Protocol, it grants the UN the authority to investigate violations within its borders through two distinct legal pathways:

1. **The Individual Communications Procedure:** If an individual or a group believes their rights under the CRPD have been violated by their state, and they have already exhausted all legal options/appeals within their own country's court system, they can submit a formal complaint directly to the UN Committee on the Rights of Persons with Disabilities.
2. **The Inquiry Procedure:** If the UN Committee receives reliable information indicating that a state party is committing "grave or systematic violations" of the convention, the Committee can invite the state to cooperate in an official inquiry, which may include direct visits to the country.

4. How Implementation is monitored

To ensure that countries do not simply sign the treaty and ignore it, the convention establishes a robust tracking system:

- **The UN Committee (CRPD):** A body of independent experts that monitors how well countries are doing.
- **State Reporting:** Every country that ratifies the convention must submit a comprehensive baseline report within two years, followed by periodic progress updates every four years, detailing the laws and policies they have changed.
- **Civil Society Shadow Reports:** Crucially, independent organizations and organizations of persons with disabilities (DPOs) submit their own "shadow reports" to the UN, ensuring that the Committee hears the real, on-the-ground experiences of citizens rather than just official government statistics.

2.18. National Mental Health Policy (NMHP) (2014)

National Mental Health Policy (NMHP) was unveiled on **October 10, 2014** (coinciding with the first National Mental Health Day). Developed by the Ministry of Health and Family Welfare, it represented a fundamental structural shift by moving India's strategy away from the historical, purely custodial approach of outdated legislation and toward a values-based, participatory human rights model.

1. Vision and Pro-Poor Shift

The primary vision of the NMHP is to promote mental well-being, prevent mental illness, support long-term recovery, and ensure socio-economic inclusion for all citizens throughout their lifespan.

Crucially, the policy maintains a **pro-poor orientation**. Recognizing that mental health issues and poverty exist in a destructive, bi-directional cycle, the policy designs last-mile service provisions to specifically support underprivileged and marginalized populations in rural villages who historically lacked any access to psychiatric care.

2. Core Operational Values & Principles

The strategic actions of the policy are anchored by five pillars:

- **Equity:** Directing adequate resources, budgetary allocations, and mental health services to match the diverse social, cultural, and geographic realities of remote and rural communities. It aims to ensure equal opportunity across education, housing, and employment.
- **Justice:** Prioritizing the needs of the most vulnerable, excluded, or marginalized segments of society to build a healthcare infrastructure where no individual is left behind.
- **Integrated Care:** Abandoning isolated asylum treatments by embedding a Primary Health Care approach. It integrates basic mental health management directly into routine public health programs and community-level medical setups.

- **Evidence-Based Care:** Ensuring all diagnostic methods, clinical treatments, and public interventions are guided strictly by proven research and practice-based clinical data.
- **Quality:** Requiring that mental health facilities nationwide meet international standards while remaining acceptable and culturally sensitive to local communities.

3. Primary Policy Goals

- **Reducing Disease Burden:** Lowering overall distress, disability, institutional exclusion, morbidity, and premature mortality associated with mental health conditions across a person's life.
- **Universal Access:** Establishing accessible, equitable, and highly affordable mental health services at all levels of society.
- **Suicide Mitigation:** Executing targeted prevention strategies to systematically lower the risk and incidence of suicide and attempted suicides nationwide.
- **De-stigmatization:** Actively changing public perceptions to eradicate social stigma, prevent discrimination, and protect the human rights and dignity of individuals with mental health needs.
- **Human Resource Expansion:** Increasing the volume, deployment, and distribution of skilled professionals (psychiatrists, clinical psychologists, mental health nurses, and psychiatric social workers) across the country.

4. The Implementation Engine

To put these policies into action, the government synchronized the NMHP with the **National Mental Health Programme (NMHP)** and the dynamic **"Mental Health Action Plan 365"**. This unified approach clearly defines distinct roles for central, state, and local self-governments, utilizing several operational pipelines:

The District Mental Health Programme (DMHP)

The core vehicle for grassroots delivery, the DMHP shifts tasks to the periphery. General physicians receive short-term training to handle common mental health conditions, while district mobile teams (including psychiatrists and social workers) travel out to provide scheduled community-level clinics.

Upgrading Tertiary Infrastructure

The policy secured macro-funding to upgrade regional psychiatric institutions into **Centres of Excellence**. These advanced hubs are heavily financed to expand post-graduate training seats, creating a steady stream of mental health professionals to feed back into the state systems.

Technological Innovation (Tele-MANAS)

As digital communication matured following the policy's launch, the strategy integrated **Tele-MANAS**. Operating 24/7 as a toll-free digital arm, it provides instant tele-counseling and direct triage, routing callers seamlessly down to localized, physical health units for continuous care.

2.19 Mental Healthcare Act (MHCA), 2017

The **Mental Healthcare Act (MHCA), 2017** is a landmark piece of legislation in India that completely transformed the legal landscape for mental health. Passed by the Indian Parliament and coming into force in **May 2018**, it repealed the outdated, custodial-focused Mental Health Act of 1987.

The MHCA 2017 fundamentally moved the paradigm from a paternalistic, doctor-controlled model to a **rights-based, patient-centric framework**, aligning Indian domestic law with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Key Highlights & Rights of the Patient

The core of the Act is the statutory guarantee of human rights to individuals experiencing mental illness.

- **Right to Access Healthcare:** Every person has the right to access mental healthcare and treatment from services run or funded by the government. This includes affordable access to essential medicines, outpatient/inpatient care, and integration into general hospital setups rather than isolated asylums.
- **Right to Equality and Non-Discrimination:** Persons with mental illness must be treated on par with those experiencing physical illnesses. Discrimination on the basis of gender, sexual orientation, religion, culture, or socioeconomic status is strictly prohibited.

- **Right to Confidentiality:** All information regarding a patient's mental health, treatment, and physical state must be kept strictly confidential, with very limited exceptions (such as court orders or immediate threat to life).
- **Right to Live in the Community:** The Act emphasizes that every individual has the right to live in the community and not be strictly segregated or institutionalized against their will unless absolutely necessary as a last resort.

Structural Oversight: The Regulatory Pillars

To ensure these rights are not just on paper, the Act established a two-tiered regulatory and judicial framework:

State and Central Mental Health Authorities (SMHA / CMHA)

Every state must maintain an active Mental Health Authority. These bodies serve as the administrative backbone, tasked with:

Registering all mental health establishments (public and private, including de-addiction centers).

Developing minimum infrastructure and quality care standards.

Maintaining a state-wide registry of qualified mental health professionals (psychiatrists, clinical psychologists, psychiatric social workers, and mental health nurses).

Mental Health Review Boards (MHRBs)

Established at the district or regional level, MHRBs are quasi-judicial bodies headed by a judicial officer. They serve as watchdogs for patient rights. If a patient or their NR believes they are being unlawfully detained in an establishment, or if an institutional admission is forced against the patient's will for an extended period, an appeal can be filed directly with the MHRB to review, alter, or revoke the medical decision.

4. The Decriminalization of Suicide (Section 115)

Perhaps the most heavily discussed reform of the Act was the effective decriminalization of suicide attempts, completely altering the enforcement approach of Section 309 of the Indian Penal Code (IPC):

Section 115(1): "Notwithstanding anything contained in section 309 of the Indian Penal Code, any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have been under severe stress and shall not be tried and punished under the said Code."

Under this framework, the government is legally obligated to provide medical care, treatment, and rehabilitation initiatives to individuals who attempt suicide to reduce the risk of recurrence, shifting the response from criminal punishment to psychological support.

The year 2013 marked a major turning point in India's public health planning. It was the period when the **12th Five-Year Plan (2012–2017)** was in full motion and the landmark **National Mental Health Policy (2014)** was being drafted.

The evolution of mental health infrastructure under India's macroeconomic planning, transitioning from the traditional Five-Year Plan system to policy frameworks steered by NITI Aayog, represents a major transformation over the last decade.

2.20. The 12th Five-Year Plan Era (2012–2017)

The 12th Five-Year Plan was the final official blueprint before India dismantled the Planning Commission. For mental health, this plan focused heavily on transitioning from isolated asylum architectures into a decentralized, integrated national framework.

- **Restructuring the NMHP:** The National Mental Health Programme (NMHP) was formally bifurcated into distinct tertiary level activities and district-level activities.
- **The District Mental Health Programme (DMHP) Scale-up:** The plan prioritized expanding the DMHP under the Non-Communicable Disease (NCD) flexible pool, making basic outpatient psychiatric services, target school counseling, and suicide prevention services a staple at district healthcare facilities.
- **Manpower Development Schemes (Centers of Excellence): To resolve an acute shortage of mental health professionals, the plan approved financial outlays to scale up existing state mental hospitals into "Centers** of Excellence". By boosting post-graduate training seats in psychiatry, psychiatric social work, and clinical psychology, the framework sought to narrow the massive human resource deficit.
- **Upgrading Central Institutes:** Funding was designated to upgrade the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (Tezpur) and the Central Institute of Psychiatry (Ranchi) to introduce advanced neurology and neurosurgery divisions similar to NIMHANS Bangalore.

2.21 Post-2017: NITI Aayog and the Paradigm Shift

In 2015, the traditional Five-Year Plan system was replaced by the **NITI Aayog**, functioning as a policy think tank rather than a direct allocator of state funds. Following the dissolution of the plans, mental health planning shifted heavily toward a **rights-based, localized, and digitally integrated approach** guided by the National Health Policy 2017 and the Mental Healthcare Act (MHCA), 2017.

Grassroots Primary Integration

Through NITI Aayog's push for comprehensive primary healthcare, mental wellness screening has been shifted down to health and wellness centers (**Ayushman Arogya Mandirs**). Local physicians and public health workers receive short-term training to detect common mental illnesses early, bridging the massive treatment gap right in the community.

Digital Scaling: Tele-MANAS

Launched as the digital arm of the NMHP, the **Tele-Mental Health Assistance and Networking Across States (Tele-MANAS)** initiative established 24/7 toll-free counseling networks across every state and union territory. The program offers instant psychological first aid and acts as a central router—directly linking tele-callers to nearby physical DMHP teams for clinical follow-ups.

Rights-Based Monitoring

Aligned with the MHCA 2017, the modern policy framework explicitly mandates the protection of patient rights. It enforces the creation of State Mental Health Authorities and

local Mental Health Review Boards, shifting the focus from custodial medical confinement to patient autonomy, community living, and rehabilitation.

The Path to Overcoming Systemic Bottlenecks

Through continuous inter-state review, NITI Aayog targets persistent gaps in the national delivery framework:

- **Human Resource Deficits:** While the WHO suggests at least 3 psychiatrists per 100,000 people, India stands at roughly 0.75. The strategy calls for heavily expanding the **Manpower Development Schemes** to upgrade regional mental health institutes into modern "Centres of Excellence" to boost clinical postgraduate training seats.
- **Infrastructure and Connectivity:** Upgrading regional digital networks to prevent call drops, improving workspace privacy for digital tele-counselors, and ensuring uniform procurement of medical supplies across vulnerable or highly remote geographic blocks.

2.22 **Central Mental Health Authority (CMHA)**

The **Central Mental Health Authority (CMHA)** is the apex statutory regulatory body established by the Government of India under **Chapter VII (Sections 33-44) of the Mental Healthcare Act (MHCA), 2017**.

Operating at the national level, the CMHA acts as the primary administrative and oversight architecture responsible for regulating mental health establishments, developing service standards, and advising the union government on mental health strategies.

Primary Functions and Duties (Section 43)

- **Supervising State Authorities:** Oversees and coordinates the strategic actions of individual State Mental Health Authorities (SMHAs) to ensure uniform implementation of national rules.
- **Registering Multi-State Establishments:** Functions as the direct registry authority for mental health establishments that operate across or are funded heavily by the central government.
- **Setting Quality Benchmarks:** Develops and publishes minimum infrastructure, clinical, and human resource quality standards required for psychiatric establishments to achieve legally valid licensing.
- **Professional Registries:** Maintains the digital *National Registry of Mental Health Professionals*, cataloging all validated clinical psychologists, mental health nurses, psychiatric social workers, and psychiatrists authorized to practice in India.
- **Rights Protection and Appeals:** Reviews complaints regarding rights violations, monitors compliance with rights-based treatment mandates, and issues operational directives to protect the dignity of patients.

2.23. KSMHA from 2013- 2017

1. KSMHA Core Activities & Policy Priorities (2013–2017)

Following the enactment of the 2013 State Policy, KSMHA shifted its emphasis toward community-based care, addressing high regional vulnerabilities such as elevated suicide rates, alcohol use disorders, and the psychosocial needs of an aging population.

Decentralization Advocacy: KSMHA worked alongside the Directorate of Health Services (DHS) to transition primary mental health delivery away from stand-alone psychiatric asylums. It focused heavily on supporting the District Mental Health Program (DMHP), setting up monthly clinics at local Primary and Family Health Centers.

Integrating Medical Traditions: Reflecting Kerala's diverse healthcare landscape, the authority began drafting structural integration blueprints to include mental health guidelines across modern medicine, Ayurveda, and Homoeopathy sectors.

NGO and Voluntarism Mobilization: Recognizing the deep gaps in public institutional facilities, KSMHA prioritized partnerships with non-governmental organizations (NGOs) to create community rehabilitation pipelines, half-way homes, and targeted homeless outreach.

2.24 KSMHA in the Era of MHCA 2017

The Great Policy Shift: The Impact of MHCA 2017

When the Mental Healthcare Act, 2017 replaced the outdated Mental Health Act of 1987, it effectively forced KSMHA to redesign its regulatory, clinical, and legal architecture. The core policy philosophy shifted from an institutional, asylum-centric, custodial approach to a strict statutory rights-based framework.

Preamble

MHCA-2017 is an Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.

Statement of Objects and Reasons — The United Nations Convention on the Rights of Persons with Disabilities, which was ratified by the Government of India in October, 2007, made it obligatory for the Government to align the country's policies and laws with the Convention. The need for amendments to the Mental Health Act, 1987 was felt because the related law, i.e., the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, was also in the process of amendment. The Mental Health Act, 1987 could not protect the rights of persons with mental Illness and promote their access to mental health care in the country.

In light of above, it is proposed to bring in a new legislation by repealing the Mental Health Act, 1987, and -Recognizing that

a. Persons with mental illness constitute a vulnerable section of society and are subject to discrimination in our society;
b. Families bear financial hardship, emotional and social burden of providing treatment and care for their relatives with mental illness;
c. Persons with mental illness should be treated like other persons with health problems and the environment around them should be made conducive to facilitate recovery, rehabilitation and full participation in society;
d. The Mental Health Act, 1987 was insufficient to protect the rights of persons with mental Illness and promote their access to mental health care in the country.

b. And in order to:

I. Protect and promote the rights of persons with mental illness during the delivery of health care In Institutions and in the community;

II. Ensure health care, treatment and rehabilitation of persons with mental illness, is provided in the least restrictive environment possible, and in a manner that does not intrude on their rights and dignity. Community-based solutions, in the vicinity of the person's usual place of residence, are preferred to Institutional solutions;

III. Provide treatment, care and rehabilitation to improve the capacity of the person to develop his or her full potential and to facilitate his or her integration into community life;

IV. Fulfil the obligations under the Constitution and the obligations under various International Conventions ratified by India;

V. Regulate the public and private mental health sectors within a rights framework to achieve the greatest public health good;

VI. Improve accessibility to mental health care by mandating sufficient provision of quality public mental health services and non-discrimination in health insurance;

VII. Establish a mental health system integrated into all levels of general health care; and

VIII. Promote principles of equity, efficiency and active participation of all stakeholders in decision making.

The landscape of mental health administration in Kerala underwent a dramatic paradigm shift following the publication of the Kerala State Mental Health Policy in 2013, which was

later structurally revolutionized by the enforcement of the federal Mental Healthcare Act (MHCA), 2017 (notified in May 2018).

The transition completely altered the mandate of the Kerala State Mental Health Authority (KSMHA), changing it from a traditional licensing board into a rights-driven, regulatory powerhouse.

Post-2017 KSMHA Operational Implementations

To enforce the mandates of the MHCA 2017, KSMHA expanded into an active oversight body implementing several groundbreaking legal mechanisms:

Establishing Mental Health Review Boards (MHRBs)

KSMHA established localized **Mental Health Review Boards** across the state. These quasi-judicial bodies act as the direct watchdog for patient rights, handling applications for discharge, checking the validity of admissions, and systematically reviewing any instances of forced institutionalization or heavy physical restraints.

Mandatory Auditing & Strict Quality Standardization

The authority took over the centralized registration of all mental health establishments in Kerala, including modern psychiatric units, de-addiction centers, half-way homes, and alternative medicine facilities (Ayurveda/Yoga/Homoeopathy). Establishments must strictly adhere to state-enforced minimum infrastructure and quality care protocols to operate.

Enforcing Patient Rights Tools

KSMHA integrated legally binding documents directly into patient triage algorithms, ensuring protocols accommodate:

- **Advance Directives (AD):** Legally protected documents stating how a person wishes to be treated (or not treated) during a future mental health crisis.
- **Nominated Representatives (NR):** Formally recognized individuals appointed by the patient to make supported medical decisions if the patient temporarily loses capacity.

Compulsory Professional Registration

Beyond monitoring brick-and-mortar facilities, KSMHA functions as the central registry for all clinical psychologists, mental health nurses, and psychiatric social workers practicing within Kerala, ensuring no unqualified personnel provide specialized psychological therapies.

Judiciary and Law Enforcement Sensitization

Recognizing that the decriminalization of suicide and strict handling of homeless individuals requires a massive systemic overhaul, KSMHA systematically holds regular orientation programs for the Kerala Police, judicial officers, and legal aid providers regarding mental health laws and non-discriminatory care practices.

2.25. State Government Mental Health Programs Since 2014

1. Complete Universalization Across 14 Districts

Before 2013, the DMHP and NRHM-funded community initiatives ran concurrently but varied by district. A major turning point occurred when the specialized **Community Mental Health Programs (CMHP)**—initially pioneered by IMHANS (Kozhikode) with historic, first-of-its-kind NRHM funding—were structurally aligned with standard DMHP operations. By **March 2017**, these independent networks were officially transitioned entirely to the Directorate of Health Services (DHS). This effectively scaled the uniform community psychiatric model uniformly across **all 14 districts**, making Kerala the first Indian state to achieve complete decentralization of mental health clinics.

2. Integration with Primary and Family Health Centres

The core strategy of the NHM-DMHP nexus has been migrating mental health away from isolated tertiary "asylums" into general, day-to-day healthcare. Under Kerala's flagship **Aardram Mission** (launched via NHM framework), primary health setups were transformed into Family Health Centres (FHCs). Through this infrastructure:

- **PHC/CHC Level Clinics:** DMHP mobile teams—composed of a psychiatrist, clinical psychologist, and psychiatric social worker—conduct systematically scheduled monthly clinics directly at localized Family Health Centres.
- **Grassroots Pipeline:** Local ASHAs (Accredited Social Health Activists) and Junior Public Health Nurses trained under NHM screen and identify individuals with

psychological distress or chronic illnesses at the household level, guiding them into the DMHP treatment network.

3. Digital Mental Health Integration: DISHA and Tele-MANAS

NHM funding and logistics catalyzed extensive tele-counseling infrastructure:

- **DISHA Helpline (1056):** Initiated as a collaborative project between NHM and the Department of Health, the DISHA helpline evolved significantly post-2013 into a critical public portal providing round-the-clock emergency psychological first aid, suicide prevention, and de-addiction assistance.
- **Tele-MANAS Linkage:** Building on the existing DISHA blueprint, Kerala integrated the central **National Tele-Mental Health Programme (Tele-MANAS)** cells. Calls routed through the digital system receive psychiatric triage, with severe cases directly mapped and referred to local physical DMHP teams for continuity of care.

4. Community and Panchayath-Led Rehabilitation

A distinct element of Kerala's post-2013 model is linking NHM-DMHP funding with Local Self-Governments (Panchayaths):

- **Local Medicine Supply & Logistics:** While NHM provides the institutional backbone for bulk psychiatric medication distribution, individual Panchayaths frequently co-fund continuous supply pipelines to ensure zero-stockouts for local patients.
- **Palliative Care Synergy:** DMHP clinics overlap heavily with Kerala's widely recognized community palliative care networks, allowing volunteer home-care teams

to extend emotional, financial, and therapeutic support to bedridden or chronically ill mental health patients directly in their homes.

5. Specialized Target Interventions

NHM financing enabled the DMHP to roll out structured societal programs beyond clinic walls:

- **Amma Manassu:** A tailored program integrating mental health tracking directly into maternal and child healthcare, focusing on detecting and managing perinatal/postpartum depression.
- **School & Adolescent Initiatives (Thalir):** Regular training for class teachers, enabling early identification of learning disabilities, substance abuse issues, or behavioral changes in school children, coupled with direct referral links to the district psychiatric team.

3

State Mental Health Service Sector Planning and Programme

3.1 Long-term Objectives

a) A multi-faceted mental health programme must be developed to ensure that everyone affected by mental illness can access treatment. This should be achieved by maximizing both hospital-based and community-based facilities, while seamlessly integrating diverse interventions.

b) Low-cost and effective treatment methods must be ensured in a manner sufficient to improve the quality of life for those affected by mental illness and their family members.

c) Individuals who belong to categories requiring special consideration and medical care, as well as those experiencing mental stress, must be identified.

d) Comprehensive treatment and rehabilitation facilities must be made available as needed to implement activities preventing suicidal tendencies, alcohol and drug abuse, and to treat and reintegrate individuals addicted to substance abuse back into the mainstream of life.

e) Demographic changes occurring as a result of modernization, linked with other social transformations related tensions and mental health problems must be identified, and awareness education programmes, including life skills training, must be designed to prepare human minds to cope and adapt effectively to all of these.

f) The field of medical education must be reformed in such a way that modern medical students and degree students of other medical treatment systems are fully equipped to effectively treat, cure, and prevent commonly rising mental health issues.

g) Steps must be taken to train more specialists in the field of psychiatric treatment, including psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses.

h) Psychiatric treatment facilities must be made available and expanded at Primary Health Centres, Taluk Hospitals, and District Hospitals; following this, Mental Health Centres and the psychiatric departments of Medical Colleges should be upgraded into referral centres.

i) Every 10 years, existing problems in the field of psychiatric treatment must be analyzed, and issues that require priority must be identified and resolved.

j) Mental Healthcare Goals to conform with MHCA 2017

    a. Protecting and providing the Right to Access Mental Healthcare (Section 18)

        i. Affordable & Quality Care: Every person to get access to mental healthcare and rehabilitation services funded or run by the government.

        ii. Free Services: Individuals who are below the poverty line (BPL), destitute, or homeless are to receive completely free mental health treatment at government-run or funded facilities.

        iii. Geographic Accessibility: Services to be made available close to where the person lives so they do not have to travel long distances.

    b. . Right to Equality and Non-Discrimination (Section 21)

i. Parity with Physical Illness: Mental illness will be treated at par with physical illness in all healthcare provisions run by the Government.

ii. Insurance Coverage: Government to ensure that insurance providers and Government insurance schemes provide insurance products that cover the treatment of mental illness on the same basis as physical illness.

iii. Zero Discrimination: No discrimination will be allowed on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, or disability.

c. The Government's Duty to Support (Section 19(2))

i. Less restrictive community alternatives: Government will implement programs and places that allow individuals to live safely outside of traditional hospital wards.

ii. Half-way homes & Group homes: Government will set up transitional and supported living spaces designed to help individuals stabilize and step back into daily society.

iii. Day-care centres: Government will set up facilities providing therapeutic activities, skill training, and social engagement during the day while allowing individuals to return home at night.

iv. Supported accommodation: Government will provide supported accommodation/ housing facilities paired with varying levels of professional assistance, specifically meant for persons with mental

illness who no longer require active hospital treatment but cannot live entirely independently or do not have family support.

v. Create Integrated Day-Respite Urban Hubs: Government will launch public-private partnership (PPP) day-care centers in major urban transit hubs. These centers provide vocational training, transitional employment placement, and daily psychiatric services, allowing individuals to integrate seamlessly into the workforce.

vi. Build AI-Driven Tele-Screening for Remote Areas: Government will expand teleconsultation models (like Ayushman Arogya Mandirs) by integrating localized, language-specific AI pre-screening tools. This helps primary care workers at the village level identify early markers of psychosis or severe clinical depression, making the Right to Access geographically blind.

d. The "Compassionate Co-Responder" Emergency Model: The State will fully transition away from a punitive police approach when managing mental health crises or individuals rescued under Section 115 (Attempted Suicide). The state objective would be a Co-Responder setup, deploying a trained psychiatric social worker alongside emergency responders to handle crises humanely.

e. Workplace Burnout and Youth Resilience Frameworks: The state will institute mandatory structural stress audits across government high-pressure employment sectors and incorporate deep emotional resilience programs

directly into university curricula to address early-onset workplace and academic stress.

Short Term Goals

a) The mental health department must be integrated with the existing network of the public health department, and its operational model should be decentralized.
b) A cost-effective operational model that aligns and fits well with our culture must be developed.
c) Awareness programmes must be organized to cultivate the habit of seeking medical assistance as soon as a mental illness manifests.
d) Consumer organizations must be formed within the mental health treatment sector, and their services should be adequately encouraged in the operational network. Self-help groups of patients and their relatives must be formed at the taluk level.
e) The administrative responsibility of the mental health department must be restructured in a manner that is compatible with the Panchayat Raj system.
f) Factors that trigger mental illness in daily life must be identified, and protective factors that facilitate prevention must be promoted and nurtured.
g) Research activities related to disease control, prevention, treatment, and rehabilitation must be encouraged and fostered.
h) Medical officers (non-psychiatrists) working in the public health sector under the government must be provided with at least a mandatory 3-month psychiatric treatment training program. Measures must be taken to provide free psychiatric

treatment training to doctors who are interested in mental healthcare treatment and those operating in the private sector.

i) The infrastructure facilities and human resource capacity required to provide specialized treatment and care to patients arriving for treatment at the three mental health centers under the government sector must be expanded.

j) A week-long training session regarding mental health and the human rights of mental health patients must be provided without fail at least two times a year to the paramedical staff, including nurses, working in mental health centers.

k) Provide awareness and advocacy (via KSMHA) structured around three primary pillars:

Large-Scale Public Awareness & Anti-Stigma Drives

l) Public Sensitization: Driving public awareness campaigns to demystify mental illnesses and broadly communicate available remedial measures.

m) Attitudinal Change: A primary goal is altering deep-seated societal stigmas: Actively work to spark an attitudinal shift among general citizens and distinct stakeholders regarding how mental health disorders are treated and perceived.

n) Promoting Civic Participation: Support legal advocacy to safeguard and promote the civil and political participation of individuals recovering from mental illnesses, ensuring they remain integrated into daily community spaces.

Legal Rights & Legislation Literacy

o) Educating on Patient Rights: Broadcasting structural information regarding the statutory rights granted to patients under the Act (such as the Right to Equality, Confidentiality, and Community Living).

p) Facilitating Legal Aid: In partnership with statutory agencies like the Kerala State Legal Services Authority (KeLSA), raise awareness about free legal assistance pathways available for vulnerable patients.

Institutional Training & Sensitization

q) Law Enforcement & Judicial Orientation: Conduct target drives to familiarize police departments and judicial officers with mental health legislation. This ensures that emergency callouts or wandering individuals are treated humanely and routed to medical facilities rather than caught up in punitive criminal systems.

r) Healthcare Professional Upskilling: Actively build capacity by coordinating training regarding the implementation of the Act for general medical practitioners, clinical psychologists, psychiatric nurses, social workers, and local counselors.

s) NGO Integration: Work closely with non-governmental organizations, empowering and guiding them to deliver localized grassroots training and to run community surveys tracking mental health infrastructure needs.

4

Existing Situational Challenges

Changes to be brought in the service delivery system

4.1 Nature, depth, and severity of mental health problems

Mental illnesses can occur at any age. Their type and nature vary depending on the age group. No reliable statistical data related to this field is available. Because of this, it is becoming impossible to evaluate what is happening in our state or to effectively plan mental health programs. The major problems we are facing are among these. Several studies and surveys have been conducted in various parts of India. What is understood from all of these is that severe mental illnesses affect approximately 10 to 20 people per thousand in our population at some point in their lifetime. When calculated this way, there is a possibility that between 300,000 and 600,000 people in our state's population could be suffering from mental illness. This situation poses a very serious challenge to our public health sector.

Acute Mental Illnesses

According to etiology (the study of disease causation), there are several types of acute mental illnesses, such as Acute and Transient Psychotic Disorder, Acute Substance Withdrawal, Substance-induced Psychotic and Mood Disorders, Adjustment Disorder, Panic Disorder, Dissociative Disorders, and Postpartum Psychiatric Disorders (Depression, psychosis associated with childbirth), which fall into this category. Apart from these, functional dysfunctions occurring in the brain due to infectious diseases like malaria, typhoid fever, and bacterial meningitis; autoimmune conditions like autoimmune encephalitis, SLE, etc; Tumours; vascular conditions like stroke; traumatic brain injury; electrolyte, metabolic, and endocrine disturbances; and heavy metal and other poisoning also cause behavioral problems. Another condition that paves the way for severe complications and deterioration is epileptic psychosis; if timely treatment is not received, such conditions can become fatal or debilitating.

Chronic or Recurrent Mental Illnesses

Schizophrenia, delusional disorder, mania and bipolar disorder, depressive disorder, obsessive-compulsive and related disorders, anxiety disorders, eating disorders, behavioural addiction (gambling, internet gaming, mobile and problematic use of internet, etc.), post-traumatic stress disorder, impulse control disorders, bodily distress disorder, dementia (cognitive decline), attention deficit hyperactivity disorder, autism spectrum disorders, ODD and conduct disorders, personality disorders and mental illnesses arising from chronic physical ailments or due to the use of alcohol, drugs, and tobacco fall into this category. Modern treatment methods can either alleviate these disorders or bring about significant remission.

Child and Adolescent Mental Disorders

1. Neurodevelopmental Disorders

These conditions manifest early in development, typically before a child enters grade school, and are characterized by developmental deficits that affect personal, social, academic, or occupational functioning.

Intellectual Disabilities: Deficits in general mental abilities, such as reasoning, problem-solving, planning, abstract thinking, and academic learning.

Communication Disorders: Difficulty with language, speech sound production, stuttering (childhood-onset fluency disorder), or social communication.

Autism Spectrum Disorder (ASD): Characterized by persistent deficits in social communication and interaction across multiple contexts, alongside restricted, repetitive patterns of behavior, interests, or activities.

Attention-Deficit/Hyperactivity Disorder (ADHD): Defined by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes directly with functioning or development.

Specific Learning Disorders: Persistent difficulties learning foundational academic skills (e.g., dyslexia affecting reading, dyscalculia affecting mathematics).

Motor Disorders: Includes developmental coordination disorder, stereotypic movement disorder, and tic disorders (such as Tourette's Disorder).

2. Disruptive, Impulse-Control, and Conduct Disorders

These involve conditions that manifest as severe behaviors that violate the rights of others or bring the child into significant conflict with societal norms and authority figures.

Oppositional Defiant Disorder (ODD): A frequent and persistent pattern of anger, irritability, arguing, defiance, or vindictiveness toward parents and other authority figures.

Conduct Disorder (CD): A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated (e.g., aggression toward people/animals, destruction of property, theft).

Intermittent Explosive Disorder (IED): Impulsive, recurrent, aggressive outbursts that are radically disproportionate to the psychosocial stressor triggering them.

3. Anxiety and Emotional Disorders

Children experience anxiety differently than adults, often manifesting as physical complaints or extreme behavioral refusal.

Separation Anxiety Disorder: Excessive fear or anxiety concerning separation from those to whom the individual is attached, beyond what is developmentally appropriate.

Selective Mutism: A consistent failure to speak in specific social situations (like school) where there is an expectation for speaking, despite speaking in other situations (like at home).

Social Anxiety Disorder / Specific Phobias: Intense, persistent fear of social performance scenarios or specific objects/situations.

Generalized Anxiety Disorder (GAD): Excessive, uncontrollable worry about various everyday things (school performance, safety, health).

4. Feeding and Eating Disorders

These disorders focus on altered consumption or behaviors surrounding food that severely impact physical health and psychosocial growth.

Pica: Persistent eating of non-nutritive, non-food substances (e.g., dirt, paper, hair) over a period of at least 1 month.

Avoidant/Restrictive Food Intake Disorder (ARFID): An eating or feeding disturbance characterized by a persistent failure to meet appropriate nutritional needs, often driven by sensory traits of food or fear of aversive consequences (like choking).

Anorexia Nervosa & Bulimia Nervosa: Typically emerging in adolescence, these involve severe distortion of body image, extreme restriction of energy intake, or cycles of binge eating followed by compensatory behaviors (purging).

5. Elimination Disorders

These involve the inappropriate elimination of urine or feces and are usually diagnosed in childhood after the age when a child is developmentally expected to achieve continence.

Enuresis: Repeated voiding of urine into bed or clothes (whether involuntary or intentional).

Encopresis: Repeated passage of feces into inappropriate places (whether involuntary or intentional).

6. Mood and Trauma-Related Disorders

Disruptive Mood Dysregulation Disorder (DMDD): Characterized by severe, recurrent temper outbursts that are grossly out of proportion to the situation, diagnosed in children between 6 and 18 years old to address chronic, severe irritability.

Major Depressive Disorder (MDD): In children and adolescents, this can frequently manifest as an irritable mood rather than just a sad or depressed mood.

Reactive Attachment Disorder (RAD) & Disinhibited Social Engagement Disorder (DSED): Closely tied to early childhood neglect or trauma, resulting in markedly disturbed and developmentally inappropriate social relatedness.

Multi-center data analyzed by major psychiatry departments across Kerala indicates that approximately 20% (one out of five) of teenagers aged 12 to 19 years suffer from some tier of psychological distress. Severity Tiers: Among school-going adolescents experiencing

distress, studies categorize the severity as follows: Mild distress: ~10.5% to 11%, Moderate distress: ~5% to 5.4%, Severe distress: ~4.9% to 5%. Co-occurring alongside psychological distress, alcohol use prevalence among older adolescents in Kerala is estimated at 15% overall (heavily skewed toward boys at 23% compared to girls at 7%), scaling upward with age. So these require efficient, scientific preventive, management, aftercare, and rehabilitative efforts.

Mental Disorders in Elderly

Geriatric psychiatry categorizes late-life mental disorders into several major domains, which often present with atypical or somatic (physical) symptoms rather than purely emotional ones:

Neurocognitive Disorders (Dementias):

Alzheimer's Disease: The most common form, causing progressive memory loss and cognitive decline.

Vascular Dementia: Cognitive decline caused by blocked or damaged blood vessels in the brain (often following minor strokes).

Lewy Body & Parkinson's Dementia: Characterized by visual hallucinations, motor symptoms, and fluctuating alertness.

Late-Life Depressive Disorders:

Major Depressive Disorder (MDD): Frequently manifests in the elderly as "depression without sadness"—presenting instead as extreme apathy, cognitive slowing, or functional decline.

Vascular Depression: A subtype linked to cerebrovascular disease, marked by psychomotor slowing and executive dysfunction.

Late-Onset Anxiety Disorders:

Generalized Anxiety Disorder (GAD): Excessive worry about health, finances, or family safety.

Agoraphobia and Specific Phobias: Often presenting as an intense fear of falling or leaving the home unassisted.

Neurotic and Stress-Related Disorders:

Adjustment Disorders: Severe emotional distress triggered by major late-life transitions, such as widowhood, retirement, or physical disability.

Late-Onset Psychosis & Delusional Disorders:

Late-Life Schizophrenia / Paraphrenia: Paranoid delusions or auditory hallucinations that develop after age 60, usually without the severe emotional flattening seen in younger patients.

Substance Use Disorders:

Late-Onset Alcoholism: Used as a coping mechanism for isolation or grief.

Prescription Medication Misuse: High risk of dependency due to polypharmacy (taking multiple medications daily).

Delirium (Acute Confusional States):

A rapid, fluctuating change in mental status, highly common in hospitalized or frail older adults, often triggered by minor urinary tract infections (UTIs), medication side effects, or dehydration.

Condition Category	**Estimated Prevalence in Kerala**	**Key Insights**
Geriatric Depression	**37% – 52.4%**	Point-prevalence studies show around **39.1%** of community-dwelling seniors meet ICD-10 criteria for depression. Rural communities and older women exhibit the highest numbers (exceeding 50%).

Condition Category	Estimated Prevalence in Kerala	Key Insights
Dementia / Cognitive Impairment	**7.4% – 22.7%**	The absolute number of elderly individuals with dementia in Kerala was 414,000 in 2016 and is projected to rise to **696,000 by 2036**. Screening tools pinpoint cognitive impairment in up to **22.73%** of rural cohorts.
Substance Dependence	**~20.9%**	Principally centered around late-life alcohol and tobacco use, predominantly affecting aging males.

The Growing Care Need

The intersection of Kerala's unique demographics and changing social structures has created an impending care crisis:

The "Empty Nest" Paradigm: Massive outward youth migration from Kerala for global employment has left behind an isolated geriatric populace. The breakdown of traditional joint families leaves many older adults living completely alone or without active emotional support, accelerating depression and cognitive decline.

Under-Equipped Psychiatric Infrastructure: Kerala's healthcare system faces a significant capacity shortfall, with only 5.53 psychiatric beds available per 10,000 people seeking mental health care. There is also a critical deficit of dedicated geriatric psychiatrists and psychogeriatric nursing specialists.

The Homecare Dilemma: Because advanced age and dementia are heavily tethered to physical mobility restrictions, community pilots show that up to 90% of identified elderly psychiatric patients require home-based care follow-ups. The state faces an urgent need to

transition from traditional tertiary, hospital-centric care models to decentralized, volunteer-led, community-based mental health programs.

Alcohol Related Disorders

The consumption of alcohol impacts both the brain and the body, frequently inducing distinct psychiatric and cognitive conditions. The intersection of clinical definitions, regional statistics for Kerala, and evolving public healthcare needs reveals a complex challenge.

Comprehensive List of Alcohol-Related Mental Disorders

Under clinical psychiatric frameworks (such as the DSM-5-TR and ICD-11), alcohol-related mental health conditions are broadly categorized into Alcohol Use Disorder (AUD) and various Alcohol-Induced Disorders:

Core Use Disorders

Alcohol Use Disorder (AUD)/ Alcohol dependence: A chronic, relapsing brain condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. It is graded from mild to severe based on diagnostic criteria.

Alcohol Withdrawal Syndrome: A complex cluster of symptoms that emerge when a dependent individual abruptly stops or reduces drinking. Symptoms include autonomic hyperactivity (sweating, tremors, high heart rate), severe anxiety, insomnia, transient hallucinations, and grand mal seizures.

Induced Psychiatric Conditions

Alcohol-Induced Psychotic Disorder: Characterized by prominent hallucinations (often auditory) or delusions (frequently paranoid or jealous in nature) that manifest during acute intoxication or withdrawal.

Alcohol-Induced Depressive Disorder: Severe depressive episodes that occur exclusively during periods of heavy drinking or withdrawal, marked by intense apathy, sadness, and elevated suicide risk.

Alcohol-Induced Anxiety Disorder: Prominent anxiety, panic attacks, or phobias brought on by the neurochemical imbalances of heavy alcohol usage or withdrawal states.

Alcohol-Induced Sleep Disorder: Severe disruptions in sleep architecture, typically manifesting as severe insomnia or fragmented sleep during active use or withdrawal.

Severe Neurocognitive Conditions

Delirium Tremens (DTs): A medical emergency during severe alcohol withdrawal characterized by profound confusion, disorientation, severe agitation, vivid visual hallucinations, and intense autonomic instability.

Wernicke-Korsakoff Syndrome: A dual-stage neurological condition caused by severe thiamine (Vitamin B1) deficiency secondary to chronic alcoholism.

Wernicke's Encephalopathy: The acute phase, causing mental confusion, abnormal eye movements (nystagmus), and unsteady gait (ataxia).

Korsakoff's Psychosis: The chronic, irreversible phase, marked by severe anterograde amnesia (inability to form new memories) and confabulation (fabricating imaginary experiences to fill memory gaps).

Alcohol-Related Dementia (ARD): Global cognitive decline resulting from the direct neurotoxic effects of long-term, high-volume alcohol consumption on brain tissue.

2. Prevalence in Kerala

Kerala presents an outsized statistical burden regarding alcohol use and related disorders within India:

Overall Adult Consumption: According to the National Family Health Survey (NFHS-6) data, nearly 1 in 4 men (22.7%) aged 15 and older in Kerala consume alcohol. This marks a relative rise of 14% in male consumption compared to previous years. Consumption among women remains low, at around 0.3%.

Alcohol Dependence & Problem Drinking: Localized epidemiological and community-based surveys reveal stark realities. In urban and rural pockets of districts like

Thiruvananthapuram and Thiruvalla, community screening utilizing the AUDIT (Alcohol Use Disorders Identification Test) framework flags problem drinking and hazardous use at 12.8% to 18.3% among adult cohorts. Among dedicated male alcohol users, clinical alcohol dependence rates range significantly between 15% and 38% depending on socio-demographic factors like unemployment or relational disharmony.

Lowering Age of Initiation: Public health tracking shows the average age of a person's first drink in Kerala has dropped dramatically over the past few decades. The percentage of individuals starting to drink before the age of 21 has scaled from 2% to over 14%, resulting in a higher likelihood of severe dependence later in life.

The Growing Care Need

The rising trend in consumption and structural shifts in the state are driving an urgent need for expanded psychiatric and social infrastructure:

Massive Treatment Gap: National mental health metrics indicate that substance use disorders—particularly Alcohol Use Disorder—have an incredibly high treatment gap (frequently exceeding 85%). Only a minute fraction of individuals experiencing hazardous or dependent drinking actively receive formal medical de-addiction or therapeutic counseling.

High Financial & Medical Burden: Out-of-pocket medical expenditures for managing chronic liver disease, alcoholic pancreatitis, and severe alcohol-induced psychiatric conditions place an immense financial strain on households in Kerala.

Socio-Psychological Ripple Effects: Heavy alcohol dependency heavily correlates with domestic instability, high rates of vehicular accidents, and co-occurring family mental health crises (such as clinical depression and anxiety in caregivers and spouses).

Need for Community Integration: Relying strictly on specialized tertiary de-addiction wards is insufficient to handle the caseload. There is a critical, growing demand for integrated primary care screenings (using tools like ASSIST/AUDIT at local health centers), decentralized community counseling networks, and stigma-reduction programs to encourage early intervention.

Substance Use Disorders

Under international clinical frameworks (like DSM-5-TR and ICD-11), substance-related mental disorders are split into substance use disorders (SUDs) (dependence and harmful use) and Substance-Induced Disorders (psychiatric conditions directly triggered by the drug's chemical effect on the brain):

By Substance Category

Cannabis-Related Disorders: Ranging from chronic cannabis use disorder to acute cannabis-induced anxiety or psychotic disorder (often characterized by sudden paranoia or severe panic).

Stimulant-Related Disorders (Amphetamines, MDMA, Cocaine): These substances highly alter dopamine pathways. Disorders include stimulant use disorder, stimulant-induced psychosis (featuring intense tactile/auditory hallucinations and persecutory delusions), and severe withdrawal-induced depressive states.

Opioid-Related Disorders: Covering both illicit opiates (heroin) and diverted pharmaceuticals (morphine, tramadol, buprenorphine). Conditions include severe opioid dependence, opioid-induced depressive disorder, and life-threatening withdrawal syndromes.

Sedative, Hypnotic, or Anxiolytic Disorders: Typically involving the misuse of prescription medications like benzodiazepines. Chronic misuse alters GABA receptors, causing severe dependence, cognitive clouding, and a dangerous withdrawal syndrome that can induce grand mal seizures.

Hallucinogen and Inhalant Disorders: Misuse of classic psychedelics (LSD) or volatile solvents/glue, leading to hallucinogen persisting perception disorder (HPPD/"flashbacks") or permanent inhalant-induced neurocognitive deficits.

Induced Psychiatric Phenotypes

Substance-Induced Psychotic Disorder: A condition where hallucinations or delusions present as a direct physiological consequence of heavy intoxication or sudden withdrawal from a drug.

Substance-Induced Mood/Anxiety Disorders: Severe, clinically significant presentations of deep depression, mania, or panic attacks that are chemically driven by active substance usage cycles rather than a baseline primary mental illness.

Overall Prevalence in Kerala

The statistical landscape of non-alcohol substance use disorders in Kerala is undergoing a massive shift:

The Baseline Estimates vs. Current Reality: The landmark National Mental Health Survey (NMHS) initially pinned Kerala's clinical prevalence for "other substance use disorders (excluding alcohol and tobacco)" at a relatively low 0.08%. However, public health experts and law enforcement track an exponential multi-year spike since that baseline.

The Synthetic Drug Surge: Kerala records the highest NDPS (Narcotic Drugs and Psychotropic Substances) case rate in the country, tracking at approximately 78 cases per lakh population.

Campus & Youth Demographics: Cross-sectional student mental health evaluations across urban hubs like Ernakulam, Kozhikode, and Thiruvananthapuram indicate that local substance experimentation rates among college cohorts sit between 19% and 34%. There has been a definitive behavioral transition away from traditional natural cannabis (ganja) toward highly addictive synthetic agents like MDMA (ecstasy), methamphetamine, and diverted pharmaceutical pills.

The Evolving Care Need

The explosive shift toward high-potency synthetic drugs has profoundly altered the clinical demands placed on Kerala's mental health infrastructure:

Need for Specialized Psychiatric Detoxification: Unlike alcohol or cannabis withdrawal, synthetic stimulants (like methamphetamine) and heavy prescription opioid mixtures

induce severe, unpredictable psychiatric crises during withdrawal, including acute psychosis and high suicidality. Standard general hospital beds are structurally unequipped; the state requires specialized psychiatric de-addiction infrastructure.

Dual-Diagnosis Management Capability: A huge portion of individuals presenting with synthetic drug dependency show co-occurring "dual diagnoses"—meaning their substance use masks or exacerbates an underlying major depressive disorder, severe anxiety, or personality trait. Treatment models must advance beyond basic detoxification to long-term psychiatric rehabilitation.

Overcoming Evolving Legal & Social Barriers: The high rate of legal enforcement under the NDPS Act creates a paradoxical barrier where young individuals experiencing severe substance-induced mental crises evade seeking medical care out of fear of criminalization or extreme familial stigma. Integrating strictly confidential psychological support systems at the primary care tier remains a critical development target.

Behavioural Addiction

Behavioral addictions involve a repetitive compulsion to engage in a non-substance-related behavior despite clear negative consequences to a person's physical, mental, social, or financial well-being. Much like substance dependencies, these behaviors trigger reward pathways in the brain, leading to functional impairments.

Comprehensive List of Behavioral Addiction Mental Disorders

Clinical frameworks (such as the DSM-5-TR and ICD-11) officially recognize or continuously study several distinct behavioral addictions:

Gambling Disorder: The only non-substance behavioral addiction fully classified alongside substance use disorders in the DSM-5. It is characterized by persistent, maladaptive wagering behavior that compromises personal, familial, or vocational pursuits.

Gaming Disorder (Online/Offline): Characterized by impaired control over digital or video gaming, prioritizing gaming over other life interests and daily activities, and escalation despite negative outcomes.

Problematic Smartphone / Screen Overuse: Compulsive device engagement that severely alters sleep patterns, face-to-face social interactions, and attention spans.

Compulsive Buying / Shopping Disorder: An obsession with purchasing unnecessary goods, driven by a temporary emotional high during the transaction phase, frequently culminating in financial crises.

Social Media Addiction: Compulsive checking and scrolling through digital platforms, driven by intermittent dopamine rewards from likes, notifications, and social validation.

Compulsive Sexual Behavior Disorder: A persistent pattern of failure to control intense, repetitive sexual impulses or urges, resulting in significant distress or impairment.

Work Addiction (Workaholism): An uncontrollable, compulsive drive to work excessively, causing the neglect of physical health, relationships, and leisure time.

Overall Prevalence in Kerala

Due to high digital penetration and swift socioeconomic transitions, Kerala exhibits distinct spikes in specific behavioral addictions—most notably those tied to technology:

Condition Category	**Estimated Prevalence in Kerala**	**Key Insights / Affected Cohorts**
Smartphone Addiction	**35.2% – 39.9%**	Cross-sectional studies using standardized tools (like MUST) among young adults (18–23 years) show an alarmingly high prevalence. Risk significantly scales with late-night usage and coming from nuclear families.
Childhood Screen Addiction	**~50%**	Research conducted by teams at the Government Medical College, Thiruvananthapuram, indicated that nearly half of children aged 5–12 years display baseline signs of mobile phone addiction.

Condition Category	Estimated Prevalence in Kerala	Key Insights / Affected Cohorts
Internet & Gaming Addiction	**19% – 52.75%**	Problematic internet use hovers around 19% among older adolescents. Among specialized professional student cohorts (like MBBS students), overall internet dependency markers reach up to 52.75%, strongly correlating with clinical depression and anxiety.

The Growing Care Need

The sudden explosion of digital and behavioral addictions in Kerala has generated an urgent structural strain on family systems and health infrastructure:

- Systemic Sleep and Mental Health Disruptions: Findings from the State Department of Economics and Statistics highlight that widespread behavioral screen addiction directly results in severely disturbed sleep architectures, reduced academic focus, and sudden behavioral volatility among adolescents.
- Severe Withdrawal and Crisis Risks: Public health experts note that abruptly curtailing device usage in heavily addicted children without psychological supervision can cause acute withdrawal symptoms, extreme emotional outbursts, and, in severe cases, tragic self-harm or suicidal tendencies.
- The Launch of Digital De-Addiction Centers (D-DAD): Recognizing this clinical gap, the Kerala Police, in tandem with the Health and Education departments, launched the 'D-DAD' (Digital De-Addiction Center) project. Initially deployed across major hubs like Thiruvananthapuram, Ernakulam, and Kozhikode, the state is actively expanding these centers to all 14 districts. They offer free, continuous counseling and psychometric testing (such as the Internet Addiction Test) to help children develop healthy boundaries with technology.

- Need for Life-Skills and Curricular Integration: Medical experts across Kerala advocate for shifting from purely reactive treatments to proactive community models. There is a growing demand to formalize digital literacy and assertiveness training inside school curricula, while simultaneously coaching parents to modify their own device habits.

Psychosexual Disorders

Psychosexual disorders encompass a broad range of psychological conditions that deeply impact sexual functioning, identity, and behavior. These disorders stem from a complex interplay of biological, psychological, interpersonal, and socio-cultural factors.

1. Comprehensive List of Psychosexual Disorders

Clinical diagnostic frameworks (such as the DSM-5-TR and ICD-11) divide psychosexual disorders into three major domains: Sexual Dysfunctions, Sexual Pain Disorders and Paraphilic Disorders. Additionally, there are culture-bound syndromes.

Due to deep socio-cultural taboos, population-wide epidemiological data on psychosexual health is heavily underreported in India. However, localized clinical studies and data from specialized marital health institutes in Kerala reveal specific insights. General Medical Clinics: A landmark multi-year analysis of over 15,000 patients presenting to a major institute of sexual and marital health in Kochi, Kerala, revealed that up to 60% of patients presenting with sexual dysfunction had an underlying, undetected physical health problem (such as diabetes, thyroid disorders, or coronary artery disease) underlying their psychosexual distress. In inpatient alcohol de-addiction settings in Kerala, between 37% and 70% of male patients suffer from co-occurring sexual dysfunctions, with erectile dysfunction, orgasmic dissatisfaction, and low libido topping the list. The Diabetic Population: In a specialized study tracking diabetic patients in South Kerala, 65% met clinical criteria for sexual dysfunction, representing 46% of female diabetic participants and an overwhelming 78.6% of male diabetic participants. Outpatient Patterns: Among general psychiatric outpatients seeking psychosexual help, Erectile Dysfunction (ED) is the most common complaint (~29.5%), closely followed by Premature Ejaculation (PME) (~24.6%) and Dhat Syndrome (~18.1%).

There is therefore a need for Integrated Marital and Mental Health Infrastructure: Modern relational stress, combined with poor sex education and modern performance anxiety, means that psychosexual conditions quickly cascade into chronic depression, low self-esteem, and marital dissolution. Kerala requires the integration of psychosexual screening directly inside family counseling templates, de-addiction centers, and general endocrinology clinics.

4.2 Existing Service Delivery Systems

According to data from the Kerala State Mental Health Authority, as of 2025, there are 155 psychiatric units with inpatient facilities. This amounts to 7083 beds. This figure does not include registered mental health facilities designated as rehabilitation and deaddiction centers that do not have a psychiatric unit.

District	Population	Number of psychiatric units	Number of IP beds	IP beds per 100 000 population
Alappuzha	2139591	5	254	11.871
Ernakulam	3487940	34	1098	31.48
Idukki	1119452	8	756	67.53
Kannur	2684119	5	107	3.99
Kasargod	1322816	1	10	0.76
Kollam	1322816	11	155	11.72
Kottayam	2026253	17	516	25.47
Kozhikode	3353470	8	816	24.33
Malappuram	4419013	13	415	9.391
Palakkad	2938391	13	450	15.31

Pathanamthitta	1325013	12	404	30.50
Thiruvananthapuram	3252149	12	999	30.72
Thrissur	3327957	13	918	27.58
Wayanad	851238	3	185	21.73
Grand total	**33570218**	**155**	**7083**	**21.10**

Overall, the state has 21 inpatient psychiatric beds for every 100 000 people. The distribution of beds is presented in Table 1. There was a wide variance in the inpatient bed- to- population ratio, ranging from 0.75 beds per 100 000 population in Kasargod to 68 beds per 100 000 population in Idukki. Of these, six districts were below the state figure of 21, with three of these districts (Kasargod, Kannur and Malappuram) having fewer than 10 beds per 100 000 population. Four districts (Idukki, Ernakulam, Pathanamthitta and Thiruvananthapuram) have more than 30 beds per 100 000 population.

A total of 67.96% of the population had access to an inpatient facility within 15 min. A total of 93.34% of the population would be able to reach a centre within 30 min. A total of 96.85% of the population could reach the site within 45 min.

Psychiatry inpatient units under Government institutions are also available in selected places. Government Mental Health Centers have 1,366 beds; Government Medical Colleges have 600–700 beds; District/General/Taluk Hospitals & other government units have 250–350 beds. Total Government psychiatric beds are approximately 2,250–2,450.

4.3 Human Resources

In the past, only a very small number of people worked in the mental health sector. Now, approximately 75 to 80 new psychiatrists graduate annually in Kerala. The IPS estimates that there are currently around 1,200 psychiatrists. The number of clinical psychologists in Kerala registered with KSMHA is156. The number of PSWs registered is 113, and the number of

mental health nurses registered is 21. Although this can be considered an achievement, their numbers still need to increase further.

Mental health-related subjects have not received adequate consideration in medical education up to the undergraduate level. Moreover, nothing has yet been included in the curriculum that is capable of developing a socio-psychological perspective.

Another shortcoming is that the number of professionals working in areas such as clinical psychology, psychiatric social work, and psychiatric nursing is significantly lower than required. Furthermore, training centers dedicated to these categories are limited. Such centers have begun operating in Kerala; however, additional steps are also being taken to establish more centers. When bringing mental health activities to the primary healthcare level and transforming the current system—which is confined solely to psychiatric treatment—into a more developed and multidimensional mental health program, there are several responsibilities that must be completed under the leadership of the aforementioned non-medical staff. The services of the aforementioned non-medical sector are mostly concentrated in urban areas. This situation will not help in resolving the problems we face. Even if specialized training is provided to more people, their services are unlikely to reach the rural areas where the majority of the population resides.

4.4 Issues and Shortcomings in the Existing Mental Health Service System

Western models have heavily influenced the awakening and development of the mental health sector in our country. However, implementing such models in our environment must be done with critical evaluation. We need to develop an approach and philosophy of action that aligns with our way of life and culture.

The lack of uniformity among various institutions in the field of mental health is one of the biggest challenges we face. The standard of services provided at different levels is, in many places, not based on science. Deliberation is required on how to standardize and make the service activities occurring across various sectors effective. It is also necessary for the general public to have a clear understanding of their needs, rights, and responsibilities.

Several types of treatment systems currently exist in our mental health service sector. Modern medicine, Ayurveda, Unani, Homeopathy, and Naturopathy—the list goes on. A

significant portion of the treatment sector is dominated by religious treatment methods. Ayurveda is a branch of medicine enriched by extensive observation of nature and philosophical insight. However, no effective studies have been conducted to evaluate the unique characteristics and capabilities of that great branch of science. The situation is much the same for Homeopathy, Unani, and Siddha systems.

Since handing over community mental health programs entirely to the Directorate of Health Services (DHS) in 2017 to ensure a uniform state-wide model, Kerala has achieved 100% DMHP coverage across all 14 districts.

Grassroots Integration: Specialized psychiatric care has been successfully integrated into primary healthcare. DMHP medical teams (comprising a psychiatrist, clinical psychologist, psychiatric social worker, and community nurse) conduct scheduled monthly clinics at local Family Health Centres (FHCs) and Primary Health Centres (PHCs).

Tele-MANAS Integration: Launched to complement DMHP, Kerala's Tele-MANAS initiative provides 24/7 tele-counseling and mental health triage (via toll-free numbers 14416 or 1800-891-4416). This system bridges the gap between rural patients and psychiatrists, ensuring seamless digital referrals directly to district DMHP teams.

Specialized Sub-Projects: DMHP has adapted to vulnerable demographics. For instance, the Tribal Mental Health Project (TMHP) in Wayanad utilizes mobile intervention teams to deliver culturally sensitive psychiatric and de-addiction care directly to tribal settlements.

2. Psychiatric Rehabilitation Facilities in Kerala

Historically, "rehabilitation" meant indefinite stays inside major institutional psychiatric wards. Today, Kerala focuses on community-based psychosocial rehabilitation designed to help patients return to their families and mainstream society.

Government & Institutional Day-Care Centres

Major Mental Health Centres: Kerala's three primary public psychiatric institutions—located in Trivandrum (Peroorkada), Thrissur, and Kozhikode (Kuthiravattom)—have shifted focus from long-term custody to active rehabilitation. IMHANS Kozhikode: The Institute of Mental Health and Neurosciences (IMHANS) runs dedicated recovery facilitation and rehabilitation

units. Their facilities offer Sheltered Workshops and therapy ecosystems That Integrate occupational therapy, group therapy, and structured family support groups. While Kerala leads in integrating mental health into primary care, long-term community housing for patients without family support remains a challenge. Private psychiatric rehabilitation homes (licensed under the Mental Healthcare Act, 2017 and monitored by the State Mental Health Authority) exist, but establishing highly affordable, state-run halfway homes across all rural areas is an ongoing objective for the health department.

Administrative guidelines are necessary to improve the standard of service. In the field of psychiatric care, this is absolutely essential. The provisions in these guidelines should fall into two categories:

1. Provisions that must be strictly complied with.
2. Provisions that can be modified according to the time, place, and circumstances.

In 2013, the lack of a dedicated "head of account" meant that mental health programs were forced to fight for leftover funds within the broader, generalized budgets of the Directorate of Health Services (DHS) and the Directorate of Medical Education (DME).

The Current Scenario:

- Creation of Separate Budgetary Heads: Kerala has established dedicated, distinct budgetary heads of account specifically for mental health programs. Funding for the District Mental Health Programme (DMHP), de-addiction centers, and specialized psychiatric rehabilitation is now structurally separated from general medical funds under the DHS.
- The Aardram Mission Funding Conduit: Through the state's flagship Aardram Mission (which aims to convert Primary Health Centers into comprehensive Family Health Centers), mental health funding is now seamlessly channelled directly to local-level healthcare.
- Decentralized Local Self-Government (LSG) Funds: Under Kerala's decentralized governance, local Panchayats and Municipalities now dedicate a portion of their

annual plan budgets directly to local mental health clinics, ensuring that funding for psychiatric medicines and local rehabilitation is sustained at the grassroots level.

Epidemiological Data, Research, and Evaluation

The 2013 draft lamented a complete lack of systematic epidemiological data, which forced policymakers to blindly design programs based on sparse, outdated studies or external social science reports.

The Current Scenario:

- The Impact of the National Mental Health Survey (NMHS): The landscape shifted fundamentally with the implementation of the National Mental Health Survey (NMHS). The survey provided Kerala with its first-ever comprehensive, scientifically structured database on state-specific psychiatric morbidity.
- State-Level Epidemiological Revelations: The NMHS and follow-up clinical studies revealed critical, highly localized data:
    - Kerala was identified as having a remarkably high prevalence of anxiety-related disorders (~5.43% current prevalence) and depressive disorders (~2.49% current prevalence) compared to national averages.
    - Studies highlight a pronounced gender disparity index, with women carrying a significantly higher burden of depression.
    - This concrete data directly justified the expansion of local psychological counseling resources and specialized women-centric support systems like *Snehitha*.
- State Health Systems Resource Centre (SHSRC) & Institutional Research: Rather than relying on external social science groups, the SHSRC Kerala now acts as a central hub for medical and public health research. The SHSRC regularly approves, guides, and funds in-house clinical research projects led by public health doctors and psychiatrists within the DHS and DME, focusing on localized challenges such as geriatric mental health, adolescent stress, and pandemic-induced distress.

Comparative Progress (2013 vs. 2026)

Policy Challenge (2013)	Current Status (2026)
No Dedicated Head of Account	Distinct, secure budget heads established under DHS and DME. Co-funded by LSG / Panchayat local budgets.
Lack of Local Research	SHSRC Kerala coordinates statewide, ethics-approved clinical and community mental health research.
No Epidemiological Data	Robust baseline data established via NMHS. Transitioning into real-time digital registries to map treatment gaps.
Fragmented Administrative Oversight	Streamlined inter-departmental monitoring through the Coordination & Programme Management Division (CPMD) to execute budget commitments quickly.

Through structured funding and data-driven policymaking, Kerala has successfully transitioned from an outdated, institutional-custodial approach to a proactive, evidence-based community mental health ecosystem. More needs to be done now to make it a world-class system.

5

Principles To Be Adopted When Planning The Mental Health Sector

5.1 Model of the Action Programme

Decentralization / Public Participation (Janakeeyavalkaranam)

The process of democratization is continually expanding across all social spheres. There have been significant socio-economic and political reflections along this path. The corresponding conceptual domain is active and development-oriented. The influence of these thoughts is also reflected in the field of mental health activities.

There must be active, mutual communication and dialogue among public health workers and society, doctors and patients, and administrators and policymakers. A policy program emerging from such discussions is what needs to be implemented. This is the meaning intended by the word *Jnakeeyavalkaranam* (public participation/democratization). Through this process, the principle of decentralization will naturally be implemented. Thus, only through the path of democratization and decentralization can people be led toward self-reliance.

Equity (Samathwam)

The needs of the people will vary from region to region. The objective must be to distribute available resources usefully and equitably, taking into account the unique characteristics of each locality and understanding public needs. For this to happen, the problems and needs faced by each section of the population must be identified, available resources must be mobilized, and it must be ensured that their distribution is strictly based on need and carried out justly.

Ethical Awareness (Naithika Bodham)

Ethical reflections in the field of psychiatric care are continually evolving. This growth is active and evident in every aspect of medical education. New policy approaches are

developing in all areas, including medical education, training, and research. These changing perspectives are also reflected in areas such as conduct toward patients and approaches toward society.

Science and Technical Expertise (Shasthravum Sankethika Vaidagdhyavum)

Technologies are growing by rooting themselves in science. With the absorption of both of these, a new awareness of life and ethical concepts is also emerging. This general perspective holds true for the mental health sector as well. However, the benefits of modern scientific and technological growth do not usually reach ordinary people. For everyone who requires medical scientific care, modern technological

benefits must be made available. For this purpose, the necessary service facilities must be extended all the way to the rural areas.

Modernization of the Mental Health Service Sector

Renaissance activities in the field of mental health are happening all over the world. The modern perspective is that it is not enough to confine these activities solely to the public health sector. Doing so would only allow us to be satisfied with bringing about minor, nominal reforms. The actual goals, however, lie far beyond that. Even small changes occurring in any field are an inseparable part of overall social and political transformations. In that sense, the public health sector cannot exist in isolation, turn a blind eye to transformations, or fail to develop.

Hospitals

We possess an extremely vast health sector and hospital system. However, the operations of our hospitals are largely confined within their own four walls. These activities do not have any major connection with the community. This situation must be changed, and these institutions must be transformed into bodies that stand supported by a vast, robust, and deep-rooted community-based service system.

The relationship of mutual assistance and cooperation between small hospitals and large hospitals must be expanded and strengthened. We must be able to utilize the vast intellectual and technological achievements that humanity has acquired so far on a need-based basis. A

service network must be developed that can easily reach even remote rural areas. Relatively minor illnesses should be managed within smaller institutions at the grassroots level itself. Cases that cannot be managed within their capacity should be referred to higher levels. A cooperative style of functioning must be developed by coordinating and integrating activities across remote-regional and referral levels. A team must be formed that works toward a single objective by exchanging knowledge and experiences, so that even the benefits of the latest international trends reach even the most remote village levels.

Quality of Services (സേവനങ്ങളുടെ ഗുണനിലവാരം)

The quality of services provided in various fields related to mental health needs to be improved significantly. The necessary resources for this must be pool-allocated. However, this alone is not enough. Radical changes are required in the attitude and awareness of life values among those engaged in service responsibilities at different levels. This means these changes should happen not just among the workers, but among the general public as well. The objective of all the activities we envision is to improve the standard of living of the people, and it goes without saying that the quality of these programs should be reflected in public life.

Responsibilities and Training of Health Workers (ആരോഗ്യപ്രവർത്തകരുടെ ചുമതലകളും പരിശീലനവും)

Ultimately, it is the health workers themselves who must lead the aforementioned changes. The duty to prepare them for this lies with our universities and medical educational institutions. There is a need for ideas and dialogue with a long-term vision regarding what role these institutions play in social progress, and deliberations are necessary. An approach that inspires a public health service driven by dedication and commitment to the public needs to be further cultivated in the field of medical education.

5.2 Practical Actions and Policy Approaches (പ്രായോഗിക പ്രവർത്തനങ്ങളും നയസമീപനങ്ങളും)

There is a significant gap between our growing needs and the available resource wealth to meet them. Reconciling the two is difficult. Therefore, the practical approach is to evaluate

these needs in terms of priority. When evaluated in this manner, the top ten things that need to be addressed urgently in the mental health sector are:

1. Priority must be given to utilizing available resources to expand existing psychiatric treatment facilities in district hospitals and taluk hospitals, and to make these facilities available in taluk hospitals where they are not currently accessible.
2. The infrastructure facilities at existing mental health centers must be developed in a manner that aids treatment and protects the human rights of the patients.
3. Appropriate training must be provided to various categories of staff, including doctors working at different levels in the public health sector, to integrate them into the chain of psychiatric treatment.
4. An effective system must be developed to benefit those at the grassroots level of society, and those who have been left out of service programs; a service policy must be formulated. For this purpose, the operation of the District Mental Health Programme must be extended to all districts.
5. Mental health centers and psychiatry departments in medical colleges must be upgraded to high-standard referral institutions. They should be transformed into institutions responsible for academic research and training in the field of mental health, as well as for evaluating activities across various sectors.
6. Suicide prevention clinics, de-addiction treatment clinics, geriatric clinics, and clinics for children and adolescents must be started in all medical college psychiatry departments, mental health centers, and district hospital psychiatry units.
7. Numerous activities related to mental health are currently taking place in private and voluntary organization sectors. All those activities must be coordinated, streamlined, regulated, and encouraged. Through this, mobilization of human resources from those sectors is also possible.
8. Along with treating mental illnesses, priority must be given to activities aimed at preventing the risk of illness. Concurrently, action plans to promote the overall mental health sector must be designed and implemented. For this purpose, facilities

for life skills training, yoga, and meditation that help alleviate mental stress must be made available.

9. Guidelines must be prepared and implemented for the respective systems of medicine among the various existing psychiatric treatment systems.
10. The lack of capacity to respond in a healthy manner to the setbacks that occur in daily life is a major cause of the rising rates of suicide and abuse of alcohol and drugs in the state. To assist such individuals, a crisis intervention center with a 24-hour tele-counseling facility must be established at the state level.

5.3. Comprehensive Systems Analysis of Mental Healthcare Frameworks: Standards, Gaps, and Remedial Strategies

1. Standards of Establishment and Care for Mental Health Establishments (MHEs)

The legislative landscape of psychiatric care in India underwent a profound paradigm shift with the enactment of the Mental Healthcare Act (MHCA) of 2017, effectively repealing the archaic and custodial Mental Health Act of 1987. This transition dismantled the paternalistic medical model in favor of a progressive, rights-based, and patient-centric framework aligned with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The foundational pillar of this legislation is the stringent standardization, regulation, and oversight of Mental Health Establishments (MHEs). Under the MHCA, an MHE is broadly defined as any health establishment—including psychiatric hospitals, general hospital psychiatric units, nursing homes, de-addiction centers, and halfway homes—where persons with mental illness (PMI) are admitted for care, treatment, convalescence, or rehabilitation.

The operationalization of MHEs is contingent upon mandatory registration with the respective State Mental Health Authority (SMHA) or the Central Mental Health Authority (CMHA). Registration requires absolute adherence to rigorous minimum standards categorized by the SMHA, encompassing physical infrastructure, the ratio and specific qualifications of mental health professionals (MHPs), and stringent protocols for the maintenance of clinical records. MHEs are mandated to maintain basic outpatient and

inpatient records, psychological assessment records, and psychotherapy records, which must be released to the patient or their Nominated Representative (NR) upon request. Due to administrative delays in notifying finalized minimum norms across various states, authorities initially relied on provisional registrations valid for twelve months, failure of which incurs substantial financial penalties.

The standard of care within MHEs is primarily governed by Chapter V of the MHCA, which codifies the inalienable Rights of Persons with Mental Illness. These statutory rights inherently dictate the institutional policies of every MHE, preventing the violation of human dignity under the guise of psychiatric treatment.

Core Statutory Rights under MHCA 2017	**Implications for MHE Standards and Clinical Care**
Right to Equality and Non-Discrimination	PMIs must receive mental and physical healthcare equivalent to standard medical patients, devoid of discrimination based on gender, sexual orientation, caste, or socio-economic status.
Right to Protection from Cruel Treatment	Absolute prohibition of unmodified Electro-Convulsive Therapy (ECT). ECT is banned as an emergency treatment and requires specialized Mental Health Review Board (MHRB) clearance for minors. Forced tonsuring, compulsory uniforms, and physical/verbal abuse are explicitly outlawed.
Right to Community Living	Prohibits long-term institutionalization based solely on familial abandonment. MHEs must prioritize the least restrictive environment and facilitate supported accommodation or halfway homes as a last resort.
Supported Decision Making	Mandatory integration of Advance Directives and the recognition of Nominated Representatives (NRs) to ensure the patient's volition is respected during periods of diminished capacity.

To operationalize these legislative standards on the ground, alignment with the World Health Organization (WHO) Quality Rights framework has emerged as a critical global benchmark. The Quality Rights initiative provides a comprehensive toolkit for assessing

and improving human rights conditions in mental health facilities, targeting the elimination of systemic coercion, seclusion, and unwarranted chemical or physical restraints.

2. Standards for Allied Agencies: Law Enforcement and Correctional Facilities

The realization of a rights-based mental health ecosystem requires the active participation and sensitization of allied agencies, predominantly law enforcement, the judiciary, and the penal system. Historically, homeless persons with mental illness (HPMI) were subjected to systemic criminalization, often detained under vagrancy laws or incarcerated via magistrate reception orders that prioritized public order over medical assessment. The MHCA 2017 radically restructures these protocols, imposing explicit statutory duties on allied agencies to facilitate therapeutic interventions.

The transformation in law enforcement duties is codified in Section 100 of the MHCA. If a police officer encounters an individual wandering at large who appears incapable of self-care or poses a risk to themselves or others due to mental illness, the officer has a duty to take the person into protection. The legislation explicitly prohibits detaining such individuals in a police lock-up or prison under any circumstances. The standardized protocol mandates that the police must inform the individual of the grounds for protection, lodge a First Information Report (FIR) for a missing person to initiate family tracing, and transport the individual to the nearest public health establishment for a medical assessment within 24 hours. If the medical officer determines that the individual does not require inpatient admission, the police are responsible for returning the person to their residence or a safe community setting. Furthermore, Section 101 places a duty on police officers to report any known cases of ill-treatment or neglect of a PMI to the local magistrate, ensuring localized judicial oversight.

Correctional facilities are similarly subjected to rigorous new standards under the MHCA. Section 103 mandates that the medical officer of any prison must submit quarterly reports to the State Mental Health Review Board confirming the absence of prisoners with severe mental illness. The MHRB is empowered to visit prisons to ascertain why any

inmate with mental illness has not been transferred to a psychiatric MHE, ensuring that the penal system is not utilized as a surrogate asylum.

A monumental systemic shift accompanying these allied agency standards is the effective decriminalization of suicide. Section 115 dictates that any individual attempting suicide is presumed to be suffering from severe stress and is entirely exempt from prosecution under Section 309 of the Indian Penal Code. This legislative mandate forces a pivot from a punitive response to a therapeutic one, placing a legal obligation on the government to provide the survivor with immediate care, treatment, and rehabilitation to mitigate the risk of recurrence.

3. Unmet Needs Assessment and Developing Remedial Programs

The formulation of effective remedial mental health programs requires a robust, data-driven understanding of the epidemiological burden. Globally, mental disorders account for nearly 7% to 13% of Disability-Adjusted Life Years (DALYs), with India alone contributing to 15% of this global burden. Recognizing this escalating public health crisis—exacerbated by demographic transitions, increased longevity, and pervasive poverty—the Ministry of Health and Family Welfare commissioned the National Institute of Mental Health and Neurosciences (NIMHANS) to execute the National Mental Health Survey (NMHS).

The NMHS 2015-16 represented the most exhaustive unmet needs assessment in India's history, utilizing a multi-stage, stratified, random cluster sampling technique across 12 states, interviewing 34,802 adults via the Mini International Neuro-Psychiatric Inventory (MINI) instrument. The survey revealed a current mental morbidity prevalence of 10.6% and a lifetime prevalence of 13.7%. States with advanced socio-educational indices, such as Kerala, exhibited even higher morbidity, with a current prevalence of 11.36% and a lifetime prevalence of 12.43%.

Psychiatric Condition / Metric	**NMHS-1 National / State Findings**
Depression (Current)	2.7% national prevalence; lifetime prevalence in Kerala recorded at 4.8%.

Neurosis and Stress-Related	3.5% national prevalence.
Substance Use Disorders	22.4% national prevalence; heavily driven by alcohol and tobacco dependence.
Severe Mental Disorders (SMD)	0.8% national prevalence; lifetime prevalence of schizophrenia in Kerala at 0.7%.
The Treatment Gap	Ranged from 70% to 85% for common mental disorders and 60% to 70% for SMDs. In Kerala, only 15% of afflicted individuals actively sought professional treatment.

The most alarming insight derived from the NMHS was the staggering treatment gap, exposing a profound unmet need driven by structural barriers, inadequate healthcare financing, and systemic social stigma. To continually monitor these shifting epidemiological dynamics, NMHS-2 has been initiated. This subsequent phase expands its purview to include adolescents (13-17 years), assesses the socio-economic impacts on family caregivers, and targets emerging morbidities such as technology addiction, internet gaming disorders, and the localized psychological fallout of the COVID-19 pandemic and climate change. The insights generated from these macro-assessments dictate the strategic decentralization of resources, shifting policy focus from urban psychiatric hospitals to community-based integration models.

4. Service Delivery Gaps and Programs to Improve Them

Service delivery gaps in mental health primarily manifest as a geographic and financial concentration of care in urban tertiary centers, leaving rural populations isolated and generating highly fragmented continuity of care post-discharge. Remedial programs must therefore focus on integrating psychiatric interventions into the foundational general primary healthcare matrix.

The District Mental Health Programme (DMHP), a critical offshoot of the National Mental Health Programme (NMHP), serves as the primary architecture for this decentralized service delivery. The fundamental objective of the DMHP is to provide sustainable, community-oriented psychiatric services directly through existing Primary Health

Centres (PHCs) and Community Health Centres (CHCs), thereby alleviating the pressure on tertiary medical colleges and reducing the travel burden on patients and caregivers. Multidisciplinary DMHP teams—typically comprising psychiatrists, clinical psychologists, psychiatric social workers, and mental health nurses—conduct regular scheduled clinics in peripheral institutions. In Kerala, the Institute of Mental Health and Neurosciences (IMHANS) piloted highly successful community mental health programs across Malappuram, Kozhikode, and Kasaragod, operating dozens of PHC-level clinics and demonstrating that decentralized, localized care models are both clinically effective and economically viable.

A highly refined targeted intervention addressing the service delivery gap is **Kerala's Sampoorna Manasikarogyam (Comprehensive Mental Healthcare Program)**. Recognizing that a major failure point in psychiatric care is treatment abandonment once acute symptoms subside, this program integrates field-level surveillance. Accredited Social Health Activists (ASHAs) are trained to conduct door-to-door visits at the ward level, engaging families to identify hidden psychological distress. Utilizing a structured 13-point case detection questionnaire, ASHAs collect data which is subsequently evaluated by DMHP psychiatrists. Newly identified cases are integrated into local Family Health Centres (FHCs) for routine management. By deploying over 19,000 trained ASHAs, the state transforms passive clinical delivery into active epidemiological surveillance, ensuring patients remain on medication, thereby preventing relapse and chronic institutionalization.

Further supplementing these efforts are programs like the Kerala Palliative Care Grid, which seamlessly integrates psychiatric support into home-based palliative care for patients with chronic health suffering, and dedicated clinical facilities like Aswas counseling centers that provide specialized depression and trauma screening outside of intimidating hospital environments. Additionally, the state has actively deployed Master of Social Work (MSW) interns into government hospitals to act as patient navigators, streamlining the patient experience and augmenting the multidisciplinary treatment approach.

5. Networked Awareness Programs with Correction of Awareness Gaps

A primary determinant sustaining the massive treatment gap is the pervasive deficit in mental health literacy and the corresponding entrenchment of social stigma. Misconceptions regarding the etiology of mental illness—often attributed to supernatural causes or personal weakness—and skepticism regarding the efficacy of allopathic psychiatric treatment deter individuals from seeking timely clinical intervention.

To dismantle these barriers, networked awareness programs leverage trusted, pre-existing community infrastructure rather than relying solely on sterile, top-down public health broadcasts. The Kudumbashree poverty eradication and women's empowerment mission in Kerala represents a pinnacle of this approach. Kudumbashree volunteers, deeply embedded in local micro-societies, act as frontline advocates and key informants. Through specialized mechanisms like the Snehitha Gender Help Desk, the network operates 24-hour support systems that provide direct counseling, short-stay services, and awareness regarding the intersection of domestic violence and mental distress.

Operating on the principle of institutional convergence enhance statewide the models that work like Snehitha which collaborates directly with legal services authorities, police departments, and Child Welfare Committees (CWCs) to create a holistic safety net. For example, the integration of a Snehitha counseling center directly within the Kannur Town Police Station campus ensures that cases involving women and children in distress receive immediate psychological first aid alongside legal recourse. By utilizing community peers as the vehicle for awareness, these networked programs contextualize psychiatric information, significantly lowering ideological resistance and fostering an environment where seeking psychological support is normalized. Concurrent IEC (Information, Education, and Communication) activities by the DMHP, such as community street plays and localized stress management workshops, further saturate the public consciousness with destigmatizing narratives.

6. Training and Sensitization Gaps and Programs to Correct the Same

The most severe structural bottleneck in the Indian mental health ecosystem is the profound deficit of qualified mental health professionals (MHPs). Expanding physical infrastructure is futile without the concurrent generation of specialized human resources. Furthermore, task-shifting strategies require meticulous capacity building among primary care physicians, paraprofessionals, and allied state actors.

Beyond specialized clinicians, systemic sensitization targets the broad base of frontline workers. The training of ASHA and Anganwadi workers goes beyond basic health metrics, encompassing psychological screening and counseling techniques. In initiatives spanning multiple districts, ASHA workers have been crucial in bridging the gap between district-level psychiatric programs and isolated patients, especially demonstrated during the COVID-19 pandemic where they facilitated home delivery of psychotropic medications and sustained continuity of care.

Furthermore, to actualize the rights-based ethos of the MHCA 2017, the Ministry of Health and Family Welfare developed specialized training manuals specifically for Legal Aid Providers. These modules familiarize legal professionals with the socio-medical nuances of psychiatric disorders, the complex mechanics of capacity assessment, and the intricacies of supported decision-making. By sensitizing the legal community, the state ensures that PMIs are competently represented before Mental Health Review Boards, preventing unwarranted institutionalization and safeguarding human rights.

7. School Mental Health Awareness Program Expansion

The epidemiological reality that a vast majority of psychiatric disorders precipitate during late childhood and adolescence necessitates the establishment of schools as the primary vector for universal, selective, and indicated mental health prevention. The modern educational environment exposes youth to escalating academic stress, complex peer dynamics, cyberbullying, and ready access to substance abuse, demanding holistic interventions that extend beyond traditional scholastic parameters.

A globally recognized flagship model for school mental health integration is the Our Responsibility to Children (ORC) program. Originating as a pilot initiative in Kozhikode in 2010 to combat rising juvenile deviance, ORC was subsequently integrated into the Integrated Child Protection Scheme (ICPS) under the Department of Women and Child Development. The conceptual foundation of the ORC operational manual is the psychological understanding that deviant behaviors in youth—such as aggression, substance abuse, and vandalism—are rarely indicative of inherent criminality; rather, they are complex manifestations of underlying bio-psycho-social vulnerabilities, familial breakdown, or undiagnosed learning disabilities.

The ORC program aims to construct an "invisible wall of protection" around vulnerable students by fostering a solution-focused partnership encompassing education, law enforcement, health departments, and civil society. The intervention is deeply structured across three levels:

Intervention Level	**Programmatic Mechanism under ORC**
Universal Capacity Building	Training nodal teachers and school counselors to identify early warning signs of behavioral and emotional distress within the standard classroom environment.
Selective Mentoring	Providing individualized, school-level attention and structured mentoring to youth hailing from high-risk or disadvantaged socio-economic backgrounds.
Indicated Expert Care	Establishing a referral matrix to map and direct children exhibiting severe psychiatric symptoms to impaneled clinical psychologists and psychiatrists for advanced management.

The outcomes of the ORC initiative are highly quantifiable and impactful. The program has successfully reached over 3.39 million children and trained nearly 16,000 teachers. By intervening pre-emptively, ORC effectively diverts vulnerable adolescents away from the punitive juvenile justice system, replacing isolation with psychological reintegration. Complementary programs operating in parallel—such as the Souhrida clubs, the Thalir

program driven by the DMHP, and the Chiri tele-helpline—further densify the psychological safety net for the student population.

8. Life Skills Education and Stress Management in Schools and Colleges

To foster enduring psychological resilience and buffer the escalating stressors inherent in modern adolescence, Life Skills Education (LSE) has emerged as a scientifically validated, pre-emptive clinical intervention. The World Health Organization (WHO) defines life skills as adaptive, positive behaviors that enable individuals to deal effectively with the demands and challenges of everyday life, and explicitly identifies 10 core competencies necessary for optimal psychosocial development.

The National Institute of Mental Health and Neurosciences (NIMHANS) has formulated comprehensive guidelines, operational manuals, and pedagogical frameworks to facilitate the seamless integration of these skills into Indian educational curricula. The NIMHANS model approaches LSE not as a didactic academic subject, but through experiential, participatory learning that relies heavily on peer dynamics and contextual problem-solving.

The ten WHO core skills are operationalized into distinct, actionable domains within the educational environment:

1. **Self-awareness & Empathy:** Recognizing one's strengths, weaknesses, and emotional triggers, while developing the capacity to comprehend and validate the emotional states of peers, which is critical for conflict de-escalation and preventing bullying.
2. **Critical & Creative Thinking:** Analyzing information objectively, resisting detrimental peer and media influences, and generating novel solutions to interpersonal or academic obstacles.
3. **Decision Making & Problem Solving:** Evaluating the long-term consequences of present actions (particularly concerning substance use and sexual behavior) and navigating complex life choices systematically.

4. **Effective Communication & Interpersonal Relationships:** Mastering active listening, assertiveness, and refusal skills (the ability to say 'no' to peer pressure without inducing conflict).
5. **Coping with Stress & Emotions:** Developing an internal locus of control, recognizing physiological stress responses, and deploying healthy emotional regulation techniques rather than resorting to self-harm or aggression.

NIMHANS has further tailored these core skills to address highly sensitive adolescent issues, including navigating gender stereotypes, understanding sexuality and consent, and processing traumatic memories. Empirical evaluations of the NIMHANS LSE model have demonstrated profound clinical efficacy; adolescents participating in structured LSE programs exhibited statistically significant improvements in self-esteem, superior perceived coping mechanisms, better adjustment parameters (both academically and with teachers), and markedly increased pro-social behaviors compared to non-participating cohorts.

9. Programs for Drug-Free Campuses

The proliferation of substance use disorders among student populations constitutes an acute public health crisis that directly compromises educational outcomes and triggers severe psychiatric comorbidities. To eradicate the availability and cultural appeal of narcotics and alcohol on educational campuses, highly structured, multi-agency deterrence and diversionary programs have been institutionalized.

In Kerala, the Vimukthi (De-addiction) Mission, orchestrated by the Excise Department in collaboration with educational institutions, serves as the primary policy mechanism. Under this initiative, Lahari Vimukthi (Anti-Narcotic) Clubs have been established across the educational spectrum, encompassing over 4,800 schools and nearly 900 colleges. These student-led organizations operate in close liaison with designated Excise Officials to monitor campus perimeters, gather intelligence on drug peddling, and conduct high-visibility awareness campaigns, including cycle rallies, street plays, and flash mobs.

To ensure rigid institutional accountability, the government issued specific directives mandating the formation of specialized anti-narcotic committees:

- **Nerkoottam:** Broad campus-level committees chaired by the Principal, comprising student representatives, NSS/NCC coordinators, parent-teacher association members, and local law enforcement, tasked with formulating overarching preventative strategies.
- **Sradha:** Targeted committees functioning specifically within college hostels, led by wardens and student representatives, designed to monitor residential areas and rescue students exhibiting early signs of substance dependence.

A particularly innovative sociological intervention operating under the Vimukthi umbrella is the **'Unarvu'** program. Recognizing that mere punitive enforcement is insufficient, Unarvu targets educational institutions situated in highly vulnerable socio-economic zones. The program seeks to channel the physiological energy and dopamine-seeking behaviors of at-risk youth into highly structured, creative pursuits. By heavily subsidizing sports infrastructure and arts training, Unarvu utilizes physical exertion and creative achievement to outcompete the psychological allure of narcotic substances, thereby engineering an inherently drug-free psychosocial environment through positive reinforcement rather than policing alone.

10. Programs for Stress Reduction in the Workplace

Occupational stress is a profound determinant of adult mental morbidity, severely diminishing productivity, inducing chronic burnout, and precipitating anxiety and depressive disorders. The psychological toll is exponentially higher in professions characterized by constant exposure to trauma, irregular shift patterns, and intense public scrutiny, such as law enforcement and frontline healthcare.

Recognizing the acute vulnerabilities within its ranks, the Kerala Police implemented specialized workplace mental health and stress reduction programs, most notably the **'Santhwanam'** (Consolation) and **'Prasanthi'** initiatives, heavily supported by robust Tele-counseling infrastructure. The exigencies of the COVID-19 pandemic—which forced

police personnel into highly stressful lockdown enforcement roles while isolating them from their families—catalyzed the launch of the "Doctor just a phone call away" telemedicine program by the Kerala Police Academy. This system allowed officers and their dependents to access psychiatric consultations and psychotherapy via digital applications securely. By institutionalizing scheduled, confidential tele-counseling, the organization effectively bypassed the deep-seated stigma traditionally associated with seeking mental health support in hyper-masculine, rigidly disciplined environments. Furthermore, occupational therapy units have been integrated as effective rehabilitation vectors for personnel recovering from severe stress or substance dependencies, ensuring they can process occupational trauma and return to active duty safely.

The necessity for workplace stress reduction extends critically to community health workers. ASHA and Anganwadi workers, while acting as the backbone of public health initiatives, frequently face severe occupational stressors including delayed remuneration, lack of protective equipment during crises, and the emotional burden of managing community trauma. Addressing the psychological well-being of these frontline workers through structured peer-support, institutional counseling, and equitable labor practices is increasingly recognized as a prerequisite for sustaining broader public health programs. Across corporate and academic sectors, the integration of Employee Assistance Programs (EAPs), confidential psychosocial help desks, and institutional sensitization workshops is becoming imperative for fostering psychological safety and mitigating workforce attrition.

11. Programs for the Care of the Elderly

India is currently undergoing a rapid demographic transition marked by increased life expectancy, which has precipitated a concurrent surge in geriatric mental health conditions, including dementia, Alzheimer's disease, late-life depression, and severe isolation-induced anxiety. The traditional joint-family support structure, which historically absorbed the burden of eldercare, is eroding due to urbanization and migration, necessitating robust, state-sponsored geriatric care interventions.

Kerala, featuring the highest proportion of elderly citizens in the nation, has aggressively codified policies targeting the 'Silver Economy' and 'Care Economy'. This commitment is reflected in a dedicated Elderly Budget, under the newly formed Department for the Elderly, featuring a consolidated outlay of ₹46,236.52 crore for 2026-27, specifically designed to address both the physiological and psychosocial needs of the aging demographic while combating the 'feminization of aging'.

The architecture of geriatric care operates through several interconnected flagship initiatives:

- **Vayomithram Scheme:** Executed by the Kerala Social Security Mission (KSSM), this project integrates healthcare delivery by providing mobile medical clinics, free essential medications, palliative care, and dedicated help desks directly to senior citizens (above 65 years) within their municipal wards. By eliminating the geographic and financial friction of accessing healthcare, the scheme mitigates the physical comorbidities that frequently catalyze or exacerbate geriatric depression.
- **Ormathoni (Dementia-Friendly Initiative):** Backed by a ₹1 crore budget allocation, Ormathoni is a pioneering project aimed at establishing Kerala as a dementia-friendly state. Modeled on successful pilots at the Cochin University of Science and Technology (CUSAT), the initiative emphasizes early identification through primary screening by grassroots ASHA workers, advanced diagnostic screening via localized Memory Clinics, and comprehensive training of family caregivers. Crucially, Ormathoni combats the cultural misconception that dementia is a normal psychological failing of old age, promoting scientific management and establishing specialized day-care centers ('pakal veedu') tailored for dementia patients.
- **Sayamprabha Homes:** To combat the profound loneliness, social isolation, and stress driving late-life mental morbidity, the Social Justice Department funds comprehensive day-care centers, currently expanding to 116 locations. These homes provide a barrier-free environment for socialization, offering recreational activities,

yoga, physiotherapy, and psychosocial counseling, effectively acting as holistic preventive psychiatric interventions.

- **Legislative and Emergency Support:** The state strictly implements the Maintenance and Welfare of Parents and Senior Citizens (MWPSC) Act of 2007, operating Maintenance Tribunals across 27 revenue divisions supported by specialized technical assistants for speedy grievance redressal. Emergency interventions are handled through the Vayoraksha scheme (which provides immediate financial and medical assistance for abandoned elderly) and Elderline (14567), a national toll-free helpline that provides legal guidance, emotional support, and rescue services.

12. Positive Mental Health Campaigns

Shifting the paradigm from purely curative models to promotive and preventive care requires robust positive mental health campaigns. In Kerala, initiatives like 'Jeeva Raksha' (Saving Lives) focus on community-based suicide prevention by training thousands of community gatekeepers (teachers, police, religious leaders, and healthcare workers) to identify early warning signs and provide psychological first aid. Another critical campaign is 'Amma Manas' (Mother's Mind), a joint venture between the Mental Health Program and the Reproductive and Child Health Program. It targets maternal mental health by embedding psychological screening into routine antenatal and postnatal care, utilizing Junior Public Health Nurses and ASHAs. Furthermore, programs like 'Ottakkalla Oppamund' (You are not alone, we are with you) were launched during the COVID-19 pandemic to provide widespread psychosocial support and counseling, demonstrating the state's capacity to deploy rapid positive mental health interventions during societal crises.

13. Mental Health Epidemiology and Population Research Initiatives

Evidence-based policymaking in public mental health relies heavily on continuous epidemiological research. The National Mental Health Survey (NMHS-1) of India (2015-16) provided the first robust baseline data on mental health morbidity and treatment gaps in Kerala. Building on this foundation, NMHS-2 is currently expanding its scope to

assess the mental health impact of the COVID-19 pandemic, climate change, and emerging issues like technology addiction across multiple districts and demographic groups. State mental health surveys may be started to assess the changing epidemiologic trends from 2027 and be carried out every 10 years, and a decade after NMHS 2 is published, State Mental Health Surveys to assess care pathways can also be started and carried out every 10 years.

5.5. Kerala State Mental Health Policy as a Living Document Framework

Introduction

A mental health policy should not be viewed as a static document that is developed once and implemented indefinitely. Instead, it should function as a **living document** that continuously evolves in response to emerging scientific evidence, changing population needs, service delivery experiences, technological advancements, legal developments, and stakeholder feedback. The Kerala State Mental Health Policy adopts this dynamic approach, ensuring it remains relevant, responsive, evidence-based, and accountable throughout its lifecycle.

The living document framework recognizes that mental health systems operate within complex and evolving social, economic, cultural, and healthcare environments. Continuous review and adaptation are therefore essential to achieving equitable, accessible, person-centered, and rights-based mental healthcare across the state.

Phases of Kerala State Mental Health Policy as a Living Document

I. Formulation

Policy formulation constitutes the foundational phase during which the vision, objectives, guiding principles, and strategic priorities of the Kerala State Mental Health Policy are established.

The formulation process should be grounded in:

- Epidemiological evidence on mental health burden within Kerala
- Existing national policies, including the National Mental Health Policy (2014)

- Mental Healthcare Act (2017)
- World Health Organization (WHO) Mental Health Action Plan
- Sustainable Development Goals (SDGs)
- State-specific health indicators
- Existing service delivery gaps
- Human resource availability
- Financial feasibility
- Social determinants of mental health

The formulation process should actively involve multidisciplinary experts including:

- Psychiatrists
- Clinical psychologists
- Psychiatric social workers
- Psychiatric nurses
- Public health specialists
- Health economists
- Legal experts
- Persons with lived experience
- Family caregivers
- Civil society organizations
- Community representatives
- Government departments

Key outputs include:

- Vision statement
- Mission
- Policy principles
- Strategic goals
- Operational objectives
- Governance mechanisms
- Financing framework
- Monitoring indicators
- Implementation roadmap

II. Discussion

Following preparation of the draft policy, structured discussions are undertaken to ensure that the policy reflects collective wisdom and practical realities.

Discussions should occur across multiple platforms:

Government consultations

Inter-departmental discussions involving:

- Health Department
- Social Justice Department
- Education Department
- Labour Department
- Local Self Government Institutions
- Women and Child Development
- Police Department
- Prison Department

- Disaster Management Authority

Professional consultations

Consultations with:

- Medical colleges
- Professional associations
- Mental health institutions
- Research organizations
- Universities

Community consultations

Community-level meetings involving:

- Panchayats
- Municipalities
- NGOs
- Community leaders
- Faith-based organizations
- Youth groups
- Self-help groups
- Persons with lived experience

These discussions facilitate:

- Identification of practical barriers
- Local contextualization
- Consensus building

- Clarification of implementation strategies

III. Feedback Collection

A transparent and inclusive feedback process enhances ownership and legitimacy of the policy.

Feedback should be solicited through multiple mechanisms:

Public consultation

- Public release of draft policy
- Online submissions
- Written memoranda
- Public hearings

Technical review

Expert review by:

- Academic institutions
- National mental health experts
- WHO collaborating centres
- Professional societies

Stakeholder-specific feedback

Separate consultations with:

- Mental health professionals
- Service users
- Caregivers
- NGOs
- District Mental Health Programme teams

- Primary healthcare workers
- Community volunteers

Feedback categories may include:

- Technical corrections
- Ethical concerns
- Rights-based recommendations
- Financial implications
- Feasibility issues
- Equity concerns
- Implementation barriers

All feedback should be documented systematically using predefined templates.

IV. Revision

The revision stage involves critical appraisal of all collected feedback and evidence before incorporating modifications into the draft policy.

Revision should follow a structured methodology:

Evidence appraisal

Each recommendation should be assessed based on:

- Scientific evidence
- Legal consistency
- Financial implications
- Administrative feasibility
- Equity considerations
- Expected public health impact

Recommendations may be:

- Accepted
- Modified
- Deferred
- Not accepted (with documented justification)

Major revisions may include:

- New strategic objectives
- Updated implementation mechanisms
- Revised governance structures
- Enhanced financing approaches
- Modified monitoring indicators

Revision should maintain transparency by documenting changes between versions.

V. Submission

Following revision, the finalized draft is formally submitted for governmental approval.

Submission generally includes:

- Final policy document
- Executive summary
- Financial implications
- Implementation framework
- Monitoring framework
- Stakeholder consultation report
- Legal compliance review

- Cabinet note where applicable

Appropriate approvals may be sought from:

- Department of Health and Family Welfare
- State Mental Health Authority
- Law Department
- Finance Department
- Council of Ministers
- Government of Kerala

Formal approval establishes the policy as the official framework guiding mental healthcare across the state.

VI. Implementation

Implementation converts policy commitments into operational programmes and measurable actions.

Key implementation components include:

Governance

Establishing:

- State Steering Committee
- District Mental Health Committees
- Technical Advisory Groups
- Programme Management Units

Capacity building

Training for:

- Medical officers

- Nurses
- Psychologists
- Social workers
- Community health workers
- ASHAs
- Anganwadi workers
- School counsellors
- Police personnel

Service strengthening

Expansion of:

- District Mental Health Programme
- Community mental health services
- Child and adolescent services
- Common Mental Disorder Care
- Geriatric mental health
- Addiction services
- Suicide prevention programmes
- Tele-mental health
- Crisis intervention services

Resource allocation

Implementation requires:

- Human resources

- Infrastructure
- Essential psychotropic medicines
- Information technology systems
- Financial investments

Implementation should occur in phased timelines with clearly defined responsibilities.

VII. Monitoring

Monitoring is a continuous process that measures implementation fidelity and progress.

Monitoring should occur at multiple levels:

Input monitoring

Assessment of:

- Budget utilization
- Human resource deployment
- Infrastructure development
- Medicine availability

Process monitoring

Monitoring:

- Training activities
- Programme implementation
- Outreach services
- Community engagement
- Referral pathways

Output monitoring

Measurement of:

- Number of patients served
- Community awareness activities
- Screening coverage
- Service utilization
- Follow-up rates

Monitoring indicators should be incorporated into the state's Health Management Information System (HMIS).

Routine monitoring intervals may include:

- Monthly
- Quarterly
- Annual

District-level reviews should feed into state-level dashboards.

VIII. Outcome Assessment

Outcome assessment evaluates whether policy implementation is achieving intended public health goals.

Outcome evaluation should measure:

Health outcomes

- Reduction in untreated mental illness
- Increased treatment coverage
- Improved recovery rates
- Reduced suicide rates
- Improved quality of life

- Reduced disability

System outcomes

- Improved accessibility
- Reduced waiting time
- Improved continuity of care
- Better referral systems
- Increased workforce capacity

Social outcomes

- Reduced stigma
- Improved community participation
- Increased employment among persons with mental illness
- Enhanced educational participation
- Greater social inclusion

Outcome assessments should employ:

- Population surveys
- Facility assessments
- Patient satisfaction studies
- Independent evaluations
- Research collaborations

Both quantitative and qualitative methods should be used.

IX. Outcome-Based Revisions

Evaluation findings should directly inform policy improvements.

Outcome-based revision ensures that policy evolves based on actual performance rather than assumptions.

Revision triggers may include:

- Poor programme performance
- Emerging disease patterns
- New scientific evidence
- Legislative changes
- Technological innovations
- Community demands
- Public health emergencies
- Economic changes

Examples include:

- Expansion of digital mental health
- New suicide prevention strategies
- Integration with primary healthcare reforms
- Climate-related mental health interventions
- Disaster mental health preparedness

Policy revisions should follow a documented version-control system to maintain transparency and institutional memory.

X. Continuous Quality Assurance

Continuous Quality Assurance (CQA) is the overarching process that sustains excellence throughout the policy lifecycle. Rather than a single phase, it functions across all stages—from formulation to implementation and revision—promoting a culture of learning, accountability, and improvement.

Key elements include:

Governance and Accountability

- Establish quality assurance committees at state and district levels.
- Define clear roles and responsibilities for policy implementation.
- Conduct regular performance reviews and public reporting.

Standards and Guidelines

- Develop and periodically update clinical and operational standards.
- Ensure adherence to national legislation and international best practices.
- Promote standardized care pathways and service protocols.

Performance Measurement

Monitor quality indicators such as:

- Accessibility and equity of services
- Service utilization rates
- Continuity of care
- Patient safety
- Human rights compliance
- User satisfaction
- Workforce competency
- Financial efficiency

Audits and Accreditation

- Conduct periodic internal and external audits.
- Promote accreditation of mental health facilities.

- Benchmark services against state, national, and international standards.

Research and Innovation

- Encourage implementation research.
- Support operational research through academic collaborations.
- Pilot innovative service models and evaluate their effectiveness.
- Integrate digital health technologies and data analytics to improve service delivery.

Learning Health System

Develop mechanisms to:

- Capture lessons learned from implementation.
- Disseminate best practices across districts.
- Foster communities of practice among professionals.
- Build institutional memory through documentation and knowledge-sharing.

Community and Service User Participation

Ensure continuous engagement of:

- Persons with lived experience
- Caregivers
- Community organizations
- Civil society groups
- Local self-governments

This participatory approach enhances accountability, transparency, and responsiveness to community needs.

The Living Policy Cycle

The Kerala State Mental Health Policy should be conceptualized as a cyclical and iterative process rather than a linear sequence. Each phase informs the next, creating a continuous loop of learning, implementation, evaluation, and refinement:

Formulation → Discussion → Feedback Collection → Revision → Submission → Implementation → Monitoring → Outcome Assessment → Outcome-Based Revisions → Continuous Quality Assurance → Back to Formulation

This iterative cycle ensures that the policy remains responsive to changing epidemiological trends, advances in mental health research, technological innovations, legal reforms, and evolving societal needs. By embedding regular review, stakeholder participation, and evidence-based decision-making into every stage, Kerala can maintain a mental health policy that is adaptive, accountable, equitable, and capable of delivering sustained improvements in mental health outcomes for all its citizens.

6

Approach To Be Adopted While Implementing Mental Health Programs

6.1 Knowledge and skills related to mental health should be disseminated to the lowest levels of the health department.

Knowledge and skills related to mental health should not be confined to the field of mental health but should be spread across all operational areas of the existing health department. They should be disseminated to public health workers at all levels. Then, ordinary public health workers at the village level will be able to resolve the relatively minor mental health problems they encounter. A common person from a remote village will no longer need to travel to the city to seek expert help. This means mental health service provision should begin from the grassroots level. Strengthening the psychiatry departments in district and taluk hospitals, making these facilities available in centers where this service is not currently available, expanding the activities of the District Mental Health Programme, and providing necessary training to those working in the health sector will help in this.

6.2 Different levels of the service sector

Along with establishing a functional chain including village-level workers, sub-centers, Primary Health Centers, Community Health Centers, taluk hospitals, district/general hospitals, medical colleges, and mental health centers, the responsibilities to be carried out at each level must also be defined. Only such a collaborative operational system can achieve effective results in this field. A referral system must be established to comprehensively coordinate all types of activities.

Level 1: Community

- General mental health education.
- Early identification of the patient.

- Provide necessary mental health awareness to groups like ASHA workers, Kudumbashree, and Janashree.
- Follow-up treatment.
- **Family Cooperation:** The family is the basic unit of society. They are the first to desire the patient's well-being and to step forward to provide necessary services. The importance of the family in this context is significant. Families must be equipped to scientifically face problems by providing them with the necessary medical knowledge, guidance, and support.
- **Social Integration of Recovered Patients:** Patients who have recovered must be empowered with the ability to adjust to their own families and to society.

Level 2: Primary Health Centre / Community Health Centre

- **Early Diagnosis:** Train Junior Public Health Nurses to identify and refer patients.
- **Regular Treatment and Follow-up:** Supervision of patients under the care of Primary Health Centres should be the responsibility of the psychiatry department in district/taluk hospitals.
- Emergency treatment.
- Family cooperation, health education.
- Integrating the patient with the community.
- Rehabilitation guidelines.
- General mental health education.

Level 3: Taluk Hospitals – Community Health Centres

- Function as referral institutions at the primary level.
- Comprehensive psychiatric treatment.
- Provide necessary service support to Primary Health Centres for patients with complex conditions.

- Provide inpatient treatment for patients with severe conditions.
- Support the patients' families.
- General mental health education.
- Jails, observation units, orphanages.
- Provide necessary medical services to mental health patients in institutions like certified schools.

Level 4: District/General Hospitals

- Comprehensive psychiatric treatment.
- Referral support for taluk hospitals and primary health centers.
- Day-care facilities.
- Collaborate with voluntary organizations for intermittent and long-term treatment.
- Provide training to doctors, health workers, and voluntary organizations at primary health centers.
- Provide support to the patient's family members.
- Provide medical treatment support to inmates in institutions like jails, observation units, certified schools, and orphanages.
- School/College Mental Health.
- Public Mental Health Education Program.
- Coordinate the activities of various service sectors.
- Suicide prevention.
- Necessary treatment for those with drug habits.
- Make counseling, etc., available for sexual mental problems and those affected by OCD.
- Establish facilities such as day homes and old age care centers.

Level 5: Mental Health Centres

- Specialized services including rehabilitation programs.
- Human resource development – Clinical psychologists, psychiatric social workers, psychiatric nurses, etc.
- Medical education for health department staff at the district level.
- Training for administrators/training for trainers/leadership training.
- Research.
- Government cooperation.
- Defining/assigning responsibility for legal procedures related to the treatment of psychiatric patients.
- Rehabilitation and permanent stay of patients in mental health centers.
- Implementation of the District Mental Health Program.

Level 6: Medical Colleges

- **Comprehensive Mental Health Services:** Maintaining continuous child mental health and anti-addiction (de-addiction) activities.
- **Specialized Care:** Geriatric care, clinics for sexual and marital issues, and special clinics designed to alleviate mental stress.
- **Referral Support:** Providing referral assistance and coordination.
- **Education & Training:** Training for medical students and other postgraduate training related to psychiatric treatment.
- **Healthcare Professional Training:** Training for primary health center (PHC) staff and training for all medical practitioners.
- **Research:** Conducting psychiatric and mental health research.
- **NGO Support:** Providing encouragement and support to voluntary organizations.

- **Inter-Sectoral Coordination:** Integrating various sectors.
- **School & College Mental Health:** Programs specifically targeting schools and colleges.
- **Rehabilitation:** Implementing rehabilitation programs.
- Providing necessary assistance and support to mental health centers in times of need.
- Assessment of the District Mental Health Program.

Level 7: Institute of Excellence (Envisaged under National Medical Commission)

The **Institute of Excellence (IoE)** represents the highest tier of the Kerala State Mental Health Service Delivery Framework. It serves as the state's apex institution for advanced mental healthcare, academic leadership, research, innovation, policy development, and system strengthening. The Institute functions as the principal referral centre for highly specialized and complex mental health conditions while providing strategic direction for mental health services across Kerala. It also serves as the state's centre of excellence for developing evidence-based policies, evaluating programmes, and promoting innovation in mental healthcare.

The major roles and responsibilities of the Institute of Excellence include the following:

1. Higher-Order Comprehensive Mental Health Care

The Institute shall provide highly specialized, multidisciplinary, and quaternary-level mental healthcare for complex, treatment-resistant, and rare psychiatric disorders that require expertise beyond the scope of Medical Colleges.

Services should include:

- Advanced diagnostic evaluation
- Management of treatment-resistant psychiatric disorders
- Specialized psychopharmacology services

- Advanced neurostimulation therapies (such as Electroconvulsive Therapy (ECT), Repetitive Transcranial Magnetic Stimulation (rTMS), and other evidence-based neuromodulation techniques)
- Neuropsychiatry and behavioural neurology services
- Advanced child and adolescent psychiatry
- Geriatric psychiatry
- Perinatal mental health
- Forensic psychiatry
- Eating disorder services
- Complex addiction medicine
- Advanced psychotherapy services
- Crisis intervention and psychiatric intensive care
- Specialized rehabilitation for severe and persistent mental illness

The Institute shall function as the apex referral centre for the state and provide expert consultation for particularly challenging clinical cases.

2. Centres of Excellence in Subspecialty Mental Health Services

The Institute shall establish dedicated centres focusing on priority areas of mental healthcare.

These may include:

- Centre for Child and Adolescent Mental Health
- Centre for Addiction Medicine
- Centre for Suicide Prevention
- Centre for Geriatric Mental Health

- Centre for Women's Mental Health
- Centre for Neurodevelopmental Disorders
- Centre for Neuropsychiatry
- Centre for Psychosocial Rehabilitation
- Centre for Digital Mental Health
- Centre for Disaster Mental Health and Psychosocial Support
- Centre for Community Psychiatry

These centres shall promote specialized clinical services, training, research, and innovation.

3. Epidemiology, Mental Health Surveillance, and Data Intelligence

The Institute shall function as the nodal agency for mental health epidemiology and surveillance in Kerala.

Its responsibilities shall include:

- Conducting periodic state-wide mental health prevalence surveys
- Monitoring trends in mental disorders, suicide, self-harm, and substance use
- Establishing state mental health registries
- Developing surveillance systems for priority mental health conditions
- Monitoring emerging mental health challenges
- Identifying vulnerable populations and geographical disparities
- Supporting predictive analytics and early warning systems
- Integrating mental health data with state health information systems

The Institute shall generate high-quality epidemiological evidence to guide planning, resource allocation, and service delivery.

4. Policy Development and Advisory Functions

The Institute shall serve as the principal technical advisor to the Government of Kerala on matters relating to mental health policy, legislation, and strategic planning.

Responsibilities include:

- Providing evidence-based policy recommendations
- Supporting the formulation and periodic revision of the Kerala State Mental Health Policy
- Advising on implementation of the Mental Healthcare Act, 2017
- Developing state clinical practice guidelines and operational standards
- Preparing policy briefs and technical reports
- Advising on resource allocation and financing strategies
- Supporting legislative and regulatory reforms
- Facilitating interdepartmental policy coordination
- Representing the state in national and international technical forums

The Institute shall ensure that mental health policy remains evidence-based, rights-oriented, and responsive to emerging needs.

5. Programme Evaluation and Health Systems Strengthening

The Institute shall undertake independent evaluation of mental health programmes and provide strategic guidance for system improvement.

Key responsibilities include:

- Evaluation of the District Mental Health Programme (DMHP)
- Assessment of state mental health initiatives and flagship programmes
- Evaluation of service quality, accessibility, equity, efficiency, and effectiveness

- Monitoring implementation of policy objectives
- Conducting health systems and implementation research
- Developing quality indicators and performance benchmarks
- Identifying service delivery gaps and best practices
- Recommending programme modifications based on evidence
- Supporting continuous quality improvement across all levels of care

Programme evaluation shall inform future planning and strengthen accountability within the mental health system.

6. Advanced Education and Workforce Development

The Institute shall provide leadership in mental health education and the development of a highly skilled workforce.

Responsibilities include:

- Super-specialty and fellowship programmes
- Advanced multidisciplinary training
- Continuing Professional Development (CPD)
- Leadership training for mental health administrators
- Faculty development programmes
- Training of trainers (ToT)
- Capacity building for researchers and public health professionals
- Development of competency-based curricula
- National and international academic collaborations

The Institute shall support the continuous professional development of mental health personnel across the state.

7. Research, Innovation, and Knowledge Generation

The Institute shall function as the state's premier centre for psychiatric, public mental health, and health systems research.

Priority areas include:

- Clinical psychiatry
- Public mental health
- Community psychiatry
- Neurosciences
- Suicide prevention
- Digital mental health
- Artificial intelligence applications in mental healthcare
- Mental health economics
- Health policy and systems research
- Psychosocial rehabilitation
- Climate change and mental health
- Disaster mental health
- Precision psychiatry
- Translational neuroscience

Research findings should inform clinical practice, programme design, and public policy.

8. Technical Stewardship and Support

The Institute shall provide technical stewardship to all levels of the mental healthcare system.

Functions include:

- Development of clinical guidelines
- Standard treatment protocols
- Operational manuals
- Quality assurance frameworks
- Accreditation standards
- Clinical audit systems
- Technical mentoring for Medical Colleges and District Mental Health Programmes
- Tele-mentoring and specialist consultation
- Emergency technical support during disasters and public health emergencies

The Institute shall ensure consistency, quality, and standardization of mental healthcare throughout Kerala.

9. National and International Collaboration

The Institute shall foster partnerships with national and international organizations to promote excellence in mental healthcare.

Collaborative activities may include:

- Academic exchange programmes
- Multicentre research
- Joint training initiatives
- Technical cooperation with national institutes
- Collaboration with international agencies such as the World Health Organization
- Participation in global mental health networks
- Knowledge exchange and innovation partnerships

These collaborations shall facilitate the adoption of global best practices while adapting them to the local context.

10. Innovation, Digital Mental Health, and Emerging Technologies

The Institute shall promote innovation in service delivery through the adoption and evaluation of emerging technologies.

Key functions include:

- Development of digital mental health platforms
- Telepsychiatry networks
- Mobile health applications
- Artificial intelligence-assisted clinical decision support
- Electronic mental health records
- Digital therapeutics
- Remote monitoring systems
- Big data analytics
- Evaluation of innovative models of care

Innovation should be evidence-based, ethically governed, and accessible to all sections of society.

11. Advocacy and Strategic Partnerships

The Institute shall provide leadership in mental health advocacy and multisectoral collaboration.

Activities include:

- Statewide awareness campaigns
- Anti-stigma initiatives

- Human rights advocacy
- Collaboration with civil society organizations
- Support to service-user and caregiver networks
- Engagement with educational institutions, workplaces, and community organizations
- Promotion of mental health across sectors

These initiatives shall contribute to a socially inclusive and mentally healthy Kerala.

12. Monitoring, Quality Assurance, and Continuous System Improvement

The Institute shall lead the development of state-wide quality assurance mechanisms for mental health services.

Responsibilities include:

- Developing quality standards and key performance indicators
- Conducting external quality assessments and accreditation support
- Monitoring adherence to clinical and operational guidelines
- Establishing benchmarking systems across districts and institutions
- Publishing periodic State Mental Health Reports
- Supporting continuous quality improvement through audit, feedback, and learning collaboratives
- Guiding outcome-based revisions of programmes and policies

The Institute shall promote a culture of excellence, accountability, and continuous learning throughout the mental health system.

Conclusion

The **Institute of Excellence** serves as the **apex clinical institution** of Kerala's mental health system, providing leadership that extends beyond specialized clinical care to encompass **epidemiological surveillance, policy formulation, programme**

evaluation, advanced education, research, innovation, and strategic governance. By integrating quaternary clinical services with robust public health intelligence, evidence generation, and policy advisory functions, the Institute ensures that Kerala's mental health system remains scientifically rigorous, person-centered, equitable, and responsive to emerging challenges. As the state's highest technical authority in mental health, it drives continuous improvement, strengthens system resilience, and supports the realization of a comprehensive, recovery-oriented mental healthcare system for all citizens.

Level 8: Regulatory Body- Kerala State Mental Health Authority

Functions of SMHA

As per section 55 of the Mental Healthcare Act, 2017, the following are the functions of the State Mental Health Authority.

1. **The State Authority shall-**

    i. Register all mental health establishments in the State except those referred to in section 43 and maintain and publish (including online on the internet) a register of such establishments;

    ii. Develop quality and service provision norms for different types of mental health establishments in the State;

    iii. Supervise all mental health establishments in the State and receive complaints about deficiencies in provision of services;

    iv. Register clinical psychologists, mental health nurses and psychiatric social workers in the State to work as mental health professionals, and publish the list of such registered mental health professionals in such manner as may be specified by regulations by the State Authority;

    v. Train all relevant persons including law enforcement officials, mental health professionals and other health professionals about the provisions and implementation of this Act;

vi. Discharge such other functions with respect to matters relating to mental health as the State Government may decide:

Envisaged Roles and Functions

In light of the Mental Healthcare Act, 2017, the SMHA's role and functions have increased beyond the routine work of licensing as well as inspection of psychiatric hospitals/nursing homes. The following are the envisaged roles and functions of SMHA.

a. **Regulatory Role**

i. Making guidelines for ensuring minimum standard of quality for Mental health facilities providing mental health services like Long Stay Home (LSH) and Half Way Homes (HWH), General Hospital Psychiatric Unit (GHPU) and De Addiction centers

ii. Initiate setting of accreditation standards and processes for capacity building and training of mental health professionals of different competencies, such as counselors, general practitioners etc. Facilitate and encourage the delivery of mental health training by the NGO sector.

b. **Development of services**

i. Large scale awareness drive and sensitization about mental health problems and remedial measures; public awareness about issues like legal rights, mental health and illness and other related subjects

ii. Strengthening role in bringing about an attitudinal change among various stakeholders on the subject and treatment of mental health problem;

iii. Focusing on the role of NGOs in addressing homelessness problem of mentally ill with support from government bodies, legal authorities and police agencies;

iv. Strengthening role of NGOs as nodal agencies in monitoring, evaluation and continuous updated surveys of mental health issues;

v. Facilitating legal assistance to mentally ill patients and provide legal aid in conjunction with agencies like Legal Services Authorities

vi. Sensitization/orientation drive for police and judicial officers and other regarding mental health legislation & Mental Healthcare Act of 2017.

vii. Increase awareness and support advocacy for civil and political participation of people with mental illness in every day process of the society.

viii. Help the State Government draft the comprehensive State Mental Health Plan including mental health services, human resource development and long-term system of ongoing analysis and monitoring of mental health needs and services in the State.

ix. Have the mandate to prepare, implement, monitor and correct Standard Operating Procedures (SOPs) governing MHRBs, MHEs and other institutions coming under the Act

6.3 Need-Based Balance in Regional Resource Distribution

Priority must be given to regions that lack adequate mental health service facilities. The primary focus and effort should be directed toward establishing and strengthening these services in areas where they are currently inaccessible.

- Government cooperation.
- Defining/assigning responsibility for legal procedures related to the treatment of psychiatric patients.
- Rehabilitation and permanent stay of patients in mental health centers.
- Implementation of the District Mental Health Program.

6.4 Integrating the Public Health Department with the Primary Mental Healthcare Sector

This integration facilitates the provision of psychiatric treatment alongside regular medical care for individuals with relatively minor mental health disorders. It enables the

identification and treatment of mental health issues during routine medical examinations similar to physical illnesses. Furthermore, this creates opportunities for public health workers to understand how social and psychological factors contribute to ill health and suffering. The Mental Healthcare Act mandates a shift from specialized, isolated institutional care to generalized public healthcare systems. Under **Section 18(5)(a)**, the appropriate Government is legally obligated to:

- **Integrate mental health services into general healthcare services** at all levels of care.
- This explicitly includes integrating services into **Primary Health Centres (PHCs)**, Community Health Centres (CHCs), and secondary-level district hospitals alongside routine physical medical care.

2. Geographic and Financial Accessibility

Primary care acts as the first line of defense. The Act mandates that the government ensure mental healthcare is: **Geographically accessible** to all citizens, minimizing the need to travel long distances to major psychiatric institutions. **Affordable and available** in sufficient quantities at the primary care level, ensuring basic outpatient services and essential psychiatric medications are handled locally.

To ensure primary care facilities can safely identify and manage mental illnesses, the Act places clear training mandates on the state government to guide this policy. Therefore the following will be done:

- The government must implement systematic programs for **training primary health professionals** (including PHC medical officers, nurses, and community workers).
- This ensures that frontline doctors can screen for, diagnose, and manage common mental disorders without requiring immediate specialist intervention, effectively linking primary care with the broader goals of the District Mental Health Programme (DMHP).

6.5 Linking with Community Development Programs

A key approach is to involve more social welfare workers at the state, district, and block levels in the implementation of the mental health program. Community intervention is essential in efforts to prevent and rehabilitate issues such as alcohol and drug abuse, criminal tendencies/behavioral problems observed in children and adolescents, and the avoidable side effects of rapid social changes. Further studies are required regarding the indispensable factors and socio-psychological issues associated with these activities.

A development style that encompasses all spheres of social life—including education, housing construction, urban planning, and law enforcement—must be shaped in the future. Therefore, research and study activities are necessary to raise awareness and technical knowledge of comprehensive mental healthcare among those working across all these sectors.

6.6 Various Sectors Related to the Mental Health Action Plan, Their Scope, and Extent of Operation

This service sector includes sub-programs such as **treatment, rehabilitation, and disease prevention**.

Treatment

The focus of the treatment program is on those affected by the illness. Treatment guidelines consistent with the respective treatment methods must be prepared under the supervision of a committee comprising the **Branch of the Indian Psychiatric Society, Kerala**, the organization of clinical psychologists, the Psychiatric Social Workers Association, and representatives of those engaged in other medical systems such as Ayurveda and Homeopathy. This should be implemented at the local level as described below.

a) Treatment at the Sub-Center Level in Rural Areas

Necessary training must be provided to public health nurses, supervisors, ASHA workers, and members of Kudumbashree/Janashree. Under the supervision and assistance of the

Medical Officer, the following tasks must be carried out within the community falling under their operational jurisdiction:

1. **Handling psychiatric emergencies:** (e.g., sudden mental agitation/acute psychological distress). For this purpose, mild medications and technical methods may be utilized as per the doctor's instructions.
2. **Follow-up treatment:** Continuous follow-up treatment for long-term chronic patients must be conducted under the supervision of supervisors.
3. **Support, counseling, and referral:** Act as a link between children affected by behavioral disorders, intellectual disabilities, etc., and their teachers to work toward solving their problems. Seek solutions through counseling for issues related to alcohol consumption, drug abuse, etc. These responsibilities can be carried out using simple practical guidelines recommended by periodically updating the psychiatry-related sections in the training manual for PH [Public Health] Nurses. The difficulties directly encountered in executing each responsibility must be clearly identified, and problems that do not fall within the scope of one's own capability must be referred to a higher level for expert service.

b) Primary Health Centre

4. Training must be provided to Medical Officers on the following matters:
5. **Supervision:** Supervise to ensure that the designated mental health action responsibilities are being carried out by subordinate staff with their assistance.
6. **Evaluation:** Conduct neurological examinations and mental health assessments in accordance with pre-prepared guidelines to diagnose mental health issues. Evaluate each case.
7. **Treatment of functional psychosis**.
8. **Treatment of psychiatric complications** following physical illnesses like malaria and typhoid, mild or somewhat severe depression, emotional disorders, early-stage functional psychosis, etc.

9. **Resolve mild psychological distress/stress** associated with problems in social life without the aid of medications.

10. **Conduct observations and studies** regarding illnesses occurring in each respective locality in connection with its specific social environments, evaluate them, compile the findings, and submit them to higher authorities in a manner that helps plan future action programs in a timely manner. Just as in the case of health workers and supervisors, Medical Officers must also function on the basis of guidelines. Cases that do not fall within the scope of one's own capability must be referred to higher institutions.

c) Taluk Hospital

11. Since the Taluk Hospital is an effective link that exists to integrate mental health activities at various levels between Primary Health Centers and District Hospitals, the services of a psychiatrist must be made available at these centers. It must function as a first-level referral institution. Along with other activities, these institutions also have the responsibility to assist Primary Health Centres in providing treatment for complex (recalcitrant/treatment-resistant) illnesses.

12. **Provide treatment for severe mental illnesses.** The psychiatric departments in District Hospitals, Medical Colleges, and Mental Health Centres will serve as referral institutions for Taluk Hospitals. Those who require more expert services must be referred to the said institutions.

d) District Hospitals

13. Since District Hospitals are an integral component of district-level health services, the services of psychiatry specialists are absolutely essential here. The primary services are:

14. **Provide necessary medical guidance** to doctors working at the primary care level regarding problems associated with severe mental illnesses.

15. **Inpatient treatment:** Admit and treat individuals suffering from severe emotional disturbances, eating disorders, those who need to take high doses of medication

within a short period, those with severe brain-related diseases, and those who require shock therapy (ECT). There should be 30–60 beds under the control of the psychiatric department.

16. This institution must maintain a link with Mental Health Centres and the psychiatric departments of Medical Colleges .must be maintained. District Hospitals must also have referral facilities to these higher institutions.

e) Mental Health Centres and Medical Colleges

17. The activities of these higher institutions must be dynamic in a way that supports the activities taking place at the regional level. Specialized treatment required for illnesses that are difficult to cure must be conducted at this level. Expert treatment facilities such as occupational therapy units, group therapy units, marital counseling, and behavior therapy must be available in these institutions.

18. Currently, these institutions exist solely as higher treatment facilities. In addition to that, these institutions must also take up and conduct the responsibility for all types of mental health education programs. Necessary training must be provided to psychiatrists who have to bear the responsibilities of mental health programs. It is also their responsibility to record and preserve all details related to treatment programs.

19. The action plan described above demonstrates that specialist doctors need a working style that elevates them from the level of a mere practitioner or clinical specialist to a leader who provides guidance for higher-level state mental health activities. A larger portion of the expenses incurred for hospital-level treatment should be directed toward training programs and the training and supervision of non-specialized personnel engaged in primary health activities will have to be spent. Therefore, these subjects must also be included in the training curriculum for specialists.

(f) Rehabilitation Program

20. This is a program intended for those who require long-term medical care. Individuals affected by severe mental illnesses and those suffering from epilepsy fall under this

category. This is a community-based program. Daycare homes (pakal veedukal) must be established at the block panchayat level. The block panchayats must take the lead in this activity. Assistance will be available from the district chapter of the organization 'World Association for Psychosocial Rehabilitation' (WAPR).

21. In addition to that, the help and cooperation of mental health experts, relatives and guardians of long-term mental health patients, local socio-cultural-religious-educational organizations, and Primary Health Centres must be coordinated. The cooperation of mental health hospitals and psychiatric units in district hospitals must be maintained. The services of these institutions, acting as referral centers, must continue to be available to rehabilitation centers. Institutional rehabilitation centers must be established at the district level. High-quality rehabilitation centers centered around top-tier referral institutions must be set up at all levels.

22. The Government of Kerala implements a robust network of psychosocial and mental health rehabilitation programs aimed at integrating cured, partially cured, and destitute individuals back into mainstream society.

23. These initiatives are executed through the **Social Justice Department (SJD)** and the **Health and Family Welfare Department**, operating across multiple structural levels from community-based initiatives to specialized state-run institutions.

1. State-Run Rehabilitation Homes (Asha Bhavans)

24. The Social Justice Department directly runs **Asha Bhavans**, which serve as dedicated rehabilitation centers for individuals who have been cured or partially cured of mental illnesses but have been abandoned or lack a support system.

25. **Target Group:** Destitute individuals discharged from Government Mental Health Centres who are fit for community reintegration.

26. **Locations:** There are six Asha Bhavans across the state, operating in districts including **Thiruvananthapuram, Ernakulam, Thrissur, and Kozhikode**.

27. **Services:** They provide free accommodation, medical supervision, counseling, and human rights protection while actively preparing residents for mainstream life.

2. Institutional Care for the Intellectually Challenged

28. For individuals requiring long-term care due to intellectual and mental challenges, the SJD operates specialized care homes:

29. **Pratheeksha Bhavan (Thavanur, Malappuram):** A government-run care home dedicated to the rehabilitation of mentally challenged men.

30. **Prathyasa Bhavan (Thrissur):** A parallel state facility specifically serving mentally challenged women.

3. The Pratheeksha Scheme (Public-NGO Partnership)

31. To address overcrowding in state facilities, the Kerala Government utilizes the **Pratheeksha Scheme** to collaborate with registered non-governmental organizations (NGOs).

32. Under this framework, the government provides financial grants to credible, NGO-run Psycho-social Rehabilitation Centres.

33. The fund assists in covering the annual costs of food, medicine, clothing, and personal hygiene for orphaned or destitute individuals who fall under the RPwD Act 2016.

4. Rehabilitation for Acquitted & Undertrial Prisoners

34. Kerala has introduced a specialized rehabilitation scheme targeting vulnerable individuals within the legal system—specifically **undertrial prisoners with mental illness** and **persons acquitted by courts on grounds of mental illness** who continue to reside in health centers.

35. This program transitions individuals from psychiatric hospitals to approved, NGO-run psycho-social rehabilitation centers.

36. Backed by state funding, it ensures targeted financial assistance per resident to provide a safe, structured, and rehabilitative environment.

5. Community & Preventive Support Systems

Program	Nodal Agency / Level	Primary Focus
Pakal Veedukal (Daycare Homes)	Local Self-Governments (Block Panchayats)	Community-based day rehabilitation and family respite care for chronic patients.
District Mental Health Programme (DMHP)	Primary Health Centres (PHCs) to District level	Integrating follow-up care, psychiatric emergency management, and community interventions at the grassroots level.
Sahajeevanam Help-Desks	Block Support Centres	Doorstep delivery of government services, immediate assistance, and mental distress support for the differently-abled.
Jeevani Project	Directorate of Collegiate Education	Specialized mental health and counseling centers operating across state Arts and Science colleges.

(g) Disease Prevention Program

37. This is a highly important and community-based field of activity among various mental health service programs. It includes providing scientific guidance and direction to those who come forward with a willingness to serve in the field of mental illness prevention.

38. The vision is to reduce risk factors by strengthening disease prevention activities.

(h) Universal Prevention Measures

39. Everyone in society must be mobilized for these activities so that they benefit all people, not just those who are identified as mental health patients. Just as universal disease prevention vaccination programs and other initiatives are currently being carried out with immense social cooperation to prevent other diseases, a strong community-based disease prevention program must be formulated with the objective of preventing mental illnesses, and its protection must be made available to everyone, including newborn babies. Programs that prevent damage to the brain, promote the use of helmets, and encourage the abstinence from alcohol and drugs are measures that prevent the possibility of mental illness.

(i) Specialized Programs

40. Specific situational risks exist for certain individuals and groups to develop mental illnesses. Special model intervention systems must be developed for the protection of such people. Children born with a lower-than-average birth weight must be examined by visiting them at homes and daycare centers. Special nursery programs must be planned for children belonging to poor segments in nearby localities. Special care systems must be set up for the elderly and those affected by severe physical illnesses such as AIDS and cancer. These are some of the areas mentioned where specific interventions are necessary to prevent mental illnesses.

(j) Targeted Interventions

41. This action program is intended for individuals who manifest identifiable, yet minor/low-level symptoms of mental illness. This working method has proven to be

effective for conditions such as alcohol addiction, behavioral disorders, depressive illness, suicide attempts, schizophrenia, and Alzheimer's disease.

42. NHM financing enabled the DMHP to roll out structured societal programs beyond clinic walls:

- **Amma Manassu:** A tailored program integrating mental health tracking directly into maternal and child healthcare, focusing on detecting and managing perinatal/postpartum depression.
- **School & Adolescent Initiatives (Thalir):** Regular training for class teachers, enabling early identification of learning disabilities, substance abuse issues, or behavioral changes in school children, coupled with direct referral links to the district psychiatric team.

6.7 Promotion of Mental Health

43. This sector comprises action programs aimed at resolving disillusionment/frustration and mental stress, restoring individuals to their original state, and enhancing their capacity and strength to face problems. Services must be provided to increase the competence, functional capacity, sense of security, and self-esteem of not only individuals but also of society as a whole

6.8 Mental Health Training Program

44 There are currently an insufficient number of mental health experts in our state to deliver all necessary services and carry out all responsibilities associated with mental health activities. Alternative ways are being explored to address this shortage. The first among the practical solutions is to train and include regular doctors who are currently in service into this field of activity. They should be trained so they gain the capability to perform the activities detailed above within their respective operational jurisdictions. The essential matters related to their responsibilities must be introduced to them. However, in the future, arrangements must be made to ensure that doctors, nurses, and other paramedical category staff receive training on this subject during their course of study itself for future activities. The training they currently receive is highly inadequate. During

a five-year medical education period, the time allocated for psychiatry study is a mere four weeks. Changes must be made to the content of medical education as quickly as possible. Newly graduated doctors must also be able to identify and manage mental health problems within the community.

45 The matter of nursing education deserves equal importance, and necessary mental health knowledge must be included in their study and training curriculum. Staff associated with the administration of the public health sector, employees in various departments of Primary Health Centres, judges, and law enforcement personnel must also receive training tailored to the requirements of their respective operational fields. These study and training programs will prove to be an asset for future mental health action programs.

6.9 Substance Dependence / Drug Addiction

46 Those who become dependent on alcohol and drugs often develop various types of psychological disorders. Many of these tend to be chronic/persistent, and even if they subside temporarily, they recur frequently, resulting in mental and physical disabilities. Safe and effective de-addiction treatment can only be carried out in institutions equipped with expert supervision and specialized treatment methods. From the perspective of it being a public health issue

47 The Government of Kerala has fundamentally shifted its approach to alcohol and substance use disorders, building a strategy that treats addiction as a complex public health challenge rather than an isolated law-and-order issue. In mid-2026, the state government launched aggressive, whole-of-government campaigns that combine modern tech infrastructure, heavy law enforcement, and expanded local healthcare integration.

1. Project 'Mayangilla Keralam' & India's First Digital Vigilance Portal

48 Launched in late June 2026, **Mayangilla Keralam** is the flagship anti-drug and multi-sectoral campaign introduced by the Kerala State Excise Department. The core objective balances heavy enforcement with community prevention, scientific treatment, and structural rehabilitation.

49 **The Janajagratha Portal & App:** As part of the campaign, the state launched India's first public digital anti-drug coordination platform. This tool allows citizens to securely and anonymously report cross-border trafficking and local sales. It also provides online self-assessment tests for substance use and immediate online registration for treatment and counseling.

50 **Preventive Infrastructure:** Under this umbrella, anti-narcotic clubs are expanded in schools alongside *Shradha-Nerkoottam* student vigilance committees in colleges to catch early signs of addiction.

51 **Enforcement Upgrades:** Concurrently, the state announced a dedicated **State Narcotic Control Bureau** within the Excise Department and is constructing automated, laboratory-grade "Model Excise Offices" to eliminate operational delays.

2. Operation Toofan: The Narco Hunt

52 While *Mayangilla Keralam* focuses on public integration and awareness, **Operation Toofan** (launched June 2, 2026) is the sweeping law-enforcement offensive run by the Home Department and Kerala Police.

53 **Interstate Crackdown:** Formulated to dismantle cross-border drug syndicates supplying synthetic drugs like MDMA, Operation Toofan relies heavily on a joint command structure among South Indian states. Kerala instituted a permanent interstate coordination mechanism with Tamil Nadu, Karnataka, and Puducherry using dedicated SP-rank nodal officers.

54 **Medical Regulation:** Operation Toofan mandates joint inspections by the health department and police at medical pharmacies to strictly prevent the unauthorized over-the-counter sale and misuse of prescription medicines with narcotic potential.

55 **Legal Swiftness:** The operation has seen the deployment of the *District Anti-Narcotic Special Action Force (DANSAF)* and accelerated the setup of specialized NDPS courts in Thiruvananthapuram and Ernakulam to clear cases without standard legal delays.

3. The Expansion of Vimukthi De-Addiction Centres

56 The **Vimukthi Mission**, originally launched in 2016 under the Excise Department, remains the foundational medical arm for free treatment and counseling. To cope with the evolving influx of synthetic drug addiction, the state is undergoing an aggressive decentralization and clinical overhaul of the system:

57 **Expansion to All Taluks:** Historically operating as 14 specialized district-level inpatient wards, the government is expanding dedicated de-addiction and counseling facilities to **all Taluk Hospitals** across the state with an envisioned number of 77 inpatient wards. These will be manned by psychiatric professionals and other Mental Health Professionals (MHPs)

58 **Upgrading Treatment Protocols:** Vimukthi centers have shifted from general, rigid fixed-dose medical treatments to localized Standard Operating Procedures (SOPs). Centers now implement risk stratification protocols (low, intermediate, and high-risk categorization) and nurse-administered CIWA-Ar rating systems for inpatient alcohol and drug withdrawal management, dramatically optimizing patient recovery and safety.

59 **Social & Vocational Reintegration:** Discharged patients from Vimukthi units are mapped into localized rehabilitation packages. Through local block panchayats and sports organizations, the government provides job-readiness skill development, self-employment financial grants, and family support counseling to prevent relapses.

6.10. Other Mental Health Programs and Services Across Ministries

This intense fragmentation ensures that a single citizen experiencing complex psychological distress might interact with five different ministries, none of which share patient records, standardize diagnostic criteria, or pool their budgetary allocations to ensure a unified continuum of care.

Government Department	Operational Mental Health / Psychosocial Programs	Primary Limitations of the Siloed Approach
Health & Family Welfare	DMHP, Aardram clinics, Tele-MANAS, IMHANS.	Severe human resource deficits; strictly reactive institutional care.
Higher / Collegiate Education	Jeevani (Psychology apprentices in colleges).	Lacks direct clinical referral pathways to psychiatric hospitals.
Home / Kerala Police	D-DAD (Cyberdome), Chiri, Operation Toofan.	Blurs lines between penal enforcement and clinical therapy; unregulated counseling standards.
Excise	Vimukthi Mission, Mayangilla Keralam, Unarvu.	Operates a parallel health system independent of medical directorates.
Social Justice	Vayomithram (elderly care), Snehapoorvam.	Psychosocial care is secondary to generalized welfare distribution.
Women & Child Development	ORC, Childline, Makalkkoppam.	Interventions are highly localized and lack long-term psychiatric follow-up.

6.10 Private Sector

60 The private sector has a major role to play in the success of the mental health care sector in the state. They can effectively carry out the following activities: emergency interventions, rehabilitation programs, and services for the elderly and street children. It is also worth remembering at this juncture that a large majority of our society prefers private medical services. Today, institutions in this sector providing treatment can be classified into four types:

a) General hospitals

b) Upper middle-level hospitals

c) Upper-level hospitals

d) Private psychiatric hospitals and nursing homes.

61 The number of private institutions in the field of psychiatric treatment needs to increase further. Encouragement should be given to expand their services to this area as well.

62 A consensus on this matter should be reached through discussions with organizations like the Branch of the Indian Psychiatric Society Kerala State, Qualified Private Medical Practitioners Association (Q.P.M.P.A) and the I.M.A. This primarily concerns the following points.

63 As far as psychiatric care is concerned, more facilities need to be developed in the private sector. Training facilities related to the mental health field must also be made available to workers in the private sector.

64 They should be able to participate in relevant action programs. Alongside this, they must also have participation in various social welfare programs.

General Medical Sector

65 Maladjustments in daily life often cause strong emotional problems to manifest as physical symptoms. It is estimated that about 20% of patients who seek care from general

medical doctors fall into this category. In reality, this is a mental health issue. We need to find ways to resolve it.

66 The content of our medical education curriculum has not given the deserved importance to subjects related to psychiatric treatment. As a result, such patients bear an unnecessary burden. Their diagnosis often goes wrong. Not only that, they are subjected to unnecessary multiple tests and forced to take medications that offer no benefit. Often, they are referred to various other institutions. It is not just the patients, but their relatives too, who end up bearing this burden.

67 Doctors themselves tend to develop an aversion toward such patients whose illness does not improve no matter what is done. This is a situation that is disgraceful to the existing system of medical care itself.

68 Providing psychiatric training to doctors in the general medical sector is an effective way to resolve this problem. Through training, they acquire the skills to treat mental illnesses to some extent during emergencies and to provide the necessary follow-up care. A majority of the doctors in this category have already gained the trust of patients as family doctors. As far as treatment is concerned, this is a crucial factor.

69 Utilizing this circumstance, it is possible to provide health education to the patient's family members, foster a cooperative attitude within the family toward the patient, and strengthen his social relationships.

Medium-level Hospitals

70 Multi-specialty hospitals should be encouraged to undertake treatments related to psychiatric illnesses as well. These institutions should be encouraged to take up emergency treatment required for psychiatric patients, childhood/adolescent/geriatric mental health problems, rehabilitation activities, and so on.

Tertiary Care Hospitals

71 Large hospitals falling under this category can take the lead in activities that require specialized services in many areas. These institutions can effectively perform specialized

services in areas such as liaison psychiatry, child psychiatry, geriatric psychiatry, and de-addiction treatment, in collaboration with other branches of medicine.

Private Psychiatric Hospitals/Nursing Homes

72 The private sector should be encouraged to establish and run psychiatric hospitals, nursing homes, and rehabilitation centers within the scope of the Mental Healthcare Act of 2017.

6.11 Psychotherapy and Counselling Centers

73 Counseling is a field in which people have placed a great deal of trust within the field of psychiatric treatment. Counseling centers are springing up like mushrooms across the state. Unfortunately, in most centers, counseling is conducted by those who lack the necessary training or educational qualifications. The unscientific counseling provided by such individuals can cause serious, harmful effects on the mental health of the general public.

74 Therefore, a registration system should be implemented for such centers to ensure the quality of service in counseling centers related to the field of psychiatric treatment and to ensure the educational qualifications of counselors.

75 To transition from unscientific practices to evidence-based, structured care, regulatory mechanisms must enforce accountability across standard clinical operations, institutional enrollment, and practice-based scientific rigor.

1. Statutory Enrolment under the Clinical Establishments Act (CEA)

76 The **Clinical Establishments (Registration and Regulation) Act** provides a powerful mechanism to standardize mental health facilities. Integrating counseling and psychotherapy centers into the CEA framework involves specific mandatory benchmarks:

77 **Mandatory Registration:** All independent clinics, therapy centers, and counseling spaces must be legally registered under the respective state-level Clinical Establishments Act councils.

78 **Defining Minimum Infrastructure Standards:** Centers must comply with physical norms specified by the council, including verified privacy protocols (soundproof rooms), safe physical infrastructure, and standard maintenance of electronic or paper case records.

79 **The "Consultation" Loophole Fix:** In states where purely "consultation-only" services have historically escaped local medical facility regulations, amendments must explicitly classify specialized psychological therapies (like Cognitive Behavioral Therapy or trauma care) as clinical interventions requiring strict oversight.

80 **Anti-Quackery Safeguards:** Under the CEA, facilities are penalized if they employ individuals who do not possess verified credentials from recognized national bodies.

2. Harmonization with the Mental Healthcare Act (MHCA), 2017

81 While the CEA controls infrastructure and business licensing, the **Mental Healthcare Act, 2017 (MHCA)** governs clinical rights and operational standards. To deliver scientific care, counseling centers must be aligned with the following MHCA bodies and mandates:

82 **Registration with State Mental Health Authorities (SMHA):** Any establishment providing mental health care—including psychosocial interventions and rehabilitation—must be officially registered with the SMHA.

83 **Oversight by Mental Health Review Boards (MHRBs):** Districts utilize MHRBs to handle patient grievances. Counseling centers must display information regarding these boards so patients can immediately report deficiencies in service or ethical breaches.

84 **Stringent Patient Rights Management:** Facilities must operationalize statutory patient protections, strictly enforcing:

85 **Informed Consent:** Clearly stating the scope, potential distress, and methods of the therapy before starting.

6.12 Non-Governmental Organizations

86 Non-governmental organizations operating in the field of treatment possess vast capabilities. They are organizations capable of designing innovative service methods in

mental health-related social service sectors such as the rehabilitation required for psychiatric patients, family education, fostering family cooperation, geriatric care, suicide prevention, and awareness programs against alcohol/drug abuse and domestic violence.

87 Non-governmental organizations should be encouraged to formulate and implement new programs in the mental health service sector. Private voluntary organizations and non-governmental organizations are movements that have long functioned by integrating into public life and addressing people's local needs of the people.

88 As far as the health sector in Kerala is concerned, there is a large workforce in this sector that has acquired special qualifications and skills. Their acceptance among the public is high because they provide effective services at minimal cost and maintain an informal approach of their operations. These movements should also be included in the mental health program to give greater momentum to the government's efforts.

89 The government and non-governmental systems currently operating in this field should be identified and documented, along with their strengths and shortcomings. A vast network that includes everyone must be formed. The training currently being provided to doctors and other categories of staff working in the private sector should also be extended to them.

6.13 Other Medical Science Systems Operating in the Mental Health Field

90 Other systems of medical science, such as Ayurveda, Homeopathy, and Unani, have been functioning for a long time, providing highly important services in the field of psychiatric treatment. All of these medical systems enjoy acceptance among the general public.

91 They should also be encouraged to conduct psychiatric treatment along with their regular medical treatments. Encouragement should be given to these systems to run intermediate hospitals and psychiatric hospitals. Alongside this, the quality standard of each respective medical system must also be evaluated.

92 Efforts should also be made to develop a health care style that aligns the mental health field with our way of life and culture.

Ayurveda

93 Treatment for mental illness is available in Ayurveda, which is India's own indigenous system of medicine. The health principles advanced by this science should be incorporated into the Ayurvedic mental health education program. Training should be provided to doctors, nurses, and other categories of paramedical staff on mental health treatment methods related to the Ayurvedic medical system.

94 Referral and medical assistance facilities should be made available to the Ayurveda system from government mental health hospitals.

95 Mental health departments with all necessary treatment facilities should be made functional in Ayurveda colleges and Ayurveda district hospitals. A unit should have at least ten beds. Topics related to mental health should be included in the curriculum at graduate and postgraduate levels.

96 Steps should be taken to ensure that the services of psychiatric social workers, clinical psychologists, and others are also made available within this system of medicine.

97 Evaluation and research into various treatment methods within the Ayurvedic system of medicine should be developed.

Homeopathy

98 Mental health topics should be included in Homeopathy at the graduate and postgraduate levels of medical education. Mental health treatment units should be started in Homeopathic medical colleges.

99 In addition, postgraduate courses in mental health treatment should be offered at these institutions. Referral and medical assistance facilities should be made available to the Homeopathy system from government mental health hospitals.

100 Research and quality evaluation should also be ensured in this field.

6.14. Role of Mental Health Professionals (MHPs)

Clinical Psychologists

101. Clinical psychologists are allied health professionals who have a major role to play in fields such as mental illness prevention, treatment, and rehabilitation. They can also energize community-based, school-based, and workplace-based disease prevention activities as well as social awareness programs. As professionals who have achieved expertise in subjects like psychometric analysis, psychotherapy, and behavior therapy, and as members of the mental health treatment team, they can contribute to developing new treatment strategies in these areas and improving the quality of existing treatment facilities. They can also organize rehabilitation activities, training programs, and awareness programs.

Psychiatric Social Workers

102. Psychiatric social workers are allied health professionals who hold an important position within the mental health treatment team. They have a vital role in formulating and implementing mental health rehabilitation projects. They can design and execute social awareness programs regarding subjects like marital health, domestic life, and child-rearing (parenting). Furthermore, they can work among children and youth to shape activities that develop their personality and interpersonal relationships, as well as organize awareness and vigilance programs against the abuse of alcohol and drugs and they can also act as a link that connects the field of mental health treatment with society.

Mental Health Nurses

103. Mental health nurses serve as critical partners in a patient's recovery journey, providing holistic care that spans clinical, therapeutic, and advocacy roles. They are responsible for conducting comprehensive mental health assessments and monitoring patients' psychological and physical well-being, which includes the careful administration and oversight of psychotropic medications. Beyond clinical tasks, these nurses build essential therapeutic relationships with patients, offering emotional support, crisis intervention during periods of acute distress, and education to help

individuals and their families manage symptoms effectively. They act as vital members of multidisciplinary teams, coordinating care across various health services while acting as staunch advocates for their patients' rights and the reduction of mental health stigma. Their primary scope involves supporting patients in diverse environments ranging from hospitals to community settings.

7

Co-operation and Co-ordination with Various Sectors

7.1 Integration with Public Health.

The mental health sector must be further integrated with the existing public health sector with complete coverage across all centres. There must be very close co-operation between experts working in the mental health field and those in other fields. Proper representation of the mental health sector must be ensured in health and welfare activities throughout the state.

7.2 Co-operation with Social Welfare Activities

There are many matters that require working in very close co-operation with social welfare programs. A social welfare worker might have to refer certain patients to a primary health centre doctor or elsewhere. Similarly, the respective medical officer might have to refer patients or their relatives to social welfare workers for other necessities. It is essential that these two groups cooperate in the field of mental health activities. Currently, the majority of mentally ill patients do not receive the eligible benefits under the RPwD Act 2016. The main reason for this is the lack of awareness among patients, their relatives, and employees of the local self-government department. Therefore, awareness programs are necessary for these groups.

7.3 Integration with School Health Programmes

Students' learning problems and social-behavioral patterns are emerging as key components of school health activities. Teachers should be getting continued training to identify important mental health problems seen in children at the initial stage itself.

Children with learning disabilities need to be identified and provided with the necessary special attention and training. For this purpose, the services of teachers who have received required training in this subject must be made available in all schools. There should be uniformity in assessing and certifying the degree of learning disability in such children.

The services of expertly trained counselors must be made available in all schools and colleges to identify children and adolescents with behavioral disorders and to provide them with the necessary counseling.

Facilities to provide necessary life skills training for students, teachers, and parents in educational institutions should be made available, and this subject should be included in the curriculum starting from the primary level itself.

To put these objectives into practice, the Health Department and the Education Department must work in coordination. Technical assistance for this can be made available from the District Mental Health Programme.

7.4 Linking Medical Colleges and Mental Health Centres with Social Activities

Medical colleges and mental health centres should be connected with social activities. They should serve as higher-level referral institutions to provide specialized treatments for

patients with complex conditions. Study and training activities must also be conducted in these institutions. These institutions should take up the responsibility of integrating everything, including the social factors related to mental health activities, to transform it into a comprehensive mental health programme. Postgraduate training should be conducted in medical colleges and mental health centres, including institutes.

They should also work in collaboration with research and study organizations and projects at the state, national, and international levels.

7.5 Periodic Reviews and Evaluations

This outline (policy) regarding the mental health action programme should be considered as a guideline. The mental health programmes implemented as part of this need to be reviewed, and necessary changes must be made from time to time based on the policy cycle.

The development activities of our state have reached different areas in various ways. Therefore, when implementing the projects, different types of regional adjustments will be necessary.

Periodic Review to be Outcome Based

Outcome Assessment

Outcome assessment evaluates whether policy implementation is achieving intended public health goals.

Outcome evaluation should measure:

Health outcomes

- Reduction in untreated mental illness
- Increased treatment coverage
- Improved recovery rates
- Reduced suicide rates
- Improved quality of life
- Reduced disability

System outcomes

- Improved accessibility
- Reduced waiting time
- Improved continuity of care
- Better referral systems
- Increased workforce capacity

Social outcomes

- Reduced stigma
- Improved community participation
- Increased employment among persons with mental illness
- Enhanced educational participation
- Greater social inclusion

Outcome assessments should employ:

- Population surveys
- Facility assessments

- Patient satisfaction studies
- Independent evaluations
- Research collaborations

Both quantitative and qualitative methods should be used.

Outcome-Based Revisions

Evaluation findings should directly inform policy improvements.

Outcome-based revision ensures that policy evolves based on actual performance rather than assumptions.

Revision triggers may include:

- Poor programme performance
- Emerging disease patterns
- New scientific evidence
- Legislative changes
- Technological innovations
- Community demands
- Public health emergencies
- Economic changes

Examples include:

- Expansion of digital mental health
- New suicide prevention strategies
- Integration with primary healthcare reforms
- Climate-related mental health interventions
- Disaster mental health preparedness

Policy revisions should follow a documented version-control system to maintain transparency and institutional memory.

Continuous Quality Assurance

Continuous Quality Assurance (CQA) is the overarching process that sustains excellence throughout the policy lifecycle. Rather than a single phase, it functions across all stages—from formulation to implementation and revision—promoting a culture of learning, accountability, and improvement.

Key elements include:

Governance and Accountability

- Establish quality assurance committees at state and district levels.
- Define clear roles and responsibilities for policy implementation.
- Conduct regular performance reviews and public reporting.

Standards and Guidelines

- Develop and periodically update clinical and operational standards.
- Ensure adherence to national legislation and international best practices.
- Promote standardized care pathways and service protocols.

Performance Measurement

Monitor quality indicators such as:

- Accessibility and equity of services
- Service utilization rates
- Continuity of care
- Patient safety
- Human rights compliance

- User satisfaction
- Workforce competency
- Financial efficiency

Audits and Accreditation

- Conduct periodic internal and external audits.
- Promote accreditation of mental health facilities.
- Benchmark services against state, national, and international standards.

Research and Innovation

- Encourage implementation research.
- Support operational research through academic collaborations.
- Pilot innovative service models and evaluate their effectiveness.
- Integrate digital health technologies and data analytics to improve service delivery.

Learning Health System

Develop mechanisms to:

- Capture lessons learned from implementation.
- Disseminate best practices across districts.
- Foster communities of practice among professionals.
- Build institutional memory through documentation and knowledge-sharing.

Community and Service User Participation

Ensure continuous engagement of:

- Persons with lived experience
- Caregivers

- Community organizations
- Civil society groups
- Local self-governments

This participatory approach enhances accountability, transparency, and responsiveness to community needs.

7.6 The necessary provisions for the effective implementation of the Mental Health Care Act 2017 and Central Mental Authority Rules and Regulations and State Mental Authority Rules and Regulations and National Mental Health Program should be included in the legislation related to mental illness.

8

Research

Mental health programmes implemented on the basis of the mental health policy should be subjected to continuous monitoring and research activities. Such an approach is essential to make these activities successful. Monitoring should mainly focus on four areas. These are disease data collection, preventive measures, service delivery systems, and quality. In addition, attention must be focused on the training provided to workers at various levels, the quality of services received from them during practical implementation, and their efficiency.

Considering the scarcity of resources in our country, the balance between research and practical activities must be taken into account. The financial assistance required for the successful implementation of modern research activities needs to be made available. A large project like the mental health programme will also require collaboration with various research institutions at the international level, in addition to state and central assistance.

Research activities are to be conducted in the following manner:

1. Identify the nature and extent of the major mental health problems existing in the society and the resulting impact on the society.
2. Identify and document the factors that lead to mental health problems and those that prevent them.
3. Formulate and implement the necessary practical action programs for this and scientifically analyze the results of these studies.

4. Identify needs in Service Delivery Pathway to better Streamline Services.
5. Conducting periodic state-wide mental health prevalence surveys
6. Monitoring trends in mental disorders, suicide, self-harm, and substance use
7. Establishing state mental health registries
8. Developing surveillance systems for priority mental health conditions
9. Monitoring emerging mental health challenges
10. Identifying vulnerable populations and geographical disparities
11. Supporting predictive analytics and early warning systems
12. Integrating mental health data with state health information systems
13. Based on the conclusions of the practical studies, analyze the outcomes of formulating and implementing large-scale community-based programs.
14. Comprehensively analyze and make corrections at every stage regarding matters, including the economic evaluation of mental health projects implemented on a community basis.

An appropriate field of action comprising high-level institutions and expert researchers needs to be created. Research efforts must be formulated and evaluated in the light of the principle that 'mental health is just as important as physical health'. Experts across all medical systems working in the mental health sector in Kerala should continue research activities in their respective domains and mutually exchange their findings and perspectives.