
UNIT 5 MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

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5.0 INTRODUCTION

Health is not only *physical health* but also includes maintaining harmonious relationships with other living beings and having spiritual direction and purpose. This includes living according to one's ethics, morals, and values. Thus Health has various dimensions like Physical Health, Social Health, Emotional Health, Spiritual and Mental Health, and for an individual to stay healthy, all the dimensions are equally important. It has been proposed by WHO 'that there can be no physical health without mental health'.

Mental health disorders are common in general population and usually present themselves as– worry, tiredness, and sleepless nights and may affect more than half of the adults at some time.

5.1 OBJECTIVES

After going through this unit, you will be able to:

- explain the meaning and importance of mental health;
- identify Common mental health and Substance Use Disorders in the community;
- enlist measures for prevention of common mental health disorders;
- appreciate the need for management of common mental health/substance use disorders in the patients and make adequate and timely referrals; and
- describe the role of Community Health Nurse in Prevention and Management of these disorders;

5.2 MENTAL HEALTH

As per World Health Organization (WHO), mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Mental health needs are being recognised as an integral component of practice in comprehensive primary and secondary health care. Good mental health gives a sense of well-being to a person by enhancing confidence and self-esteem. It not only enables a person to enjoy positive relationships with other people but also to use the abilities to reach their potential and deal with life's challenges.

Poverty, discrimination, malnutrition, environmental factors (including access to safe water, toilets and sanitation), exposure to violence and absence of parental figures (death, divorce or displacement) are few factors that may have a negative influence on mental health. Thus, for a person to lead a healthy life, the mind should work in harmony and maintain the internal balance and also a balance should exist between the mind and the body as well as between the mind and the surroundings. And for this, a balance of emotions (anger, fear, anxiety, rage, sadness, happiness, jealousy), thoughts (ideas, memories, intelligence) and actions (talking, playing etc) is essential.

5.3 COMMON MENTAL HEALTH PROBLEMS

Certain unpleasant and stressful encounters like poor socioeconomic status, broken family, professional difficulties can weigh heavy on the individual and hamper healthy mental functioning and may lead to divorces, suicides, depression, sleep disorders, anxiety and substance abuse. 'Stress' with advent of industrialisation, change in the work culture, and eating habits has been incriminated as one of the important risk factor for lifestyle disorders like diabetes and hypertension and mental health disorders like sleep disturbances and substance use disorder (including alcoholism). Common mental health disorders you would find commonly in the community are:

a) **Depressive Disorders (Including Major Depressive Disorder)**

Depressive disorders are the most common mental health disorders that can be found in the community. The person suffering from these remains sad and irritable, feels hopeless and empty, and in some extreme conditions might have physical symptoms like non specific pains, marked loss of interest or pleasure in anything that significantly interfere with daily life present nearly every day for a period of at least two-weeks. The other presenting features may be significant weight loss or gain, inability to sleep or excessive sleep, feelings of restlessness, lethargy, feelings of worthlessness or excessive

guilt, distractibility, and recurrent thoughts of death, including suicidal thoughts or plans. *However suicidal thoughts or plans calls for an immediate attention, wherein the patient should be immediately connected/referred to a skilled, trained counselor at a local crisis centre.*

In children and adolescents, female youths have been seen to be about three times more likely to be predisposed as against males to experience depressive illness, though they might manifest it as irritability rather than a sadness.

The possible causes of depressive illness can be genetic, biological, and environmental factors. Adverse childhood experiences and stressful life experiences are known to contribute significantly to the risk.

b) **Anxiety Disorders**

The daily functioning of the individuals suffering from anxiety disorders is disturbed by excessive fear to real or perceived threat; that are difficult to control. These disorders can range from specific fears (called phobias), such as the fear of heights, flying or public speaking, to more generalised feelings of worry and tension. Anxiety disorders typically develop in childhood and persist to adulthood. Specific anxiety disorders include generalised anxiety disorder (GAD), panic disorder, separation anxiety disorder, and social anxiety disorder (social phobia). Lifetime phobias and generalised anxiety disorders are the most prevalent among adolescents between the ages of 13 and 18 and usually first appear around age 11 years.

Most of the anxiety disorders are caused by a combination of genetics, biology, and environmental factors. Adverse childhood experiences may also contribute to risk for developing anxiety disorders.

c) **Attention Deficit Hyperactivity Disorder (ADHD)**

ADHD is one of the more common mental disorders diagnosed among children and occurs four times as often among boys than girls. A child suffering from ADHD is less attentive in class and cannot focus on the task given, and/or has difficulty in controlling behaviour and is usually hyperactive. Thus usual complaints of teachers and parents of children suffering with ADHD is that they have difficulty in sitting through for completion of given task and interacting with other children. Thus these are poor performers in the school. Thus a child suffering from ADHD may have one or more of these (inattention, hyperactivity and impulsivity) in isolation or combination. Inattentive children may have trouble paying close attention to details, make careless mistakes in schoolwork, are easily distracted, have difficulty in completing home assignments as they soon get bored with the given task. These children talk excessively, run about in the class and find difficulty in sitting still. The teachers find them impatient as have trouble waiting for their turn and thus they might blurt out with premature answers to questions put forth and may interrupt conversations frequently. Adults with ADHD are often extremely distractible and have significant difficulties with organisation.

The genetic predisposition has been observed in cases of ADHD. Environmental risk factors may include low birth weight, smoking and alcohol use during pregnancy, exposure to lead, and history of child maltreatment.

d) **Bipolar and Related Disorders**

People suffering from bipolar and related disorders complain of sudden mood swings ranging from period of intense happiness and impulsiveness to extreme sadness and feeling of hopelessness. Behavioural changes like fatigue or loss of energy, sudden significant weight changes, complaining about pain, or suicidal thoughts or plans may also be associated. A family history is a strong risk factor for this condition.

e) **Disruptive, Impulse Control, and Conduct Disorders**

People suffering from these disorders usually have problem with control on their emotions or behaviour that might put them into a conflicting position with others in the family, school or neighbour. Oppositional defiant disorder and conduct disorder are the most common disorders in children in this category.

i) ***Oppositional Defiant Disorder(ODD)***

Children with ODD are usually those who have had a harsh, inconsistent or neglected childhood. Boys are more commonly affected and usually present with excessive anger/irritability, argumentative/defiant behaviour, or vindictiveness. The child may often lose their temper, frequently pick up fights and be resentful, or may easily get annoyed. These children may often refuse to comply with rules and become argumentative. They may also deliberately annoy others or blame others for their mistakes or misbehaviour. These symptoms must be evident for at least six months and observed when interacting with at least one individual who is not a sibling.

ii) ***Conduct Disorder(CD)***

The child suffering from CD has violent behaviour to the extent that it might disrupt the social norms for his age thus affecting the child or family's daily life. The primary symptoms of conduct disorder include aggression to people and animals (for example, bullying or causing physical harm), destruction of property (for example, fire-setting), deceitfulness or theft (for example, breaking and entering), and serious violations of rules (for example, truancy, elopement). Symptoms must be present for 12 months and fall into one of three subtypes depending on the age at onset (childhood, adolescent, or unspecified).

It most commonly affects children and adolescents, with increase seen as age advances from childhood to adolescence, with males affected more than females.

The children having behavioural problems and below average intelligence in infancy have higher predisposition for CD. Harsh or inconsistent child-rearing practices and/or child maltreatment, parental criminality, frequent changes of caregivers, large family size, familial psychopathology, and early institutional living are the risk factors that may contribute to developing the disorder. The community risk factors include neighbourhood exposure to violence, peer rejection, and association with a delinquent peer group. Family history of CD or any other behavioural disorders like ADHD, schizophrenia, substance use disorder increases the risk.

Usually CD co exist with other disorders like ADHD, learning disorders, and depression.

f) **Obsessive-Compulsive and Related Disorders (OCD)**

Patients suffering from Obsessive-Compulsive Disorder (OCD) have unwanted thoughts, urges, or images that persist and intrude in daily living (obsessions), or behaviours that he repeats ritualistically in order to control obsessions (compulsions). Obsessions may include persistent thoughts (e.g. dirty hands), images (e.g of horrific scenes), or urges (e.g to jump from a window) and are perceived as unpleasant and involuntary. The person thus compulsively puts efforts to prevent or reduce anxiety or distress, that are clearly excessive or unrealistic. A common example of an OCD symptom is a person who obsessively feels his hands are dirty and thus repeatedly washes his hands excessively to clean them. OCD symptoms are time-consuming and cause significant dysfunction in daily life.

OCD includes the presence of obsessions, compulsions, or both.

The disorder tends to begin usually in childhood or adolescence.

The positive family history and child maltreatment or traumatic childhood events act as predisposing factors for the disorder.

g) **Schizophrenia**

Schizophrenia is a disorder of brain in which the way a person thinks (often described as a “thought disorder”), and is characterised by a range of symptoms including:

- Delusions of false and persistent beliefs that are not part of the individual’s culture. For example, people with schizophrenia may believe that their thoughts are being broadcast on the radio.
- Hallucinations that include hearing, seeing, smelling, or feeling things that others cannot. Most commonly, people with the disorder hear voices that talk to them or order them to do things.
- Disorganised speech that involves difficulty organising thoughts, thought-blocking, and making up nonsensical words.
- Grossly disorganised behaviour.

Usually the patient has disillusionment with life, prefers to stay isolated, is not motivated and speaks infrequently.

h) **Trauma and Stress Related Disorders**

These disorders usually occur following previous exposure to a traumatic or dangerous event. The most common disorder in this category is post-traumatic stress disorder (PTSD). The patient can present with symptoms ranging from re-experiencing symptoms from the event, such as flashbacks or recurring upsetting dreams, upsetting memories, psychological disturbances, avoidance of stimuli associated with the traumatic event, mood changes, changing a personal routine to escape having to be reminded of an event, or getting tense to the extent that makes it difficult for him to complete the daily tasks. They might have increased reactivity like being excessively vigilant, easy distractibility, irritability or even self-destructive behaviour.

This can be seen in people who have gone through various traumatic events like rape, natural disasters, child abuse, car accidents etc.

5.4 SUBSTANCE USE DISORDERS

Substance use disorders are those that occur due to recurrent use of alcohol and/or drugs that cause dependence or significant social and functional impairment at work, school, or home. Some of these that are commonly seen in the community are as follows:

5.4.1 Alcohol Use Disorder (AUD)

The individuals have problem in controlling intake of alcohol and they continue to use alcohol despite personal and social problems arising out of drinking. The person develops tolerance to alcohol and drinks the amount that leads to risky situations or suffers from withdrawal symptoms (forgetfulness, tremors, inability to concentrate, delusions and hallucinations) in case of abstinence.

Excessive use of alcohol can predispose an individual for developing a variety of social and health problems besides those associated with intoxication and withdrawal.

Besides environmental factors like availability, peer pressure and maladjustment to stress, genetics has also been shown to be a risk factor for the development of an AUD.

5.4.2 Tobacco Use Disorder

Tobacco Chewing (gutka) and smoking damage nearly every organ in the human body, often predisposing to various respiratory disorders including tuberculosis, cardiovascular problems, diabetes and directly causes a variety of cancers (lung, oral cavity etc). People who do not smoke tobacco but stay near or with smokers are called passive smokers and these are also at increased risk of cardiovascular diseases, cancers like lung, oral cavity, respiratory diseases like asthma and tuberculosis, ear infections.

5.4.3 Stimulant Use Disorder

The most commonly abused stimulants are amphetamines, methamphetamine, cocaine and can be taken orally, snorted (nasally), or intravenously. These are used for increasing alertness, attention, and energy. However, these as well, increase blood pressure, heart rate, and respiration.

Symptoms of stimulant use disorders include failure to control and excessive craving till a person is able to procure, development of tolerance and thus increasing requirement over the time, interference social functioning and responsibilities and withdrawal symptoms after discontinuing use. The withdrawal symptoms include fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

5.4.4 Hallucinogen Use Disorder

Commonly used hallucinogens are synthetic (lysergic acid diethylamide or LSD) or naturally occurring like psilocybin mushrooms, peyote. The use of these drugs can produce feelings of detachment from one's environment and oneself, and distortions in time and perception and visual and auditory hallucinations.

Symptoms of hallucinogen use disorder are same as seen with other drugs like stimulants.

5.4.5 Opioid Use Disorder

The most commonly abused drugs available over the counter are cough and cold remedies containing dextromethorphan followed by painkillers. Illegal opioid drugs such as heroin and drugs available on prescription like relievers (oxycodone and hydrocodone), oxytocin have potential for dangerous use. These are meant to reduce perception of pain but can also cause effects on brain leading to drowsiness, mental confusion, euphoria that make them likely candidate for abuse. Some people use them by snorting or injecting also for a higher response which might lead to overdose.

Symptoms of hallucinogen use disorder are same as seen with other drugs like stimulants and hallucinogens.

Co-occurring Disorders: These are the disorders that describe people that suffer with both substance use and mental disorders at the same time. E.g. alcohol abuse with depression or panic disorder.

Check Your Progress 1

1) Fill in the blanks:

- a) Symptoms of depression must be present for atleast..... and cause significant impairment or dysfunction in daily life.
- b) Usually in children co exist with other disorders like ADHD, learning disorders, and depression.

c) People suffering with both substance use and mental disorders at the same time are said to have.....

d) Schizophrenia is also known as.....

2) Answer the following Questions in Brief :

a) What are Post Traumatic Stress Disorders (PTSD)?
.....

b) What are withdrawal symptoms of alcohol use disorder?
.....

c) What are the health effects of Tobacco Use Disorder?
.....

5.5 MENTAL HEALTH ACT, 2013

The Mental Health Care Bill, 2013, which repeals Mental Health Act, 1987, was introduced in the Rajya Sabha on August 19, 2013. The new Bill was introduced with an aim to adequately protect the rights of persons with mental illness and promote their access to mental health care. The key features of the Bill are :

- 1) **Rights of persons with mental illness:** Every person shall have the right to access to affordable and quality mental health care and treatment from services run or funded by the government. Persons with mental illness also have the right to equality of treatment, protection from inhuman and degrading treatment, free legal services, access to their medical records, and complain regarding deficiencies in provision of mental health care.
- 2) **Advance Directive:** A mentally-ill person shall have the right to make an advance directive that states how he wants to be treated for the illness during a mental health situation and who shall be his nominated representative. The advance directive has to be certified by a medical practitioner or registered with the Mental Health Board.
- 3) **Setting up of Central and State Mental Health Authority:** Every mental health establishment has to be registered with the relevant Central or State Mental Health Authority. These are administrative bodies required to:
 - a) Register, supervise and maintain a register of all mental health establishments,
 - b) Develop quality and service provision norms for such establishments,
 - c) Maintain a register of mental health professionals,
 - d) Train law enforcement officials and mental health professionals on the provisions of the Act,
 - e) Receive complaints about deficiencies in provision of services, and
 - f) Advise the government on matters relating to mental health.
- 4) **Mental Health Review Commission and Board:** The Mental Health Review Commission is a quasi-judicial body that will periodically review the use of and the procedure for making advance directives and advise the government on protection of the rights of mentally ill persons. The Board will have the power to (a) register, review/alter/cancel an advance directive, (b) appoint a nominated representative,

(c) adjudicate complaints regarding deficiencies in care and services, (d) receive and decide application from a person with mental illness/his nominated representative/any other interested person against the decision of medical officer or psychiatrists in charge of a mental health establishment.

- 5) **Decriminalising suicide and prohibiting electro-convulsive therapy:** A person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code. Electro-convulsive therapy is allowed only with the use of muscle relaxants and anaesthesia. The therapy is prohibited for minors.

5.6 NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

Over last few decades, there has been an increase in mental health disorders including epilepsy and psychiatric illnesses. Most of these patients live in rural remote areas where either there is lack of any modern mental health facility or there is a stigma attached to seeking care. Thus these patients are likely to be under-diagnosed or missed.

Thus in response to the rising burden of mental health and related disorders and inadequacy of mental health care infrastructure, Government of India launched the National Mental Health Programme (NMHP) in 1982 with aims to:

- 1) Prevent and treat mental and neurological disorders and their associated disabilities.
- 2) Use of mental health technology to improve general health services.
- 3) Application of mental health principles in total national development to improve quality of life.

5.6.1 Objectives

The Objectives of the programme are to:

- 1) Ensure availability and accessibility to minimum mental health care for all, particularly to the most vulnerable and underprivileged sections of population.
- 2) Encourage application of mental health knowledge in general health care and in social development.
- 3) Promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

5.6.2 Strategies

The Strategies under the programme are:

- 1) To integrate mental health with primary health care through the NMHP to alleviate stigma attached with seeking care;
- 2) To utilise the existing infrastructure of health services and also to deliver the minimum mental health care services.
- 3) To link health services with the existing community development programme.
- 4) Ensure strengthening of tertiary care institutions for treatment of mental disorders. Assistance has been provided for modernisation of state run mental hospitals from custodial care to comprehensive management. Funds have been provided for strengthening of the psychiatric wings of government medical colleges/hospitals in terms of manpower, infrastructure and equipments.

- 5) Setting up regulatory institutions like the Central Mental Health Authority, and State Mental health Authority for protecting their rights. To provide appropriate task oriented training to the existing health staff.

5.7 DISTRICT MENTAL HEALTH PROGRAMME (DMHP)

DMHP was launched under NMHP in the year 1996 in 4 Districts and was later expanded to 123 Districts in XI plan. With the objective to provide Community based Mental Health Services and integrate the mental health with general health services through decentralisation of treatment from Mental Hospital based care to primary health care services.

5.7.1 Component

DMHP had following components :

- 1) **Early detection and treatment:** Imparting short term training to medical officers/ general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist. Ensuring early detection and timely treatment of mental illness in the community through OPD/indoor and followup.
- 2) **Training:** The Health workers to be trained in identifying persons suffering from mental disorders ill persons.
- 3) **IEC:** Increasing public awareness to reduce stigma related to mental disorders.
- 4) **Monitoring:** Data generation for future planning and improvement in service and research.

In addition, Life skills education and counselling in schools and colleges, stress management at work place and suicide prevention services have also been included as a part of the DMHP. Accordingly, at various levels, adequate manpower has been placed.

5.7.2 Activities at District Level

- 1) At the district level, a team of Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatric/Community Nurse, a Programme Manager, a Programme/Case Registry Assistant and a Record Keeper have been placed.
- 2) The on-site, distance based and short residential training courses shall be done by the district DMHP Team with support from visiting experts from Department of Psychiatry, Government Medical Colleges and /or Centres of Excellence (in the State if available) to ensure minimum competencies among the medical and paramedical workers along with on job supervision and support.
- 3) Outpatient and Inpatient services for walk-in and referred patients from the Taluk Hospital/CHC and PHCs. A provision of 10 beds and 5 nurses have been made for short stay admissions to assess and treat. School based services are being provided for identifying and managing mental health problems in children and running an outpatient service for children with more severe mental health problems.
- 4) To train staff posted in labour rooms and maternal health care units in detecting post partum depression / psychosis and referring them to the PHC/Taluk/DH for treatment and/or counselling and ensuring effective follow up.
- 5) Making referrals for day centres, medium stay centres and long stay centres.
- 6) Disability Certifications to be done by the Psychiatrists at the District Hospitals.

- 7) Necessary laboratory services including Therapeutic Drug Monitoring for psychotropic medications.
- 8) Counselling and Management Services for persons who have survived a suicide attempt.
- 9) Provide services for inpatient and outpatient detoxification, user/care-giver education, link users with community based alcohol/drug rehabilitation services and voluntary services for patients suffering from Alcohol and Substance use disorders.
- 10) Outreach Services in the form of outpatient clinic by the visiting psychiatrist at more frequent intervals (e.g. Once a week). Districts may also consider using Telemedicine facilities for linking up with Taluk Hospitals/CHC for providing support and supervision to general health staff in managing mental illness.

5.7.3 At the Taluk Hospital/Community Health Centres (CHC)

- i) Outpatient and inpatient (short stay upto 5 days) services for walk in and patients referred by the PHC.
- ii) Medical and Social Care and Support to Continuing Care services in their area.
- iii) Counselling services (for those referred to the Psychologist by the Community Mental Health Workers (CMHW) from the PHC. CMHW may refer patients requiring specialist psychological counselling to the Psychologist at the Taluk Hospital.

5.7.4 At the Primary Health Centre Level

- 1) **Training of medical officers** in identification and management including timely referral and follow up of common mental disorders and emergencies.
- 2) Depending on the workload, each PHC to have 2–4 **Community Mental Health Workers** (CMHW, or community counsellors) as ‘front-line’ mental health care providers. These will have to be local residents and educated upto Xth and would be paid an honorarium for their work. Adequate training will be given to them to detect and provide counselling for patients with common mental illnesses (like depression, anxiety and alcohol abuse) and ensuring treatment adherence for long standing illnesses.

In the community they will be able to detect probable cases of mental illness in community settings, and refer them to the health facility for diagnostic assessment, provide support to the families and care-givers, work towards stigma alleviation and prevention of discrimination against these patients and also help them in accessing social benefits and entitlements.

Regular supervision and refresher courses will be provided by the District DMHP Team, which will be combined with mental health promotion exercises for these staff.

- 3) **Availability of Drugs** for management of common mental disorders and substance use disorders. For the convenience of the patients and care givers and cost reduction strategy, psychotropic medicines on the Essential Drug List will be available at all PHCs and these may be provided the patients put on long term medications by the specialist at the CHC/District Hospital at regular intervals.
- 4) **Home based and Community based Continuing care and support** to persons with severe mental disorders including referrals and follow up.

- 5) Identification of **mental health emergencies** and referral to district/taluk hospitals. 108 Ambulance services with trained staff will be available free of cost to transport patients to the District Hospital in an emergency. The funds have been provided through National Health Mission (NHM).
- 6) **Counselling services** and help in accessing social care benefits.
- 7) To provide a range of **community based rehabilitation** interventions.
- 8) **Pro-active case findings and mental health promotion and literacy** activities.

Community Based Continuing Care Services: Continuing care in the community for persons with residual symptoms is an important aspect of service provision for persons with chronic mental disorders. Thus these patients can be placed at Day Centres with vocation training and employment support as a part of rehabilitative care will be set up in two taluks of the district with each day centre having a capacity for 25 person places. Residential continuing care for short stay upto 6 months, each in two taluks of the district each with a capacity for 25 beds/places The long term residential continuing care can be done through public private partnership.

5.8 DRUG DEADDICTION PROGRAMME

The drug deaddiction programme was started in India by Ministry of Health and Family Welfare in 1985-86 and was later revised in 1994 and then in 1996 again. The programme started as a scheme with funding from central government and implementation by state. The strategies under the programme needs coordination between various departments and ministries. The activities under the programme are broadly divided into two arms:

- a) **Supply Reduction:** The activities under supply reduction focuses on reducing the availability of illicit drugs within the country. Ministry of Home Affairs with Department of Revenue act as nodal agency.
- b) **Demand Reduction:** Includes awareness generation, counselling, treatment and rehabilitation of users and addicts. These activities are run by the agencies under Ministry of Health and Family Welfare and Ministry of Social Justice and Empowerment. The Ministry of Health and Family Welfare is mainly responsible for providing treatment services to addicts.

Aims and Objectives

- 1) To create awareness about ill effects of alcoholism and substance abuse to the individuals.
- 2) To develop culture specific models for prevention of addiction and treatment and rehabilitation of addicts.
- 3) To evolve and provide a complete range of community based services for identification, motivation, detoxification, counselling, aftercare and rehabilitation of users.
- 4) Increase community participation and public cooperation for reduction in demand of substances having potential for abuse.

National Drug Dependence Treatment Centre (NDDTC) has been established under All India Institute of Medical Sciences, New Delhi while deaddiction centres in PGI Chandigarh and NIMHANS have been upgraded to 30 beds facility. Also the deaddiction centres have been established in Dr Ram Manohar Lohia hospital, Smt Sucheta Kriplani Hospital, New Delhi and Jawaharlal Nehru Institute of Postgraduate

Medical Education and Research (JIPMER), Pondicherry. NDDTC is a centre for deaddiction and rehabilitation services to the users, research along with training and capacity building for doctors to treat substance use disorder.

The funds are also being provided for setting up of deaddiction centres across the country and to the NGOs for deaddiction services and rehabilitation.

Under Ministry of Social Justice and empowerment, National Drug Demand Reduction Policy has been proposed in March 2013 with the objectives to:

- a) Create awareness about ill effects of substance use.
- b) Provide a range of community based awareness.
- c) Strengthen human resource development.
- d) Facilitate research, capacity building and documentation.
- e) Active efforts to avoid stigma and discrimination against users.

5.9 PREVENTIVE AND PROMOTIVE MENTAL HEALTH SERVICES

As physical exercise and nutritious food are important to strengthen and endure the health of the physical body; mind also requires exercise and constant stimulation by healthy discussions, socialising, meeting new people, meditating and if required by medicating to endure the strain of day to day life.

The public health nurses and the health care providers working in close contact with the community can provide a supportive role to the individual, family and community in such situations by counselling them on the preventive and promotive mental health approaches against these problems and referring them to right places for management. Also the strategies to reduce stress like spending time with family and friends, exercising, meditation, etc. are important in prevention of occurrence of mental health disorders.

- 1) **Mental Health Help Line:** A National Mental Health Help line with a toll free number has been setup to provide information about the availability of services at public health facilities.
- 2) **Suicide Prevention Programme:** With support of local NGOs, a suicide prevention helpline providing services for 24 hours on all seven days in the week has been set up to provide support through telephonic counselling to prevent the attempt of suicides and reattempt in survivors. The medical officers, health workers, senior health inspectors, teachers, panchayati raj institution members, bank officers and the police department etc will have to be trained for the same.
- 3) **Life Skills Programme:** For early detection of mental health problems in adolescents and growing children, school based counselling services will be provided through a uniform cascading model through the school teachers by training them by modular trainings. School based counselling services also to focus on early interventions for adolescents with mental health problems.

5.10 SCREENING, MANAGEMENT AND REFERRAL

With increasing industrialisation, and stress, there have been increase in mental disorders like, anxiety disorders, depression leading to high rates of suicide. Factors like broken love affairs, conflict at home, stress at school etc. have been identified as important factors that arise in the families and community. Alcohol and substance use disorder

are the other common problems encountered by the CMHNS, PHC medical officers, DMHP teams that need to be addressed by early detection by screening and referral for adequate management.

The Community Mental Health Nurses, public health nurses, ANMs, ASHAs and the health care providers working in close contact with the community can be of great help in providing counselling services for prevention and promotion of mental health, early identification of mental disorders by screening, awareness generation for stigma alleviation and timely referral for adequate treatment. They can also have an important role in community based services for continuation of treatment and rehabilitation. Community Mental health nurses (CMHN) play a role in community mental health centers, detoxification centres, group homes for individuals with mental retardation or serious mental illnesses, and residential substance abuse treatment programmes. Thus the role of Community Mental Health Nurses (CMHN) in Mental health programme can be broadly placed under following categories:

- 1) **Assessment of family:** CMHN should study the risk factors for mental disorders related to family conditions to be able to address them through counselling.
- 2) **Assessment of community:** The community factors also contribute towards effect and causation of mental disorders. The CMHN should be able to assess and delineate them to address the modifiable ones and refer the patient to higher levels for coping the non-modifiable risk factors.
- 3) **Planning and implementation:** She should be able to plan and implement various preventive and promotive events for the community like counselling/meditation and yoga under Life Skills Programme for prevention of mental disorders among school and college children.
- 4) **Family interventions:** She should be able to plan family interventions for the factors identified in assessment. e.g. counselling of parents for dispute that might be an underlying cause of depression in the child.
- 5) **Community interventions:** She should be able to plan community interventions for the factors identified in assessment. e.g. Stigma alleviation in seeking care.
- 6) **Evaluation:** Evaluation of the local interventions and assessment of the patients' condition for referral to the higher level. She is also to provide active support to patients referred back from the higher facilities for continuation of treatment, family support and rehabilitation after recovery.

The clients identified by the CMHW/PHN/ANMs/ASHAs in the community should be referred to the PHC medical officer for detailed assessment and initiation of treatment. In cases of Emergency or conditions that are difficult to be treated at the PHC level should be referred to the CHC or district level for appropriate management.

Check Your Progress 2

- 1) Fill in the blanks:
 - a) The activities under the Drug Deaddiction programme are broadly divided into two arms..... and
 - b) Under DMHP, each PHC is to haveCommunity Mental Health Workers (CMHW, or community counselors) asproviders.

2) Write in brief:

a) What are the rights of persons with mental diseases as per the Mental health act?

.....
.....

b) Mention various categories under which the Community Health Nurses have a role to play in Mental health programme.

.....
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5.11 LET US SUM UP

According to the data available from various sources, approximately 6–7% of population at any point of time suffers from mental disorders. Depression, anxiety, Bipolar disorder, ADHD and schizophrenia are some common mental disorders. The substance use disorders (alcohol, tobacco, stimulants and hallucinogens) are also commonly seen in the community. However, there is a stigma attached with the treatment of mental disorders. Thus, most of the cases either do not come to the notice of the health care workers or are under treated. Thus Government has taken initiatives to address the problem by launching NMHP and further decentralising it to the district level by training the medical officers and integrating the mental health services into general health services. The community workers including community health nurses have a special role to play by mobilising the community for screening and timely management including rehabilitation, ensuring referrals, alleviation of stigma attached and carrying out preventive and promotive mental activities in community, schools, colleges etc.

5.12 KEY WORDS

- Delusions:** a false idea or belief that is not true
- Hallucinations:** perception of something that is not present.
- ANM:** Auxillary Nurse Midwife
- PHN:** Public Health Nurse
- ASHA:** Accredited Social Health Activist.

5.13 MODEL ANSWERS

Check Your Progress 1

- 1) a) two weeks b) Conduct disorders c) co occurring disorders
d) Thought disorder
- 2) a) PTSD are the disorders usually occur following previous exposure to a traumatic or dangerous event.
- b) Withdrawal Symptoms of Alcohol Use Disorder include forgetfulness, tremors, inability to concentrate, delusions and hallucinations.

- c) Tobacco use predisposes to various respiratory disorders including tuberculosis, cardiovascular problems, diabetes and directly causes a variety of cancers (lung, oral cavity etc). Passive smokers are also at increased risk of cardiovascular diseases, cancers like lung, oral cavity, respiratory /diseases like asthma and tuberculosis, ear infections.

Check Your Progress 2

- 1) Fill in the blanks: a) Source reduction, Demand reduction b) 2–4, front line workers
- 2) a) Every person shall have the right to access to affordable and quality mental health care and treatment from services run or funded by the government. Persons with mental illness also have the right to equality of treatment, protection from inhuman and degrading treatment, free legal services, access to their medical records, and complain regarding deficiencies in provision of mental health care.
- b) The role of Community Health Nurses in Mental health programme can be broadly placed under following categories:
 - 1) Assessment of family
 - 2) Assessment of community
 - 3) Planning and implementation
 - 4) Family interventions
 - 5) Community interventions
 - 6) Evaluation