

Project Shifa

a model for a rural
community-based mental health service
in resource-poor settings



Johann Ebenezer



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Introduction

What is this book about?

The Shifa model was not conceived of all at once. It grew over time, and continues to adapt and accommodate new challenges and changes. What we hope to describe in this book is the basic model of care, and basic organizational issues, with the aim that others in similar rural third-world settings can adapt or incorporate into their own particular cultural and socio-economic settings. Our targeted readership includes anyone interested in improving mental health services in rural areas – psychiatrists, other mental health professionals, other doctors (especially in primary care), nurses, social workers, lay health workers, administrators and any other stakeholders in rural mental health work. This book does not attempt or intend to be a textbook of psychiatry or community mental health; the emphasis is on the model of care and not on particular clinical strategies for various disorders.

The model is deliberately designed to be low-cost (see chapter on ‘Economics of running a rural mental healthcare program’). It requires relatively few personnel, and the core of the workforce is lay healthcare workers (see chapter on ‘Organizing a rural mental health team’). Though the model does require at least one psychiatrist or trained mental health professional, this role as conceived in the model could be filled by any physician or experienced nurse with some training and supervision by a psychiatrist (even through online or telephone support).

What we try to emphasize throughout is the general organizational principles in the model, which we believe to be relevant in any rural setting. However, these principles may need to be adapted to suit local socio-cultural needs. Wherever possible, we include anecdotes of our experiences. These are not intended to be prescriptive, but to serve as examples that might be useful for others as they adapt the principles for their settings.

This model is specifically designed with rural areas in mind, and heavily relies on supportive families and community bonds (such as the strong joint family system in our setting). However, many aspects of it could conceivably be adapted for other settings such as semi-urban, urban or refugee camp settings with some modifications. We encourage a flexible approach in adopting the model, one that suits local needs and makes use of local resources.

How to use this book

Each chapter provides basic information and some suggestions about specific aspects of rural mental healthcare. Though intended to be read in order, each chapter can also be read as a stand-alone chapter. The appendix contains our screening tool (the Padhar Community Mental Health Screening Instrument – PaCoMSI), outcome evaluation tool and a suggested format for clinical records.

Our project (and this book) covers epilepsy, substance dependence and developmental disorders in addition to severe and common mental disorders. In our resource-poor setting there are no available neurologists, pediatricians or other specialists who otherwise could have been managing some of these cases. Many people in our rural settings have no problem being seen by a mental health team for conditions such as epilepsy and developmental disorders. This is also in line with the World Health Organization’s MHGap guidelines.

However, we encourage readers to adapt the aims of the model to suit their needs and resources. For example, a team might decide to focus exclusively on epilepsy, or psychosis, or developmental disorders. Still others might only want to work on alcohol dependent patients through community detoxification camps. We believe the principles in this book are applicable across all these potential variations, and we encourage others to correspond with us regarding their experiences using modifications of the model, and suggestions for improvement.

Fonts used in this book

Our description of the model appears in this font.

Examples from our own experience are shown in this font.

The Shifa model of rural mental health care: an introduction

Background

Shifa is the community mental health (CMH) project at Padhar Hospital. Shifa is an Urdu word meaning 'healing'. Padhar Hospital is a 200 bedded multispecialty Lutheran mission hospital located in Betul district in the central Indian state of Madhya Pradesh. The area surrounding Padhar is rural, with most people employed in agriculture and many of the communities are very poor. Villages are situated in areas with very limited accessibility by road with negligible public transport. The population is multi-ethnic, mostly consisting of tribals such as the Gonds and Korkus besides the local Hindi-speaking population, as well as a sizeable Marathi-speaking population and even some ethnic Bengalis – who migrated as refugees during the 1971 Indo-Pakistani war. There is also considerable religious diversity – although Hindus are a clear majority, there is a large Christian minority centered around Padhar Hospital, and a smaller Muslim minority as well. Many tribals practice a primitive form of religion with strong animistic belief systems and practices.

When I joined Padhar Hospital and started the psychiatry department here in 2014, it was the first and only full time mental health service in a radius of 200 km. I soon realized that most of the patients who came to the psychiatry outpatient department, as well as our inpatients and referrals from other departments, were predominantly from urban areas, with hardly any actually coming from the surrounding rural areas (where the bulk of the local population is from).

It was in this context that Project Shifa was initiated with the aim of reaching out to the rural areas surrounding Padhar and providing accessible and culturally-acceptable mental health care. In a short span of less than 3 years, this project grew from a non-existent service into a project that was shortlisted as a finalist in the British Medical Journal (BMJ) Awards South Asia 2016 in the category 'Excellence in delivering primary care.' It has also been invited to be showcased on the website of Mental Health Innovation Network, jointly run by the World Health Organization and the London School of Hygiene and Tropical Medicine.

As of now, 530 patients have been registered under Project Shifa. Of these about 200 have received medications in the field, and a core group of about 170 are being regularly followed up in their community setting. Most of the remaining patients have been referred to the base hospital for further evaluations, more intensive non-pharmacological interventions or referrals to other departments. For those interested, a selection of important half-yearly reports detailing the progress of the project, including details on outcomes of patients, is available online on Project Shifa's innovation page on the website of Mental Health Innovation Network (<http://www.mhinnovation.net/innovations/project-shifa-community-mental-health-project-padhar-hospital>). Other online resources include a brief video clipping introducing the project (<https://www.youtube.com/watch?v=qqrpzdaJoJc&feature=youtu.be>).

Basic description of the model

The target area currently covered by us includes 75 villages in a radius of about 20km from the base hospital. To facilitate follow up and administration, the entire area has been divided into 11 clusters, each with 6 to 8 villages, based on geography and accessibility.

The core activities of the project include:

- Awareness-building about mental health issues, developmental disorders and epilepsy
- Door-to-door screening by field workers using a specially-designed family-level screening tool for psychiatric disorders and epilepsy making use of local terms and concepts.

- Weekly outreach clinics by the entire team. One cluster is targeted each week, though this is flexible (for example, clusters can be clubbed to make up in the event that some visits are cancelled for any reason). Medications are provided to patients with severe illnesses (like schizophrenia, bipolar disorder and epilepsy); they are followed at their homes twice a month by field workers. Patients with less severe mental health issues are referred to the psychiatry department for pharmacological or psychotherapeutic interventions.
- Group therapy sessions: families are empowered with the skills required to care for patients at home and encourage recovering patients to get back to agricultural or domestic work as early as possible.

Basic clinical management strategies

The following are the basic strategies we follow in the Shifa project, and reflect our priorities and resources. These are flexible, and can be adapted to better reflect local needs and resources. For detailed discussions on the various drugs and non-pharmacological strategies we employ, please refer the chapters on 'Drugs', 'Role of the family in a rural mental healthcare program' and 'Group therapy in a rural mental healthcare program'.

Severe mental disorders (psychosis, bipolar disorder, psychotic depression) and epilepsy:

- Screening and identification
- Medication provided in the community setting
- Family and patient psycho-education through group therapy
- Home-based rehabilitation strategies using family.

Common mental disorders (depression, anxiety, neurotic conditions):

- Screening and identification
- Mostly referred to base hospital for relevant tests/medications/psychological interventions
- A few are provided medication in the field on a case to case basis.

Developmental Disorders:

- Screening and identification
- Intensive screening for treatable co-morbidities like seizures, psychosis, involuntary movements, aggression and hyperactivity (which are aggressively treated in the community setting)
- Parent/family psycho-education through group therapy
- A few are referred to base hospital for more intensive interventions (if willing and able).

Alcohol use disorders:

- Mostly referred to base hospital for interventions
- Since June 2016, we have started (as a related project) community based alcohol detoxification camps in selected villages with enrolled patients being formed into self-help groups. A brief discussion on these camps is also included in the chapter titled 'Community-based detoxification camps', although it is not a core component of the Shifa project.

Organizing a rural community mental health team

As currently designed, this model does not require vast numbers of personnel. The team can be easily put together from available (and willing) volunteers of any background, and the nature of their tasks is deliberately designed so that the skill base required is not specific to particular professional groups. The only exception to this is the role of the psychiatrist, but even this can conceivably be taken over by an interested medical officer, nurse, psychologist or other health professional under the supervision or guidance of a psychiatrist providing minimal support such as occasional visits or telephone/online support. Similarly, the role of the coordinator could be taken over by someone of any background, or may even be dispensed with altogether if the team can delegate the required tasks among themselves in very resource-constrained environments. The roles of the field workers and students can be taken on by any interested lay individuals of any background, provided they are willing and able to take up these roles.

The entire team meets for a short meeting at the end of the week that usually lasts about 30 to 45 minutes. Problems encountered in the past weeks, challenges, individual patients issues and immediate plans for the next week are discussed. It offers an ideal time and place for brainstorming solutions as well as providing feedback, as well as enhancing group cohesion and team spirit. It can also be used as a period for brief workshop-style training for the field workers/students on specific clinical issues that might present in the field, such as managing violent/suicidal patients or dealing with non-compliance. For details regarding how to conduct these meetings, please refer the chapter on 'Team meetings'.

Team members of Project Shifa

Psychiatrist / lead clinician

- Leader of the project
- Responsible for all clinical aspects including diagnosis, treatment plan and supervision of long term care as well as clinical documentation
- Group therapy in field
- Responsible for research activities & outcome evaluation
- Responsible for networking and wider publicity
- Organizing & writing weekly, monthly and half-yearly reports
- Leading the weekly meeting of all team members on Saturday

Coordinator

- Delegates, organizes field staff
- Responsible for ensuring smooth and efficient communication between team members
- Responsible for ensuring adequate documentation of follow up work by field workers

Field workers (*this number can vary based on local needs and resources, we have ten*).

- Screening all homes in the target area using screening tool PaCoMSI (Padhar Community Mental Health Screening Instrument)
- Following up all patients given medication in the field twice a month at their homes
- Organizing field arrangements for outreach visits
- Organizing group therapy sessions when planned
- Maintaining field records of follow up
- Assisting those referred to hospital if needed
- Informing psychiatrist of any relevant issues in connection with patients being followed up in the field
- Building awareness of mental health issues and epilepsy in target area.

Nursing students and elective students (these roles can be easily taken over by any available volunteers, or can be done by the field workers themselves in resource-constrained environments)

- Dispensing medications on outreach visits, maintaining drug register
- Registration of patients, including giving unique project ID cards
- Helping to educate patients and families.

Team meetings

Team dynamics and coordination are crucial to the success of any program. In mental health work these factors are all the more significant because of the huge impact that the relationship of the patients (and families) with the team plays in determining prognosis. A demoralized, disinterested team will never be able to achieve the outcomes it desires, often because much of these negative emotions and thoughts are unconsciously taken up by the patients and their families. By contrast, a confident and compassionate team models these same characteristics to the patients and families they serve. Coordination is equally important, as poor planning and execution by the team can make even the presence of a highly experienced mental health professional impotent. On the other hand, a well-organized team with pristine execution might be able to offer excellent care even in the absence of a full-time mental health professional.

There is no substitute for personal face-to-face meetings of all team members. This cannot be done daily in most settings, but should be attempted at regular intervals convenient for the team. In case it is not possible for all members to be physically present, video conferencing is an option where feasible. Wherever possible, all absent members should be updated about major decisions by e-mail. Some of the key issues related to the team meetings are briefly highlighted below.

Choose a convenient interval in which to have meetings

This decision has to be based on available time and the workload of the team members (especially in settings where the team members multi-task with more than one project).

In the Shifa project, all team members are existing hospital staff or students who multi-task with a number of activities apart from this particular project. We currently meet once per week (usually on Saturdays). However, if it is difficult to meet this frequently, it can conceivably be done once in a fortnight or even once a month provided adequate communication is maintained in these longer intervals.

Define the primary agenda of the meetings beforehand

The basic minimum that needs to be discussed should include problems encountered since the last meeting, any specific patient's issues and plans for the outreach visits scheduled to happen before the next meeting. If needed, time can be set apart for brief workshop-style training of field workers or students in specific clinical scenarios they may encounter (eg. dealing with violent, suicidal or non-compliant patients in the field).

In the Shifa project, the meetings normally last between 30 to 45 minutes long. Most weeks the focus is primarily on problems encountered in the past week, specific patient issues and planning the next week's outreach visit. Plans for the next week's outreach visit generally include deciding which cluster to target, deciding locations of the camp sites and approximate timings for each site, and whether new patients will be seen or only follow ups.

Attempt to involve all team members in decision making

Often decisions are most useful when they are pragmatic and feasible. The field workers are often the best judges of logistics on the ground, and the coordinator is often best placed to decide issues of delegation. The psychiatrist is the best judge for most clinical decisions but would need some help to understand the logistics of field work. Bearing

these special roles and proficiencies in mind, a 'bottom-up' approach in decision making is sometimes appropriate, rather than the psychiatrist or coordinator taking all decisions.

Many key decisions in Project Shifa did not originate from the psychiatrist. For example, the decision that the field workers should follow up all community-based patients every two weeks at home rather than just prior to the outreach camps came from the coordinator. That was probably the most impactful decision made since the project began, since it led to an unexpectedly good compliance rate among our follow up patients. Any effective program will certainly benefit from all team members having some say in the decision making processes.

Make time and effort for sharing success stories

Nothing boosts morale better than hearing of success stories of patients improving, especially during the early stages of the program. This sort of sharing helps tremendously in building strong group dynamics and cohesion, and enhances the sense of purpose in the team. Making a repository of short success story write ups is also useful, especially to generate effective reports.

Attempt constructive feedback

The team should provide honest feedback for when things go well and when things go wrong. Celebrate successes whether they are seemingly unimportant things like crossing the first 100 registrations or great accomplishments such as national or international recognition. On the other hand, inefficiencies and problems should not be glossed over, but pointed out and discussed in as constructive a manner as possible. Feedback should be both ways – for example, the psychiatrist and the coordinator also need to ask if the field workers and students see deficiencies in the system which they should correct.

When the community detoxification camps for alcohol dependent patients were first planned, I (the psychiatrist) was initially hesitant about managing withdrawals in the absence of nursing staff. The field workers and coordinator, however, were confident that it could be managed without nursing staff provided proper screening and monitoring were done. This ultimately proved to be correct, as the chapter on 'Community-based detox camps' shows.

Record the major decisions

One designated member of the team should note down major decisions and circulate these later to relevant authorities and team members. This can be done as an e-mail to relevant people, or written in a file or register.

In the Shifa project, the psychiatrist writes a brief e-mail containing the major decisions and sends it to the coordinator (who shares it with the field workers and subsequently delegates which worker will take up which task). The mail is also shared with the Medical Superintendent of the hospital and other relevant authorities.

Choosing a target area

This is an important part of getting started. A successful mental health intervention involves good follow up, which can only be done if the team is familiar with the area and has safe and free access. The team should be able to easily penetrate the entire area, and become familiar with the terrain, layout and geographical distribution of villages. This model was specifically designed with rural areas in mind; slightly different strategies might have to be adopted for urban or suburban areas.

Some of the key factors that should be taken into consideration when choosing the area of operations:

Choose an area that would clearly benefit from community mental health services

Although any area could potentially benefit, it would be more meaningful and effective to choose an area that has little access to other mental health facilities. This not only ensures that the residents benefit, but also prevents replication of work in a sector of health care that is overstretched in most low and middle income countries.

Choose an area should be accessible from the base centre

All parts of the target area should be within a defined radius or distance from the base of operations. It is important to bear in mind that mental health work is burdened by the twin challenges of large numbers of patients as well as time-intensive long-drawn treatments. The chosen area and population should be an area that your team can effectively handle. Better to take a smaller area and ensure good follow up services than ambitiously attempt a very large area which is becoming difficult to follow up. See chapter on 'Follow up' for more information on this most important aspect of the model.

The Shifa project is based in an area of 75 villages, all of which lie within a radius of less than 20 km from the base hospital. This ensures that the team is easily and frequently able to access all parts of the target area whenever required.

Divide the area into clusters

This can be based on geographical location, or according to the local government's administrative divisions. This will help to make follow up easier, and may help field staff to divide their work better.

In the Shifa project, we have divided the 75 villages into 11 clusters each having 6 to 8 villages based on geography. There are other possible ways of doing this as well – for example following local government administrative groupings of villages (eg. 'Panchayats' in India).

Choose locations in each cluster to hold outreach visits

This decision must be based on the size, population and accessibility of the cluster. Patients from various parts of the cluster can be asked to come to these central points for outreach camps. However, in case the terrain or transport facilities are unusually difficult, the team may want to visit individual villages in some of the clusters.

Identify areas within these central locations where outreach clinics can be held

The outreach camps can be held almost anywhere where villagers and their authorities are willing to allow. Health centres, schools, government buildings, religious buildings, multipurpose halls, houses of willing villagers or open-air areas like the village square. It is important to fix areas earlier so that the team members can coordinate well and avoid confusion on outreach visits. Often mobile and internet range difficulties may hamper communication in resource-poor areas.

Field staff should become familiar with the entire area

A mechanism needs to be designed by which field workers cover the entire area on a regular basis.

In the Shifa project, we initially started by assigning each field worker a cluster of his or her own to manage all screening, follow up and organizational work. However, we often ran into difficulties when someone was on leave or left as other team members did not know anything about their clusters. To overcome this, we eventually made a system in which all field workers rotate through all clusters in a schedule carefully monitored by the coordinator. This ensured that work went on smoothly regardless of leaves or changes among the field staff.

Conducting an outreach visit

This chapter is in 3 sections:

1. Planning an outreach visit
2. Conducting an outreach visit
3. Reporting

PART 1: PLANNING AN OUTREACH VISIT

This section will focus on the planning arrangements that need to be done before an outreach visit, in order that the actual visit can run smoothly. For a detailed account of what needs to be done *during* an outreach visit, please see part 2 of this chapter below on 'Conducting an outreach visit'.

Choose areas to be covered sufficiently well in advance

This is crucial in order to allow time for the field workers to be able make the necessary arrangements. A good time to plan these might be during the team meetings (see chapter on 'Team meetings'). It is important not only to plan locations but also communicate them effectively to other team members in advance, as mobile phone connectivity is often a problem in remote locations (making last minute calls between team members during the outreach visits difficult and often impossible). For a detailed discussion on how to select a target area, please refer the chapter on 'Choosing an area'.

In the Shifa project, we usually plan a rough schedule at the beginning of the month, and review the plans at the beginning of each week to see if changes are needed.

Inform follow up patients and families about time and location of outreach clinic

Field workers need to notify patients and families about the details of the outreach clinic. Depending on your setting, you need to decide how much notice a patient/family needs of the planned visit, but at least a day's notice is needed to ensure patients are able to attend. Sometimes a family may need a home visit, or patients may need to be brought to the outreach clinic by the field worker and this need to be scheduled into the plan for the day. Field workers need to keep detailed notes so that the relevant information is available for the psychiatrist.

In the Shifa project, our field workers visit patients/families the day before the visits. Each patient has a unique project ID number that makes it easy to identify them as well as communicate information between team members. Some of the patients may have to be brought to the chosen camp sites by motorbike (or by the outreach team's jeep itself), and some patients who are too sick to come may have to be visited at home by the entire team. These decisions are usually left to the field worker's discretion, though they can be discussed with the psychiatrist in case of doubts. Although our team does this by personally visiting the patient's homes, this could also feasibly be done through mobile phone calls or messages in settings where this is possible.

Inform new patients about the time and location of the outreach clinic

New patients are usually identified through screening, during which the time and location of the outreach clinic can be informed to the patient/family. A reminder visit by a field worker in the days immediately before the outreach clinic may be necessary. This is a good opportunity to ensure that at least one reliable family member accompanies the patient to the first outreach visit whenever possible. This not only helps to clarify diagnosis and ensure adequate care, but is also essential for the screening process itself (see 'Screening' chapter for more details).

In the Shifa project, we usually inform the new patients one day prior to the outreach visits. Again, although we do this through personal contact, it could also be done through mobile phones.

Plan how many team members need to be involved in each outreach visit

It is not necessary for the entire team to be involved in each outreach visit. Proper planning and delegation can help ensure that precious human resources and time are not wasted. (See chapter on 'Teams' to review the roles of each of the team members, and how roles can be shared or swapped.)

In the Shifa project, the standard team that goes for the actual outreach visit consists of the psychiatrist, a driver, one or more available nursing students, and a minimum of 2 field workers. Elective students, visitors and other interested volunteers and observers also accompany when present.

Prepare the relevant equipment

This model is specifically designed to be as simple as possible, so there is little heavy equipment. All clinical records, registration documents, stationary, medications and monitoring equipment should be taken. In particular, medication stocks may need to be checked and adequately replenished. Below is a brief discussion on the minimum equipments that will be needed for outreach visits:

- **Basic examination tools for monitoring**

In the Shifa project, we take only a blood pressure apparatus with stethoscope as well as a portable weighing machine. These are taken primarily with the aims of monitoring for metabolic syndrome in those on long-term atypical antipsychotics; we also require the weighing machine for dose calculations of anti-epileptics in children. A glucometer was also considered for metabolic syndrome monitoring, but we decided against it on grounds of cost.

- **Relevant registration and record-keeping equipment**

This would include registers to maintain census, medication dispensing records, registration cards for the patients, and paper to maintain field clinical records.

In the Shifa project, we are currently maintaining manual records of all patients in a large folder maintained by the treating team, and also separate notebooks for recording patient census and medication dispensing records. These could conceivably be adapted into electronic records facilitated by mobile phone apps in settings where these are feasible or available.

- **Medications**
A limited list of low-cost, effective and available medications needs to be decided on. For a detailed discussion of this (including specific clinical suggestions), please refer the chapter on ‘Drugs’.
- **Medicine dispensing equipment**
This includes a container for transporting drugs, and bags or packets to aid with dispensing.
In the Shifa project, we use cardboard boxes to store and transport medicines, and use plastic bags if needed to dispense medicines to the patients.

Arrange transport facilities in advance

This is an often forgotten - but crucial - aspect of planning. Indeed, in resource-poor inaccessible areas, transport is quite possibly the most difficult logistic of all. It is worth remembering that one of the most important barriers to treatment in such areas (that often necessitates such community-based work in the first place) is the lack of good transport facilities. It is better to inform the transport authorities and drivers in advance of the planned locations to avoid confusion. Basic transport requirements would include:

- Access to a vehicle once a week for the outreach team
- Access to transport facilities for field workers during the week for new screening, scheduled follow up and making arrangements for the weekly outreach visits.

In the Shifa project, our field workers use motorbikes for their various tasks during and between outreach visits; these can be modified based on the local resources and facilities. On outreach visit days, the rest of the team travels to the planned sites using a large vehicle like a jeep. We inform the transport authorities about the planned locations one day prior to the outreach visits. In any case, they are aware that we plan outreach visits on Wednesdays.

PART 2: CONDUCTING AN OUTREACH VISIT

This section will focus on how to run an actual outreach visit.

Reviewing follow up patients

The psychiatrist and field workers are responsible for ensuring that all follow-up patients receiving community-based care in the cluster are reviewed. Basic things to check for should include:

- **Are the patients compliant with medications? If not, are there any reasons for this?**
Whenever possible these should be addressed. These can range from side effects to poor supervision by relatives, and even erroneous beliefs such as “these medicines may cause kidney problems” or “I had a fever last week and thought I should not have my medicines till my fever settles”.
- **Are there any drug side effects?**
Some drugs may require special monitoring, which must be done. For example, patients on atypical antipsychotics need to have their weight and blood pressure (and if possible sugars and cholesterol) monitored.

Those on carbamazepine might need to be checked for rashes, and those on phenytoin checked for gait problems. A brief checklist of such common issues can be drawn up based on the drugs chosen by the team.

- **How are the symptoms now?**

Please see chapter on 'Outcome evaluation' to look at easy to use tools/guidelines for this

- **How is their level of functioning and community re-integration now?**

Level of patient or family expectations might differ according to cultural and social factors depending on the setting. However, our outcome evaluation tool has general questions that may be asked (please see chapter on outcome evaluation).

In the Shifa Project, because we are based in a poor rural area, we focus on domestic tasks for women and agricultural or manual labour tasks for men. A patient able to regularly engage in at least these tasks would be considered functional in our context. This would, of course, vary according to setting.

- **Are there any other specific issues or concerns?**

These need not be related to the specific disorder alone, and may include family concerns, occupational issues or anything else that the patient or family brings up.

A suggested format for clinical records that covers all the above concerns is included in the Appendix of this book ('Padhar Community Mental Health Clinical Records').

Family and patient education

This is a very crucial component of the outreach visits. Ideally, all patients and families should be counseled and educated as part of the regular outreach visits. However, if time is an issue, these can be done in groups as well. For a detailed discussion of this (including the essential points that need to be covered), please see the chapter on 'Role of family'.

In the Shifa project we employ both individual and group counseling for patients and families. At diagnosis, patients and their family members are educated individually by the psychiatrist during the initial and review sessions at outreach visits, and group therapy sessions are held periodically at cluster level for all follow up patients and their families. For a discussion on how to conduct these group sessions please see the chapter on 'Group therapy in rural mental health programs'.

Assess new patients identified through screening/any other route

Any lay worker screening, whether done informally or with the help of screening tools, will result in some false positives. It is therefore essential that the psychiatrist evaluates the new patients *before* they are registered under the project. Once a diagnosis is made, the psychiatrist will finalize the management plan, including whether the patient is to be managed in the community or referred to the hospital. All patients who receive a diagnosis should be registered and given a unique ID number to facilitate identification and follow up. Those who do not have a diagnosis ('false positives') may be reassured and sent away. Please see the 'Introduction' chapter for some information on how various disorders are managed in Project Shifa.

Add new patients to follow up list

This is important in order to ensure that patients are followed up regularly by the field workers and are reviewed by the psychiatrist in subsequent outreach visits.

Do any home visits if required

Home visits can be done for specific patients who are too sick to come to the planned sites, or live in very inaccessible or remote locations. The psychiatrist and field workers should decide this on a case-to-case basis. Whenever possible, it is easier and more efficient to have the patients come to the planned sites. Home visits should be reserved for cases where there is no other alternative.

PART 3: REPORTING

Good reporting is one of the crucial aspects of a successful program. However good the team's work is on the ground, others can learn about it only if reporting is good. There are at least two types of reporting that must be done:

Regular census reports after outreach visits

These reports are intended for internal circulation among team members and important authorities in the base hospital/centre. Such reports must include at least the number of patients seen (both new and follow up), the number referred to the hospital for further evaluations, the number given medications in the field and the number of house visits made. If possible, you can give a break-up of major diagnoses as well.

More detailed reports on activities and progress of the project at regular intervals

These longer reports should provide details not only about the outreach visits, but also other activities of the team like team meetings, academic activities, research and networking activities with others. Current challenges, possible solutions and future directions can also be mentioned.

In the Shifa project, we have weekly census report circulated internally by e-mail among relevant authorities within the base hospital at Padhar. In addition, we have detailed monthly and half-yearly reports which are circulated to a wider audience of donors, well-wishers and anyone interested. These reports greatly helped in gaining support and recognition for our work at national and international levels. The half-yearly reports are available as free online resources that can be downloaded on Project Shifa's innovation page on the Mental Health Innovation Network website (<http://www.mhinnovation.net/innovations/project-shifa-community-mental-health-project-padhar-hospital>)

Follow up

The most critical ingredient of any mental health intervention is good follow up. In contrast to many other types of interventions (such as surgical procedures for example), a one-time contact arrangement is of little use for patients with mental health issues. The majority of the major syndromes are chronic conditions that need psychological support, encouragement and lifestyle changes in addition to long-term medications (which are slow-acting in most cases). In these major syndromes, better outcomes are directly related to compliance with drugs and regular contact with the treating team. Even mental health issues that do not require medications as the primary intervention (such as adjustment disorders, stress related conditions, medically unexplained symptoms, substance problems or marital and family discord) most often benefit from sustained and regular contact with the treating therapist or team.

There are multiple ways to ensure this. However, some key steps to ensure successful follow up would include the following:

Identification of patients

Develop a system that ensures proper identification of patients.

In the Shifa project, we register all patients with diagnosed mental health conditions and give them a unique ID number and card. This not only facilitates easy identification of patients in the field, but also helps with record keeping as well as makes it easier for patients to be directed to the psychiatry department if they come to the hospital.

Dividing patients into 'Community-based' and 'Referred' groups

Identify which patients need community-based follow up and which patients need referral to the base hospital. Only the 'community-based' list of patients would require regular follow up in the field (the rest would become regular outpatients in the base hospital, and would be managed as such).

We follow up predominantly patients with epilepsy, severe mental disorders and developmental disorders in the community. Most of our patients with common mental disorders are referred to the base hospital for outpatient management (see chapter on 'Conducting an outreach visit').

Planning interval of contact with psychiatrist during outreach visits

Based on available manpower in the team, work out a schedule in which the psychiatrist can see the patients on outreach visits (see chapter on 'Outreach visits' for further details). This can even be at intervals of 3 or 6 months, or even as telephone or internet-based consultations.

We follow a system by which the psychiatrist meets each community-based patient in the field on outreach visits once in 3 months. This has been done by covering roughly one cluster of villages per week on the weekly outreach visits, so that the eleven clusters are covered in approximately 3 months. This could be adapted in many other ways as well – for example, having a series of outreach visits during at the end of 3 months rather than having one every week.

Field worker follow up between outreach visits

In the intervening periods between the review consultations by the mental health professional, the field workers should review the community-based patients at regular intervals. This can be flexible based on the number of workers available and the size of the target area. **This is the single most important component of the follow up system, as it ensures frequent and regular contact with the team.** Important areas they should explore during their follow ups are:

- Compliance with medications
- Reasons (if any) for poor compliance
- General improvement in symptoms
- Functional improvement and community re-integration
- Any other specific issues including emergencies

Field workers should document these basic details on a follow up sheet. This would ensure that even if a different worker is present with the psychiatrist at the next outreach visit, there would be smooth transfer of information. In case of problems encountered, these should be informed to the psychiatrist at the earliest, or discussed at the weekly team meeting (see chapter on 'Team meetings').

Our field workers follow up each community-based patient at their homes twice a month. This is done by setting aside two days in the month in which all ten of them go out together, dividing the areas and patients between them. This makes it easier and more efficient than them each going on different days (as all of them are involved in other projects as well). It also ensures that information regarding all follow-up patients can be obtained systematically by the psychiatrist at regular intervals. However, this can be done in other ways as well. For example, each field worker can be assigned a particular area and asked to cover all his patients at his convenience at least once during a particular time interval (like a month).

Screening

There are many ways of screening for mental health issues in a population. Various tools are available for use in different settings, including tools specifically designed for community use. However, there are some difficulties in this regard – most of the available community tools are self-reported tools to be filled by the patients themselves, or are semi-structured interviews involving a considerable degree of clinical judgment and training on the part of the interviewer. Neither of these formats is easy to use in very low resource rural settings. First, many patients may be illiterate and therefore unable to read and fill forms. Second, trained manpower to conduct semi-structured interviews is sorely lacking, and training new workers to correctly pick up psychiatric syndromes is a time-consuming process (though certainly very possible).

Another problem is that most community-based screening tools focus predominantly on depression and anxiety, and neglect severe mental illness, epilepsy and developmental disorders – all conditions that cause far more morbidity and dysfunction than depression or anxiety (and are often easier to treat as well). A way out of this might be to use a combination of different tools (one for depression and anxiety, one for psychosis, one for epilepsy and one for developmental disorders for example), but this is obviously a very tedious and cumbersome process involving a lot of paperwork and time.

To overcome some of these difficulties, we designed a new family-level screening tool to screen for all major psychiatric syndromes, epilepsy and developmental disorders (*PaCoMSI – the Padhar Community Mental Health Screening Instrument*). Apart from some basic demographic details, it includes a series of 12 “yes/no” questions, and takes between 5 to 10 minutes to administer (in Hindi). It is designed to be asked to one person per household (preferably the head of the family if available), and is phrased in such a way as to capture conditions in all family members. By decreasing the number of people who need to be interviewed (one per family instead of every individual), it greatly reduces the time and effort required to screen entire village populations.

A pilot evaluation of this tool in its Hindi version had a sensitivity of 93% and specificity of 94% in picking up major psychiatric syndromes, epilepsy and developmental disorders. Larger sample sizes in different settings will of course be needed to firmly establish its validity, but these preliminary data show it appears to be useful in resource poor settings.

PaCoMSI is printed in the Appendix in this manual. We recognise that some of the questions have been deliberately phrased in idioms or language particular to our cultural context. For example the question on ‘demon possession’ was included to reflect a very common model of causation of mental illnesses among our target tribal population, and the emphasis on headaches in the anxiety question was to reflect the considerable co-morbidity of anxiety among our patients with migraines and other headache syndromes. We have found such strategies useful in picking up mental health issues which patients may otherwise not have brought up. We would encourage users to adapt these to their local contexts and assess the tool’s effectiveness in their target populations.

Screening using PaCoMSI

There are 2 phases in screening in any village or cluster as being done in Project Shifa:

Phase 1: Screening by field workers of heads of households using the PaCoMSI.

Phase 2: Face to face routine clinical evaluation by psychiatrist of those who screen ‘positive’ with the PaCoMSI.

Phase 1 screening (ie. using the PaCoMSI) is NOT a diagnostic screening. All that can be said of those who screen ‘positive’ is that they probably have a major psychiatric syndrome, epilepsy or a developmental disorder. It is possible that some of them may not have any of these, and have been falsely screened in (‘false positives’). This will be sorted out in phase 2 of screening, where all the ‘positive’ persons are evaluated by the psychiatrist. Should there be any false positives, they can be sent away with no treatment. Once a diagnosis is fixed by the psychiatrist, a relevant

management plan can be made (medications in the field, referral to hospital for psychotherapy, referral to other departments etc).

Training field workers to use PaCoMSI

Have a brief training session for new field workers (between 1 to 2 hours in total). It should involve making them read the instructions *verbatim* (as that is what ensures uniformity), and clearing any conceptual doubts they might have. It is important that the field workers understand the questions themselves, so they can clarify any doubts among the people they screen. A brief role-playing exercise in which they practice it on each other is also useful (and was used on our field workers in the Shifa project when the tool was designed).

Instructions for using the tool in the field

- Instruct the field workers to use the tool verbatim while screening, and clarify any misconceptions or doubts only if some aspect of the question is not understood by the person being screened.
- The questions should be asked to **ONLY ONE PERSON PER HOUSEHOLD**, preferably the head of the family. In case the head is not available, any other responsible person can be asked.
- If anybody in the household qualifies for a 'yes' in one or more of the 12 questions, that person (or persons if there are more than one) should be considered as 'screen positive', and should be informed to come to the next outreach visit of the psychiatrist to that cluster or village for phase 2 of screening (evaluation by a mental health professional to fix diagnosis and plan management).
- If all questions are 'no', nobody in that family needs to be assessed by the psychiatrist.

Outcome evaluation

Outcomes are a very important – and often neglected – aspect of mental health programs. Many individuals and organizations across the third world deal in compassionate and meticulous care of patients with various mental health issues, but often their stories get lost because they have been unable to generate evidence of positive outcomes. Ministries of health, donors, administrators and lawmakers want hard data, and are often unable to understand what is meant by ‘improvement’ in the context of mental health. Surgical, ophthalmological and cancer programs get so much more attention, funding and visibility than mental health because the outcomes are obvious and clearly understood by the non-specialists involved in organizing and fund-raising.

Modern mental health interventions are often effective in reducing symptoms, improving functioning and quality of life. Yet, somehow this aspect is often not projected to the donors administrators and lawmakers who determine funding and policy. We feel there are two major reasons why resource-poor mental health teams struggle so much to show outcomes:

- The traditional methods of outcome evaluation in psychiatry are rating scales that are often long, time-consuming and require at least some amount of training to administer (not to mention the paper work involved). This is clearly not a practical method in resource-poor rural programs run by lay workers who may not even be literate, let alone trained in identifying psychopathology.
- Psychiatric rating scales too often focus on improvement in symptoms and psychopathology – concepts that are difficult and often mean little to the non-specialist. Policy makers and donors need simple measures they can understand and relate to, and that they can easily quote and publicize.

To overcome these concerns, within the Shifa project we have developed a simple outcome evaluation tool that focus on outcomes most relevant for patients and non-specialist stakeholders, which are also useful for clinicians. Our outcome evaluation tool is printed in the Appendix of this book.

Outcome evaluation tool

The Padhar CMH outcome evaluation tool covers 4 broad domains:

- Symptom reduction
- Compliance with medication
- Functional improvement
- Community re-integration

There is a single question each for compliance, functional improvement and community re-integration regardless of underlying disorder. For symptom reduction there are a few simple questions, which vary by underlying disorder (for example asking about seizure frequency in epilepsy, remission of positive psychotic symptoms in psychosis etc.).

The tool is designed so that any member of the team, including lay workers, can administer it. It can be either periodically administered on patients in the field, or filled up at regular intervals using available clinical and field records. Along with the outcome evaluation tool, a suggested format for regular clinical records that will help ensure all relevant data for outcome evaluation are systematically recorded at each outreach visit is also provided in the Appendix section of this book.

We recognise that other programs might be better endowed with a greater number of trained professionals, in which case it might be feasible to use traditional psychiatric scales. Our evaluation sheet is only a suggestion, and we would encourage others to adapt it for their own particular needs. But the important thing is that simple outcome data that non-specialists can easily comprehend is essential in order to project the success (or failures) of a rural mental health program.

We have found the Padhar CMH outcome evaluation tool to be a useful tool to generate data on the overall progress of the project as a whole. We have been able to include our outcome evaluation data from our 6-monthly evaluations in a paper describing our model that was accepted for publication in the British Journal of Psychiatry International in September 2016 (yet to be printed). Our detailed 6-monthly reports are available online on Project Shifa's innovation page on the website of Mental Health Innovation Network
(<http://www.mhinnovation.net/innovations/project-shifa-community-mental-health-project-padhar-hospital>).

Many important deficiencies and learning points also came out of these evaluations – for example, we learned that our project had a far greater impact on severe mental disorders and epilepsy (with about 80% showing improvements in functional status and re-integration) than common mental health conditions (with only about 30% showing improvement). On the other hand, we found that our patients with developmental disorders fared far better than we ever expected (with about 35% showing an improvement in functional status and re-integration), probably because we aggressively screened for and treated co-morbidities. Such figures and concepts can easily be communicated to non-specialists.

Role of family in a rural mental health program

Strong joint family systems, with multiple generations and degrees of relatives living together or near each other, are a characteristic feature in many rural third world cultures. Rural India is no exception to this. Although these strongly entrenched, mostly patriarchal systems sometimes have significant social disadvantages, there is no doubt that they can exert a very positive influence on health outcomes, and even specifically on mental health (many cross-cultural studies on schizophrenia, for example, have consistently demonstrated better outcomes in lower and middle income countries – a fact that has routinely been attributed to the strong family systems in place). A detailed discussion of family dynamics in the various cultural contexts of third world countries is beyond the scope of this book, but this chapter will focus on practical ways of engaging this powerful and easily available resource in rural mental health programs.

Rehabilitation work is often easier in rural settings than in urban settings. Useful and culturally meaningful occupations or activities are easily available, and these mostly do not require very high level of cognitive functioning (see below). Also, family expectations are often less demanding than in urban settings – a factor which plays a key role in developing self-confidence and self-esteem among recovering patients. Once patients take up economically or culturally relevant tasks, they easily re-integrate into their communities.

The Shifa project engages families as the primary care providers. Families are trained to administer and supervise medications, provide support and encouragement, and facilitate rehabilitation. This dependence on families is a great strength in that it helps to lower the cost and improve the acceptability of treatment, and also facilitates quicker re-integration of patients when they are better as they are in their own natural environment. However this can also be a weakness of the model – it is difficult to provide effective care to patients who do not have supportive families. In settings where families are not so strong, alternative locally available support systems should be considered. Possibilities could include religious workers, charitable organizations, government health systems and aid agencies, among others.

Below are some brief suggestions on how to engage families (or other alternative support systems) in the model of care. These can be assessed and addressed either in individual review sessions or in groups (see chapter on ‘Group therapy in rural mental health programs’)

Educate about the illnesses in question

It is important for the team to know what the family’s understanding of the illness is, because this often guides their decisions. In many rural settings, spiritual models in particular are prevalent, and should be handled in a sensitive manner (see chapter on ‘Religion and spirituality in rural mental health programs’ for a discussion on this important issue). Biomedical or psychological models of mental disorders should be presented in a sensitive and non-confrontational manner in these settings. A useful method is to emphasize that psychiatric interventions provide symptom relief, regardless of ultimate cause of the conditions.

Tell the families exactly what they need to do in the initial acute phase of treatment

Instructions should be concise and simple, so that even illiterate people can carry them out accurately. For example, “Give one tablet of this medicine every night at 8 pm and ensure that he gets it daily and on time.” Or “Make sure that she is never left alone. Someone should accompany her wherever she goes.”

Tell the families how to manage specific emergencies

Families should be educated, on a case to case basis, regarding what they can do at their level to manage specific clinical challenges that might arise. Not all families may need to be educated about all these issues (eg. some patients may not be on medications and hence non-compliance is not an issue. Other patients may not have a suicidal risk and hence suicidal precautions need not be discussed). Some strategies that can be used include the following:

- **Non-compliance**
This is especially an issue in patients with psychotic disorders, where insight into illness is a problem. Strict supervision by family members is often the best and easiest solution. In very difficult cases, especially in extremely paranoid patients who might not trust their family members, covert medication administered in food or drinks is a viable and cost-effective option (see sections on 'Drugs' and 'Rights issues in rural mental health programs' for more on this sometimes controversial issue). In settings where depot antipsychotic injections are feasible, this option can also be discussed.
- **Drug side-effects**
A list of the most important acute side effects of the chosen medications must be made, and family members educated accordingly. (For example, severe rash with carbamazepine or severe dystonias and difficulty swallowing with older antipsychotics.) In any of these cases, they can be advised to discontinue the drug and immediately contact the team. In case of milder issues or doubts, they can wait until the next follow up by the field worker to discuss the issue.
- **Violence**
Despite the huge hype about violence among patients with severe mental illnesses, the majority of patients with chronic psychotic disorders are not violent. However, families must feel comfortable to contact the team in case of such issues. In many rural settings, the presence of joint families and strong communities usually ensures that sufficient people are around to manage a crisis, and families should be encouraged to use such local resources. Families should also be educated that drugs take time to act, and it may take a few days to weeks before all the acute aggressive behaviors are controlled. During such acute periods, patients should never be left alone.
- **Suicidal tendencies**
In patients where a strong suicidal risk is suspected, educate families about suicidal precautions. This includes minimizing access to all potential weapons (knives, scissors, agricultural poisons, ropes etc.). These patients should never be left alone: someone should sleep near them, they should never leave home unaccompanied, and doors should never be locked if they are inside a room alone. Medications (if any) should be strictly supervised and kept with a responsible family member in order to prevent overdose.

Tell them how to contact the team in emergencies

Measures should be in place so that patients and families can contact the team in an emergency.

Make sure the patient/family know how frequently team members will visit

Patients/families should know the rough frequency of field worker follow ups and outreach visits.

Assess and address family burdens and stress

Often simple strategies like making family members share the burden of care by taking turns, and giving positive feedback to the families on their good care when patients improve are sufficient to address these important issues. Rural families often do not expect much, and are very grateful when patients improve.

Address patient and family expectations

It is crucial to assess and address the expectations that the patient and family have from the interventions. The treating team needs to share realistic and honest information with them about this, and encourage them to plan rehabilitative strategies with these aims in mind. For example, expecting that a child with a developmental disorder such as mild to moderate mental retardation will do academically well in college will inevitably lead to dissatisfaction and disappointment. But such a child might be able to at least look after his personal hygiene and care, and may even be able to assist with certain domestic or agricultural tasks with some training and supervision. If families are guided through these decisions, re-integrating patients is much easier.

Address 'expressed emotions' if needed

Strong emotional reactions within the family dynamics are known to impact the prognosis of severe mental disorders. Sometimes family members are overly critical and hostile towards the patients, and this makes patients resentful and less likely to be compliant with treatment. On the other hand, some family members are over-concerned and smother patients with love and attention, often preventing them from taking active roles in their life, thus hampering rehabilitation. Either of these extremes needs to be avoided. Some strategies to deal with these include:

- Tell family members not to discuss symptoms or behavior in a critical manner in front of patients. They can do this later.
- Address stress and burden among family members (see above) so that cumulative stress is not unconsciously transferred to the patient as anger and hostility
- Educate about the illness (see point 1 above) so that they know when unpleasant or odd behavior by the patient is illness-related. Such symptoms will improve with treatment.
- Gently explain that over-protectiveness and emotional over-involvement may also hamper the patient's rehabilitation, especially when she is better. The patient should be allowed to take an active role at work or at home once symptoms have improved.

Encourage families to adopt locally relevant rehabilitative strategies

This has to be decided depending on the setting. Rehabilitative strategies in rural areas work best if they are simple, practical and acceptable in the local cultural setting. Low-resource rural programs may not have trained occupational therapists or access to good vocational rehabilitation facilities. In such settings, the family can play a crucial role. It is important to look for simple and easily available tasks that improve self-confidence and reduce family burden. For many patients even encouraging them to become independent in activities of daily living (like feeding, personal hygiene, dressing etc.) is itself a good start, eventually progressing on to household or occupational tasks. Depending on the setting these could even include basic agricultural or manual labour tasks such as looking after goats, collecting water, washing, cooking, helping with the harvest etc..

In the Shifa project, the rehabilitative strategies focus on agricultural work or manual labour for men and predominantly domestic chores for women. This reflects the rural setting as well as the culturally sanctioned and acceptable gender roles in our target area. As soon as psychotic or epileptic patients get better, families are encouraged to get them involved in these tasks in a graded manner. If feasible and available, men and women can take up any other available jobs as well: these decisions are left to the patient and family. Many of our recovering patients have been able to get jobs outside our area as well, some even in other parts of the country.

Religion and spirituality in a rural mental health program

Religion and the modern mental health professions have had an uneasy relationship over the past two centuries, with the pendulum often swinging from bitter animosity on one hand to the opposite extreme of uncritical acceptance on the other. In general, the field of mental health is currently moving towards constructive collaboration with religious workers, as both sides realize the immense value they can offer to each other in the shared goal of making hurting individuals whole again.

In rural mental health work in most lower and middle income countries, it is impossible to ignore the widespread influence of religion and spirituality on individual and group behaviour. Although there are numerous points of intersection between the rural mental health worker and the religious/spiritual healer (and a detailed discussion is beyond the scope of this book), we think the following three areas have practical relevance for setting up and running an effective and culturally-sensitive rural mental health program.

Alternative models of illness

Mental health conditions often resemble normal emotional experiences. In addition, most people undergoing crises will experience emotional turmoil and struggle with inner conflicts – all areas that traditional religious workers have dealt with for centuries before the advent of modern psychiatry. It is thus natural for most rural people with mental health conditions – including severe ones like psychosis and even epilepsy – to consider such workers as the natural “doctors of the soul”, as opposed to the medical doctors who treat obvious physical disorders. Depending on the local cultural context, various magico-religious models of causation of mental illnesses are routinely accepted by rural populations – demon possession, karma, punishment of sins, evil eye, hexes, spells etc..

It is worth remembering that, for the most part, the exact causes of most mental illnesses are still largely unknown, and all the evidence currently points to multi-factorial causation including a combination of biological and psychosocial factors. As much as we like to invoke a scientific aura about our treatments, the fact remains that most psychiatric drugs and psychological therapies are still symptomatic treatments – not ‘curative’ treatments like antibiotics, for example. This humble assessment is not, however, the way many mental health professionals present their model of etiology or treatment to patients. Often a ‘scientific’ biomedical model is arrogantly - and unfairly – presented, and alienates the cultural sentiments of the patients and communities. This often may lead to considerable dropouts from treatment.

In the Shifa project, we chose not to directly confront the existing models of causation, but rather to present our medicines and non-pharmacological interventions as primarily symptomatic treatments that relieve distress. We avoid questions of ultimate causation unless these are brought up by patients/relatives in individual (and especially group therapy) sessions. In such cases, we tend towards an agnostic position to ultimate causation, acknowledging that multiple factors play a role, possibly even spiritual ones. We find this allows space for the patients and families to retain the support of traditional religious systems while still benefitting from psychiatric interventions.

Alternative treatments

A large number of rural patients may have already approached one or more religious or spiritual healers during the course of their illness. Many others may approach these workers even after initiating psychiatric medications or alongside their psychotherapy. In many resource-poor rural settings, they are the primary ‘competition’ for the mental health team, not other mental health professionals. It must also be remembered that many of these healers

actually depend on such patients for their income. This fact alone makes them potentially formidable opponents to any new mental health program, and must be factored into the team's decision making. At times, the family may struggle to pay the high prices demanded by some of these workers, and this can be an additional burden on the families.

In the Shifa project, we have not directly confronted any of the local spiritual healers. Our few direct meetings with them have actually been friendly. In at least one instance, we treated one such healer (though not from our target area) who had a psychotic illness at the base hospital. We generally encourage our patients to continue their magico-religious interventions alongside our treatments if they want to. However, if these rituals are physically harmful (such as beatings, brandings or burnings), we would strongly discourage them. So far, we have not had any conflicts with any local healers as a result of our project.

Additional support systems

Religious establishments in general, including religious healers, are deeply enmeshed in the local cultural scenario. Although sometimes responsible for ostracizing and harming patients, they can also be harnessed as culturally-appropriate and easily available support systems. The small number of mental health professionals and teams in rural areas makes it imperative to employ as many existing support systems as possible.

Just as we attempt to harness the strong existing joint families as support systems for our patients in the Shifa project, we also encourage our patients to use whatever existing spiritual and religious support systems are available. Especially in community-based work, the time of contact with the psychiatrist and the team is limited, and any additional support is valuable. Again, the only exception to this is if physically harmful rituals are being practiced.

Group therapy in rural mental health programs

Non-pharmacological interventions are a key aspect of therapy in all mental health conditions, though the degree to which they contribute to successful outcomes is of course different across disorders. In common mental health conditions like mild to moderate depression, anxiety and substance problems non-pharmacological interventions are the key drivers of successful treatment, with evidence clearly showing they are equal and often superior to drugs alone. The situation is very different in severe mental disorders and epilepsy. Drugs are undoubtedly the primary treatment for these conditions. Non-pharmacological interventions nevertheless play a definite and clear role in ensuring good outcomes. For example, a patient with schizophrenia from a family in which there is highly charged emotional interactions with the patient as a result of which drug supervision is not good will naturally do better if the team is able to address the way the family understands the illness and helps them communicate better. There is also emerging evidence that certain specific non-pharmacological strategies such as cognitive-behavioural therapy (CBT) can benefit even in residual core symptoms of psychosis like hallucinations in drug-resistant cases, and that early intensive CBT may be more effective than drugs if given early in prodromal stages of schizophrenia.

Although it is always ideal to have good individual therapy sessions, time may be a major constraint in many community-based settings. That is where group therapy is a very useful alternative. Although there are a vast array of therapies and techniques that can be used in group format, this chapter focuses specifically on psycho-educational group sessions for patients and families with severe mental disorders and epilepsy, with an additional section on what can also be done for developmental disorders in a low-resource rural community-based setting.

In the Shifa project, we do psycho-educational group sessions for patients and families with severe mental disorders, epilepsy and developmental disorders together at cluster level at regular intervals. This compliments the psycho-educational and supportive work the team does on an individual basis (by the psychiatrist during outreach visits and by the field workers during their fortnightly home follow ups). We currently do not have non-pharmacological interventions targeting common mental disorders as part of Project Shifa; all patients with those conditions are referred to the hospital for outpatient treatment. However, motivational counseling and brief cognitive-behavioural interventions in group format are an integral part of the community detoxification camps for alcohol dependent patients organized by Padhar Hospital (please see chapter on 'Community detoxification camps in rural settings').

In our setting, the psychiatrist acts as the group therapist for these sessions. However, the techniques used have been chosen so that they can easily be delivered by other team members.

Supportive psychotherapy group for severe mental disorders

- **Members:** patients with severe mental disorders and epilepsy along with their family members/caregivers (*in the Shifa project, we also include developmental disorders as well as we cannot have separate sessions for them due to time and human resource constraints. The next section of this chapter has a brief note on what can be specifically focused on for patients with developmental disorders*).
- **Therapeutic modality:** supportive, psycho-educational and family-oriented

- **Type of membership:** heterogeneous (in view of multiple disorders, all age groups and both genders), open-system group (ie. might be having new members in each session)
- **Thematic focus:** psycho-education, building and strengthening existing defenses, building coping skills, care-giver burden and expressed emotions.
- **Duration:** 45 minutes to 1 hour
- **Structure:** *(This is a suggested framework for conducting a group session, with approximate time durations for each sub-section. Order and content can be modified based on local needs)*

a) Ice-breaking/rapport building (5 min)

This is a time when the therapist introduces himself (especially if he is not the treating therapist or the regular team member in contact with the patients). A brief introduction to the purpose of the group can be made (including a thematic introduction to mental disorders and their treatment if this is necessary) and introductions of each member (if they do not already know each other) may be required.

b) 'Free' or unstructured phase of session (10-15 min)

Basically allow members time to say whatever they feel like saying during this phase, without specifically directing the flow of the discussion. Encourage all members to have a chance to say something, and try to prevent one or more members from 'taking over the group' in as gentle a way as possible. This phase helps make members comfortable within the group and with the therapist. It also gives the therapist a chance to grasp major issues which might have to be addressed in this and future sessions, or in-between sessions, and to identify specific members who may need more intensive work. It also helps to strengthen cohesive dynamics within the group, by making every member feel valued and important.

c) Structured phase – specific agendas (15 min)

These topics need not all be covered in a single session. This depends on how many sessions can be held and how frequently. The therapist should decide which of these issues need to be focused on in which session. Some of these topics include:

- Addressing understanding of illness and models of causation
- Addressing issues of stigma
- Addressing issues of 'expressed emotions' (please see chapter on 'Role of family')
- Teaching strategies to deal with emergency situations (like non-compliance, violent behavior, suicidal behavior etc.)
- Suggesting simple rehabilitative strategies that families can practically do in their setting. (eg. Basic activities of daily living, keeping an activity schedule for the day, getting involved in simple domestic and agricultural work as early as possible etc.).

d) 'Sharing phase' (10 min)

Time for using individual patient success stories and struggles among group members as an example and encouragement for others, and for giving validation and positive reinforcement for contributions for individual or collective family members

e) Conclusion (5 min) – wrap up and conclusion

Specific strategies for patients with developmental disorders:

A similar format can be used as described for severe mental disorders, but some additional issues can be focused on:

- Educate about the permanent nature of these conditions (as opposed to many other mental disorders which may improve significantly).
- Ensure that parents/family understand that the issue is not that these patients have 'no intelligence', but that their intelligence is not age-appropriate. Often this fact alone makes parents understand how to deal with the patients much more easily. For example, *"This patient is like a 3 year old child, even though he is in the body of a 10 year old. Think of interacting with him as though he was 3 years old, and let us try to teach him skills we would expect a 3 year old to know... he might be able to those very well."*
- Attempt to develop a schedule of daily activities, and work out what the families think they can do with the patients.
- If there is time, and if there is a person with good mental health training in the team, certain simple behavior therapy strategies can be incorporated. For example, explaining about how certain behaviours can be reduced by avoiding antecedents or manipulating consequences. Simple reinforcement schedules with appropriate rewards can also be discussed. Leave these strategies out if the team has no access to a trained mental health professional. Another option would be to get one team member to go for a short period of training with a nearby mental health professional and learn some of these basic skills. In setting where it is feasible, this can also conceivably be done through video-conferencing.

Drugs

The choice of what drugs to use is one of the key factors in ensuring the success and cost-effectiveness of the rural CMH program. Rather than suggest a particular set of drugs, this section will focus on what factors need to be considered in choosing drugs to be used.

- Choose a small selection of basic drugs
- The drugs chosen should be inexpensive
- The drugs should be easily available in the given setting
- The drugs should be evidence-based and known to be effective agents in large population trials
- The drugs should have a side-effect profile that can be easily monitored and relevant interventions done in the given settings

Given below is a table containing the World Health Organization's Essential Medicines List, 2015 (adults) for the conditions we treat as well as the drugs we use in Project Shifa.

Drug class	WHO Essential Medicines List	Drugs we use in Project Shifa
Antipsychotics	Chlorpromazine Haloperidol Risperidone Fluphenzine (long acting depot injection))	Olanzapine Risperidone Fluphenazine (long acting depot injection)
Anticholinergics (to treat extra-pyramidal side effects of antipsychotics)	Biperiden	Trihexiphenidyl
Antidepressants	Amitriptyline Fluoxetine Clomipramine	Amitriptyline Fluoxetine
Mood stabilisers	Lithium Sodium valproate Carbamazepine	Carbamazepine
Anti-epileptics	Sodium valproate Phenytoin Phenobarbitone Carbamazepine Midazolam	Phenytoin Phenobarbitone Carbamazepine
Benzodiazepines	Diazepam Lorazepam	Diazepam Lorazepam Chlordiazepoxide
Vitamins	Folic acid Thiamine Nicotinamide Vitamin C	Folic acid B complex multivitamins

The above selection of drugs we use reflects the scenario we work in, and it is quite possible that an entirely different set of drugs may be more accessible and relevant in a different area. However, we would like to explain our choice of drugs in the hope that it might help readers become familiar with some of the processes involved in the selection.

Antipsychotics

Risperidone and olanzapine are atypical antipsychotics that have robust evidence of efficacy across psychotic disorders and other severe mental disorders like bipolar disorder. In India, they are also very economical with average doses (ie. 4 mg risperidone or 10 mg olanzapine) costing less than USD 3 per month. We refrained from using typical drugs like haloperidol and chlorpromazine (even though they are inexpensive) largely because we wanted to avoid extra-pyramidal side effects (particularly acute dystonias and tardive dyskinesia) as far as possible. This was, of course, balanced by a risk of weight gain and metabolic syndrome with the atypicals (particularly olanzapine). However, we felt it was easier to monitor and manage these in our setting. A considerable number of our patients are also under-nourished, so weight gain was often seen positively as well. In addition, most recovering patients with psychoses engaged in agricultural or manual labour jobs that involve considerable physical activity.

Both risperidone and olanzapine in low doses can also be used to target extreme aggression in patients with mental retardation or other developmental disorders (0.125 to 1mg of risperidone or 1.25 to 5 mg of olanzapine). Risperidone, particularly, is also useful for targeting stereotypical movements and behaviour in developmental disorders.

The formulation of olanzapine we use is mouth dissolving, and can thus be easily mixed in food or drink in an acutely agitated psychotic patient. Many families in our setting find this easier than bringing the patient to hospital for injections. We do have fluphenazine decanoate as a depot injection, but have used it on only 2 of our more than 100 patients with various psychotic disorders under the project.

Anti-cholinergics

We use trihexiphenidyl as an anticholinergic agent for managing the extra-pyramidal side-effects of antipsychotics.

Antidepressants

We chose amitriptyline and fluoxetine primarily because they are inexpensive and easily available (25 mg amitriptyline or 20 mg fluoxetine daily would amount to less than USD 2 per month). In addition, amitriptyline has two other specific advantages. First, it is sedating and can avoid the additional prescription of a benzodiazepine for sleep, thus cutting down cost. Second, it can be used for migraine prophylaxis as well, especially for those with co-morbid anxiety or depression (thus cutting down the cost of using other drugs additionally for migraines).

Mood stabilisers

The only mood stabilizer we use is carbamazepine. We do not use lithium as we cannot monitor blood levels, and we avoided sodium valproate because of cost issues.

Anti-epileptics

We use phenytoin and carbamazepine, both of which are easily available and inexpensive (300 mg of phenytoin or 600 mg of carbamazepine would amount to an average of about USD 4 per month). Other effective agents such as levetiracetam and sodium valproate are much more expensive in India. We use phenytoin as first line for all generalized epilepsy, and carbamazepine primarily for partial seizures. Carbamazepine is also used for generalized seizures in certain special cases – eg. tolerability issues with phenytoin, or in certain children with developmental disorders and hyperactivity. By and large, phenytoin has the advantage of an easy to institute regimen that does not involve gradual increases or tapering, thus enhancing compliance by preventing potential dosage errors.

In our considerably large population of patients with epilepsy (more than 60 in our target area, most of whom had generalized seizures), we have encountered only 2 patients with gum hypertrophy and one patient who developed signs of toxicity while on phenytoin (our doses are invariably in the 200-300 mg range for average adults). 80% of our epilepsy patients have had seizure reduction, and about 60% have achieved complete control. Thus, phenytoin appears to be a safe and effective drug if used in this dose-range in such settings. If available and affordable, monitoring of blood levels of anti-epileptics (especially phenytoin) is desirable¹.

Remember anti-epileptics can increase the risk of congenital anomalies in pregnancy and folic acid is used to reduce this (see 'vitamin' section below).

Benzodiazepines

We rarely ever use benzodiazepines in our regular field work. Mostly, we try and manage sleep issues by choosing a sedative primary agent (such as olanzapine for psychoses or amitriptyline for depression). Lorazepam would be our first choice in an acutely aggressive patient who needed more than just an antipsychotic. However, in most cases families find it easier to manage with a single drug rather than poly-pharmacy. We also use diazepam occasionally in the few cases of drug-induced tardive dyskinesia we encounter, as well as a muscle relaxant in some of our developmental disorders (like those with cerebral palsy). For our community detox camps (see chapter on 'Community-based detoxification camps') we use lorazepam and chlordiazepoxide.

Vitamins

We keep a stock of multivitamins, mainly for alcohol patients. Folic acid tablets are also essential, especially for female patients in the child bearing age-group on anti-epileptics or mood stabilizers (to mitigate some of the risk of neural tube defects to the fetus). Since some of these patients may get pregnant without discussing with us and may not have access to good antenatal care, we find it useful to put all young women taking carbamazepine or phenytoin on folic acid as a rule.

¹ Plasma monitoring is recommended for phenytoin, but is often not available or too expensive. In many areas phenytoin is used without monitoring, but we suggest that doses should be kept at or below 300mg/day if no monitoring possible. If phenytoin plasma monitoring is available, aim for a level of 10-20µg/ml. If the level is less than 10, increase the daily phenytoin dose by 25mg. Wait 10 days before re-checking levels.

Economics of a rural community mental health program

One of the biggest barriers in any rural project is financial costs and funding. Because psychiatry has traditionally been a very hospital-based and specialist-oriented discipline, it is often thought of as being a very resource-intensive field. Inpatient stays in mental hospitals were often very long and labour intensive affairs, and many resource-poor settings may feel they simply lack the manpower and money to add on such a department. However, there are some specific factors that make psychiatry a field that is easy to run in a cost-effective manner in community-based settings:

- Diagnoses are all clinical and not investigation-dependent: no expensive machines or diagnostic equipment are required.
- Treatments for many major disorders can be managed in a very cost-effective manner: effective medications that are inexpensive are available, and many of the non-pharmacological strategies can be mastered by non-specialists with some training and support.
- In settings where strong family systems are in place, family members can fairly easily take on the roles of hospital staff in the care of patients.

Some strategies that can help minimize the cost of the rural CMH program could include the following:

Make use of inexpensive medications

In the Shifa project we have limited our medications to a small group of effective and inexpensive medications that are easily available in our area. This has kept our medication-related expenditure to less than USD 5 per month per patient (see chapter on 'Drugs')

Make use of lay volunteers or available staff and avoid unnecessary new recruitment

In the Shifa project, all team members are existing staff or students of Padhar Hospital. As we did not recruit any new people specifically for this project alone, salaries for team members were from the hospital and did not have to be generated through Project Shifa's limited funding. We recognize that this may not be possible in all settings. But we emphasize that using available manpower efficiently can prevent the need for unnecessary recruitment of new employees that further increase costs. For a discussion of how Shifa team members share roles and minimize need for other recruits, please refer the chapter on 'Team'.

Proper planning can help avoid unnecessary travel

Project Shifa's target area is limited to a radius of less than 20 km, hence travel distances are never very large and travel expenses are limited. Early and detailed planning of locations of camps and follow up visits as well as proper delegation of follow up areas can also avoid unnecessary travel expenses by different team members. For a discussion on how to go about these planning strategies, please refer the chapter on 'Team meetings'.

Avoid unnecessary investigations

In the Shifa project we refer any patient requiring investigations to the base hospital, and as far as possible the patients are asked to pay for these services (though they can be given discounts or charity on a case-to-case basis). In settings with adequate funding, investigations may also be provided free under the program. In any case, it is essential to reduce investigations to the bare minimum in order to cut unnecessary costs.

Minimize expenses on stationary and other miscellaneous items

In the Shifa project, for example, rather than printing new cards we recycle old hospital cards as the unique CMH project ID cards to help identify patients in the field. Instead of paying for refreshments through the project, all team members pack their own lunch for each outreach visit.

All in all, through strategies like those mentioned above, we have managed to keep running expenses very low. We spend on average less than USD 5000 a year on Project Shifa (530 registered patients, 170 of whom are receiving community-based care). Most of this amount is spent on medications and transport. This is a very affordable figure, considering the large number of patients who are benefitting from the interventions (see chapter on 'Outcome evaluation'). We chose to make the community-based interventions free, and charge for the services provided in the hospital for referred patients (though charity and concessions are given on a case-to-case basis). However, this is flexible. Other teams might choose to make all services either completely free or completely paid for, depending on the setting and available resources.

Rights issues and ethics in rural mental health care

Human rights issues are now considered an essential component of mental health care. Historically, the profession of psychiatry does not always have a good track record in this area, and the media in particular has often emphasized these sad failures in its depiction of mental health care. However, there were some shining examples of humane care through these dark times in many different countries and settings, and it is now internationally accepted that basic human rights and ethical practice must be incorporated into mental health care and research, just as in other medical specialties. One aspect of this has been the large-scale shift in emphasis within the field from hospital based custodial care to outpatient and community-based care. Rural work, however, presents certain specific challenges to human rights issues and ethical practice. Hence, we felt it was necessary to include a brief discussion on rights and ethics within the specific setting of community-based rural mental health care.

We will first look at some of the broad principles of ethical care using Beauchamp and Childress' ethical framework.² This well-known classification of ethical principles is widely used for understanding medical and psychiatric ethical issues, and is thus a useful starting point for our discussions. This model uses 4 fundamental principles by which we should assess ethical dilemmas.

- **Autonomy:** the right of an individual to make decisions about themselves. For example, a patient with an anxiety disorder may choose not to have treatment and their autonomy should be respected. However, a patient with psychosis without insight may need his autonomy to be limited temporarily for his own safety.
- **Beneficence:** ensuring an intervention or decision is beneficial to an individual/family/community.
- **Non-maleficence:** interventions should not cause harm to the patient or families.
- **Justice:** this principle involves equality in the distribution of care, regardless of age, gender, ethnicity, religion, socio-economic status, nature of disorder and other potential barriers.

With these broad principles in mind, we will now consider some of the most important ethical issues and conflicts that may arise in the context of rural mental health programs.

Competence

This refers to whether or not the person is able to adequately comprehend the nature of his problem, which then determines how much control he is entitled to have over medical decisions that affect him. Thus, in the absence of competence, the ethical principle of autonomy may have to be compromised for the good of the patient and society by the treating team and family acting in the person's 'best interest'.

This has probably been the single most difficult ethical issue to navigate through within psychiatry. The core problem is the fact that a considerable number of patients with severe mental disorders may lack insight into their problems, and may thus be unable to make the right choices regarding need for treatment when they are unwell. The challenge is to decide whether or not it is a breach of human rights to initiate treatment against the patient's will in such scenarios. Legislation will differ across countries, and these differences must be factored in while planning.

A related issue is 'consent' for treatment. As consent can only be ethically obtained when all relevant information is shared with and understood by the patient, it cannot be valid in the absence of competence. Thus, family members may have to step in at times like this and act in the patient's 'best interest.'

² Beauchamp TL, Childress JF, quoted in *British Medical Journal*. 309 (184). [doi:10.1136/bmj.309.6948.184](https://doi.org/10.1136/bmj.309.6948.184).

In the Shifa project, we tackle this tricky issue by involving the family in decision making when such patients are unwell. Since the psychotic patient with poor insight is unable to competently make this decision, the family is engaged to make it for him. In our setting, the family is also responsible for care and therefore it is important to give them sufficient decision-making power as well. When a patient is better and has recovered insight, the issue of whether or not to continue treatment can be taken in an informed manner by the patient, family and treating team in a collaborative manner that does not infringe on the patient's right to autonomy. For example, we stop providing treatment for patients and families in cases where they want to stop treatment earlier than recommended after the patient gets better, provided they understand the risk of relapse.

Confidentiality

Much of contemporary western society, with its strong emphasis on individuality and liberalism, attaches great importance to privacy and confidentiality in sharing of information and decision-making powers. This is not always the case in other cultures, particularly in many lower and middle income countries where strong family and community bonds still persist. In many of these cultures, family and community interests often take precedence over the individual in many key decisions. However, it must be clear that certain areas of enquiry are to be kept strictly confidential by the team and not unnecessarily disclosed to family members, regardless of local cultural settings – for example sexual concerns and marital issues.

In our target rural area, tribal society is characterized by strong joint family systems; strong concepts of individuality and rights to privacy and confidentiality are not as dominant as in many western societies, for example. Most medical consultations (not only mental health issues) involve at least one family member. Information and decision-making that would often be considered confidential in some societies are commonly shared with the wider family as a norm.

Vulnerable populations

Certain sections of any given population are particularly vulnerable to human rights violations, and this must be given some consideration while planning. In most rural settings, these would include women, the elderly, children, those with disabilities (including severe mental disorders and developmental disorders), ethnic or religious minorities and others. Interventions as a whole should be accessible and beneficial for these vulnerable groups (the ethical principle of 'justice'), and their specific issues may need to be specially considered on a case-to-case basis as well. The team may also at times need to engage in advocacy for these groups if they cannot otherwise gain access to interventions. It is also important to be alert in case a vulnerable person's family is not providing the best care (such as when there are signs of neglect or abuse); the team may be able to intervene positively in such cases. Caring for disabled persons, in particular, can be very demanding for families, and the team may have to teach families ways of coping (see chapter on 'Role of family in a rural mental health program').

In the Shifa project, the safety and security of vulnerable groups is ensured by entrusting families with their care. As there are few state or non-governmental systems in place to ensure this in this target area, families remain the most effective and available support system in most instances. For those with disabilities, we can assist by facilitating government certification, which gives advantages like monthly

pensions, reservations and other benefits. Minority persecution is not currently an issue in our particular target area. In many other rural settings, and has to be factored into planning.

Covert medications (drugs administered without the patient's knowledge)

Occasionally patients may need to be given medicine against their will, for example in psychosis where the risk of them harming themselves or others is such that treatment is deemed to be in the 'best interests' of the patient, family and community at large. (Thus 'beneficence' takes precedence over 'autonomy'). This is a controversial issue, often with legal underpinnings, and there is no easy answer that is applicable everywhere. Local legislation and cultural acceptability will have to be factored in while making this decision. It is, however, an accepted fact that many acutely psychotic patients will need to be given treatment against their will. In settings where this is feasible, hospital admissions are one way to do this in a humane manner. Often coercive measures like physical restraints or seclusion are employed with caregiver consent and rigorous monitoring in those settings. But these are impractical in rural community-based settings, and hence covert medications administered in food or drinks by responsible family members is often the easiest and least intrusive method of ensuring treatment in these difficult scenarios. However, every effort must be made to make the patients aware of the treatment when they are better and insight has sufficiently improved. In areas where long-acting depot antipsychotic injections are feasible, this is another alternative.

In the Shifa project, we use covert medications administered by the family as a last resort if psychotic patients are refusing treatment and cannot be brought to the hospital. It has been our experience that this tremendously reduces the cost and improves the acceptability of care in our setting by avoiding unpleasant and expensive inpatient admissions. As we have been fortunate to have had supportive families who have taken over this responsibility, we have rarely even had to use depot injections (though the option is available). As patients improve, we involve them in decision making as to whether to continue treatment.

Balancing needs of the individual versus needs of the family/community

In accordance with the principle of 'beneficence', interventions should be selected that will ensure as good outcomes as possible with the available resources. However, in community-based work, it is important to remember that the emphasis must be on helping as many as possible (as well as the target community at large), even if a few individual patients might benefit less than desired. For example, some patients may not respond as well as others to the chosen drugs but the emphasis of the team is to provide inexpensive and effective care to the majority in the community. These individuals may be offered other drugs if they are available and they can afford to buy them.

In the Shifa project, we have limited our choice of drugs to medications that are inexpensive and easily available in our setting. A few patients, of course, may not respond as well as others or may develop some side effects. However, the emphasis is on helping as many as possible with our limited resources. Our choice of non-pharmacological interventions also reflects this emphasis on helping as many as possible with limited resources and time (hence the emphasis on family and group interventions over individual therapy in the community setting). However, those patients who might require more intensive individual therapy are referred to the base hospital for the same.

A related issue is the question of side effects. By the principle of 'non-maleficence', the team should attempt to avoid side effects and adverse events as far as possible. Side effects, however, are an accepted problem of almost any medical intervention. But these should be planned for and managed appropriately. Unexpected complications should also be explained in detail to the patient and family as such.

Balance side effects against harms of the disease – if a psychotic patient is at risk of harming self or others, some side effects may have to be tolerated for the 'best interests' of the patient and community (here the principle of 'beneficence' outweighs the issues of 'non-maleficence' and 'autonomy'). However, in less serious disorders (like anxiety or mild depression), side effects should be tolerated less ('non-maleficence' over 'beneficence').

In the Shifa project, we are familiar with the standard side effect profile of our limited drugs, and have measures in place to monitor and manage these (see chapter on 'Drugs' for details of these).

Legal framework

It is important to remember that legislation regarding mental health differs across countries. Detailed discussions of these are beyond the scope of this book. However mental health teams should be aware of the laws and government policies in their countries, especially pertaining to involuntary detention, competence and decision-making in treatment, and issues related to confidentiality.

Suicide in rural mental health programs

Suicide is a major public health concern across the world, especially so in developing countries. In many of these countries, suicides are unusually common among the youth (including young women). A notable contrast with most developed countries is the far lower contribution of depression, psychosis and other severe mental disorders to the suicide mortality. In general, psychosocial issues like family conflicts, financial stressors, poverty and abuse, as well as substance dependence and personality factors like impulsivity are at least as important as mental disorders as contributors to suicide.

Assessing suicidal risk

Suicide is a multi-factorial event, and it is impossible to predict with absolute certainty whether a particular individual will attempt suicide or not. However, there are certain known risk factors which if present, especially in combination, make the likelihood of attempting suicide greater in a particular individual. Some important risk factors to look for in all suicidal patients include:

- **Living alone** (single, divorced, separated and widowed individuals are at higher risk than those who live with families).
- **Age:** High risk age groups differ across various countries and cultures (and these differences should be factored in while assessing). Generally, elderly individuals living alone are at very high risk.
- **Gender:** Gender differences in suicide rates also vary across cultures. In general, women are more likely to attempt suicide but men are more likely to die by suicide (as they tend to use more lethal methods).
- **Past history** of suicidal or violent behaviour.
- **Recent major stressors** or life events.
- **Lack of community support systems:** In particular, lack of strong religious affiliation may be a major risk factor.
- **Mental health conditions:** Although almost any mental health problem can be associated with suicide, the conditions that are most associated are depression, psychosis, substance dependence (including alcohol) and certain personality disorders.

When interviewing patients with suspected suicide risk, it is important to remember that asking about suicidal thoughts does not increase their risk of suicide. If it emerges that they have thought of suicide, it is important to ask if they have been considering this for a long time, if they have any specific plans, and how much they really want to die. These simple questions may give an indication of how serious their intentions are. For suggestions on field management strategies for high risk patients, see the section below on 'specific strategies that can be employed for potentially suicidal patients'.

Another important aspect of suicide assessment is assessment of risk of repeated self-harm in patients who have just attempted and survived a suicide attempt. In addition to the factors mentioned above, some additional things that need to be assessed in these patients are:

- **Lethality of the attempt:** certain methods of suicide are more lethal than others. For example, hanging and firearms are more lethal than poisons, drug overdoses or self-mutilation.
- **Intentionality of the attempt:** did the patient really want to die prior to the event, or was it an impulsive decision on the spur of the moment?
- **Suicidal ideation:** does the patient still want to die?
- Did the patient leave any **suicide note or any other information** for others to see regarding the reasons behind the attempt?

Rural areas have some specific problems and protective factors that need to be considered based on the local culture and setting. It may be worth looking into the common presentations in your area and factoring these into your

assessment. As an illustration, we briefly discuss some specific risks and protective factors in our target area from our experience at Padhar Hospital.

The majority of suicides (86%) presenting to Padhar Hospital's emergency department are isolated, impulsive attempts of low lethality (with agricultural poisons being the predominant method), low intentionality and low risk of recurrence. 67% had diagnosable psychiatric or substance use co-morbidities, and most (71%) were preceded by clear antecedents that were most commonly interpersonal disputes within the family³. In Project Shifa we have so far had 2 patients who died of suicide: both committed suicide after their primary psychiatric disorders improved.

Specific risks in rural areas such as ours

- Easy availability of agricultural poisons such as pesticides and fertilizers.
- High prevalence of untreated and unaddressed mental health or substance issues.
- Poverty and financial issues

Specific protective factors in rural areas such as ours

- Strong communities and joint family settings

This can, of course, sometimes be a source of problems. Our experience at Padhar has been that the majority of antecedents of suicides have been interpersonal disputes within the family. However, there is no doubt that families can also be mobilized to care for and supervise suicidal patients, and can thus be a significant protective factor.

- Strong religious affiliation and spiritual beliefs
- Ease of rehabilitation of mentally ill patients due to easy availability of agrarian occupations.

Specific strategies that can be employed for potentially suicidal patients

Given below are some general strategies that can be employed in any setting to deal with potentially suicidal patients, whether they have mental health conditions or not.

- Screen and aggressively address psychiatric conditions including substance abuse if present.
- Engage and involve family in the supervision of suicidal patients (for a detailed discussion of what strategies to teach such families, please refer chapter on 'Role of family').
- Engage other support systems if needed (including religious or community bodies).
- Ensure suicide patients are never left alone: someone should sleep near them, they should not go anywhere unaccompanied and doors should never be locked if they are inside.
- Minimize access to all potential weapons (including agricultural poisons, knives, scissors, ropes etc)
- Ensure strict supervision of medications (if any) by responsible family members/others. Medications should not be in the custody of the patient.
- Ensure that patient and family know how to access or contact the team in emergencies.

³ Ebenezer JA, Joge V. Suicide in rural central India: Profile of attempters of deliberate self harm presenting to Padhar hospital in Madhya Pradesh. Indian J Psychol Med 2016;38:567-70

- Ensure specific and regular follow up by the relevant field worker and early contact with the psychiatrist if needed.

Caring for family after a death by suicide:

Deaths by suicide are especially traumatic for family and loved ones because they are so sudden, and are often associated with feelings of guilt, anger and ambivalence that may hinder the normal grieving process. Families may need support to express their feelings in a safe environment. Often, community and religious support systems are ideal for providing that kind of environment, and the team should facilitate this in as culturally-acceptable a manner as possible.

Another aspect that may need to be looked into will be the socio-economic impact of the death. For example, if the bread-winner of the family has died is there an alternative means of income available? Or if the primary caregiver of small children or a disabled person has died, are there any additional support systems available that can be mobilized? In all these cases, strong joint family systems in many rural areas are often an excellent and easily available resource to harness.

Caring for therapist and team after suicide

This is an often neglected aspect of suicide. Death is not a very frequent event in mental health work, unlike some other medical fields. However, deaths by suicide are often especially traumatic for the treating team because of the intense relationship that may have developed over time between the patient and the primary therapist or team. Therapists and teams may consciously or unconsciously blame themselves for the death, or may feel they could have somehow prevented it by better prediction or quicker action. It needs to be remembered that suicides are multi-factorial events that cannot easily be predicted, and mental disorders are only one of many factors that lead to suicide.

Whereas doctors and nurses will have experienced the death of a patient in their care, lay workers may need particular support as they may have stronger links to the patient and may feel especially responsible for the death.

The team may need to briefly reflect on the event at their next meeting. They need to reconsider if there were any treatment-related factors involved – for example wrong diagnosis, inadequate treatment or inadequate advice given to family members about precautions. These are areas which could be improved upon in similar cases in future, but it is very important that team members practice a culture of ‘no-blame’ in situations like this. The team functions as a whole, and hence is responsible for successes and failures at a whole – teams should consciously avoid making any member a ‘scapegoat’ to be blamed. Equally important, team members may need to support each other through times like this, and allow some time during meetings for expressing their own feelings.

Legal aspects of suicide

In some countries, suicide is still considered a crime punishable by law. You may need to check regarding the prevailing law in your area. This is important because many patients and families may not feel comfortable disclosing information on suicidal thoughts or attempts in such countries. This may need to be factored into your assessment. The patient and family need to feel comfortable and secure, and the team’s ability to build rapport plays a crucial role in this.

Mental health professionals the world over generally agree that criminalizing suicide is unhelpful. In areas where suicide is still illegal, there may be organizations campaigning against this.

Community-based detoxification camps

Substance dependence is a significant health problem resulting in considerable morbidity and mortality, and rural areas are no exception. The spectrum of substances commonly used in a particular rural area, of course, will depend on geographical, cultural, legal and financial factors. In the target area of Project Shifa, alcohol and tobacco are the major substance issues. Cannabis and opioids are not as easily available or accessible, and cocaine and amphetamine abuse is virtually non-existent. This discussion will thus focus primarily on alcohol detoxification camps in rural settings, but the general principles could potentially be applied to other substances as well.

The alcohol detoxification camps are not actually part of the core work of project Shifa, though they are an intimately related activity and are in any case run by the same team. These were the brainchild of our coordinator Bappa Mukherjee, who deserves full credit for the conceptualization and execution of this novel intervention. Community detoxification camps have been held in other locations before, but what is novel here is the use of lay field workers in monitoring and nursing roles without any trained nurses involved. The role of the psychiatrist is also limited, and can be easily carried with some basic training by any available and interested physician or nurse.

Description of the model

Ten alcohol dependent patients from a particular village or group of villages are admitted in a village setting for a period of one week. The setting is a room adjacent to a government school in one of our target villages. The room is large enough to accommodate ten mattresses and bedding, along with an adjacent corridor area where a mini-nursing station can be set up (consisting of clinical records, blood pressure apparatus, stethoscope and medication supplies). There is space outside for open-air cooking, and toilet facilities are available nearby. The setting is thus flexible, and can easily be improvised with available resources in any rural area.

The patients are screened by the field workers, and prior to the actual camp by the psychiatrist (see section below on 'selection of patients'). During the week-long camp, they are provided with medications to help with withdrawal symptoms, and are engaged in various activities by the team, including group therapy. Lay community field workers monitor them throughout their stay, and the psychiatrist/doctor sees all patients twice a day on rounds to supervise care. At the end of the week, the patients together are encouraged to form a 'self-help group' that will meet independently at regular intervals, which will be monitored and, if necessary, facilitated by the treating team.

Funding

Finances are organized through donations from the concerned villagers, and some contribution from the base hospital. Generally the hospital provides medication and transport expenses, while food and other logistics come from the community donations. These financial arrangements, however, are flexible and should be adapted to suit local needs.

Roles of each member of the community mental health team

Psychiatrist/doctor/lead clinician:

- Screening for medical or psychiatric complications at intake; at this stage patients who have difficult-to-manage complications may need to be screened out.
- Planning medication regime for withdrawal symptoms.
- Supervising the medical and nursing care of the patients during the camp, and conducting rounds twice a day
- Being available day/night if problems arise
- Maintaining clinical records

- Conducting motivational counselling and brief cognitive-behavioural strategies for relapse prevention in group format (this can be done by any other team member as well with some training).

Coordinator:

- Coordinating all activities and personnel, and ensuring logistics.
- May also take over some or all of the group therapy sessions

Field workers:

- Fund raising (from community).
- Screening and motivating patients to be enrolled for the camps.
- Safety and security monitoring – round the clock duties.
- Monitoring for withdrawal symptoms and dispensing medications as directed by the doctor.
- Ensuring adequate oral intake and hydration.
- Ensuring the planned activity schedule takes place through the day.
- Group sessions can be taken by field workers as well.
- Engaging the patients as much as possible in the activities of the camp, including cooking, cleaning and simple organizational tasks if possible.

Selection of patients

The most important selection criterion should be willingness and motivation. It is better to work on a group of patients who have made a serious decision to attempt abstinence. With respect to age, the group can be either homogenous (people of same age group) or heterogeneous (different ages); either has advantages. It would be better to keep them all of the same gender, and similar socio-economic status as these factors aid in strengthening group cohesion. We have mainly focused on patients with alcohol as the primary substance of abuse; the same model could potentially be used for groups with different addictions as well.

Most alcohol withdrawal symptoms are mild usually characterized by tremors, sweating, palpitations, headaches, insomnia and anxiety, often accompanied by a rise in pulse and rarely, a transient mild elevation of blood pressure. In about 5 % of cases, there can be complicated withdrawal symptoms with psychotic symptoms (like hallucinations) or seizures or delirium. Delirium is the most serious complication of alcohol withdrawal, and is best managed in a hospital setting. It would be better in community camp settings to screen out patients who had past history of complicated withdrawal, or who are likely to have complicated withdrawal due to co-existing medical illnesses (such as liver or kidney problems, uncontrolled diabetes or hypertension or recent head injury). It may also be better to also screen out patients with known severe mental illnesses like psychotic disorders.

The structure of the day

A crucial aspect of the camps is the structure of daily activities. Timings should be planned in advance and informed to all team members and patients. A useful strategy is to display a time table on the wall in a prominent location. This ensures patients are occupied and focused throughout their stay, and also fosters group dynamics like cohesion by ensuring that all members go through similar situations and challenges together.

Activities from waking up right up till bedtime can be planned. Some activities that would be mandatory would include time for freshening up, time for morning walks (supervised), and fixed times for meals, medications, doctor's rounds, group sessions and games. Additional suggestions, if acceptable and feasible, could include activities like meditation or spiritual sessions, time for television or reading, or educational sessions on general knowledge, nutrition or social skills.

Clinical monitoring of patients

Withdrawal symptoms

A simple checklist of symptoms (which should be checked at least twice a day) would include tremors, sweating, palpitations, headache and anxiety. All patients should also be asked about sleep. Field workers should be also trained to recognize complicated withdrawal symptoms like seizures, psychotic behaviour or disorientation.⁴

In particular, field workers should be trained about what to do in the event of a seizure or violent behaviour. A contingency must be in place in case these occur. The team needs to decide whether intramuscular lorazepam injections can be administered on site by the doctor, or whether these patients need to be immediately transported to the base hospital. In settings where available, intranasal or buccal midazolam, or rectal administration of diazepam, are other alternatives for acute seizure control. The doctor should be reachable and nearby throughout the duration of the camp, especially between the second and fourth days (the peak period for complicated withdrawals). Some simple strategies that can be taught to the field workers would include:

- **Seizure:** Make patient lie on the bed or ground on his side, and tip the head slightly back. Place one hand under his head, and with the other hand gently support the rest of his body until the seizure is over. Let him remain on his side until he regains consciousness. Inform the doctor immediately, and make necessary plans together.
- **Violent behaviour (this could happen in either withdrawal psychosis or withdrawal delirium):** Make sure someone is with the patient at all times. Neither the patient nor others should be in a closed locked space, and as far as possible patient should not be allowed to leave the premises alone. Make an attempt to calm the patient down by reassuring and talking in a non-threatening manner. Inform the doctor immediately and decide on what should be done. If needed, the patient should be transferred to the base hospital for further management.

Hydration status

As the intention is to avoid intravenous lines and other hospital-based equipment, a useful strategy may be to ask patients to each keep a bottle of water with them and to drink at least 2 to 3 litres per day. This can be easily monitored and supervised by lay staff. A simple way to check this would be to ask patients to stick out their tongues and assess if it is dry or not. Put the prevention first before assessing hydration?

Vital signs

Blood pressure and pulse rate should be checked regularly (minimum twice a day) and recorded in the clinical record sheets. An easy way to do this in resource poor settings (in case the field workers are unable to do it) is for the doctor to check it as part of his rounds. If nurses or nursing students are available, they can take over this and even do it at greater frequency if needed.

Safety and security

Field workers need to be present with the patients at all times, even at night. They can do this by making a duty roster that divides their work, giving adequate periods for breaks to avoid burnout. No patient should leave the premises unaccompanied, and no access to alcoholic drinks should be permitted. In case a patient has to temporarily

⁴ Although there are standardized scales available to assess and monitor withdrawal symptoms (like the Clinical Institute Withdrawal Assessment Scale), we have avoided using these as they increase the workload and paperwork of the limited manpower available. We found that training the field workers with a simple checklist of common and severe withdrawal symptoms was sufficient for our monitoring purposes. However, in settings with larger resources of trained manpower, these can be considered.

leave the premises for genuine reasons, this should be informed to the doctor and coordinator and the particular patient must give a written declaration that he will take responsibility for any events that might occur.

Other medical issues

On rare occasions other medical or psychiatric issues not mentioned above might surface. All such issues should be informed to and discussed with the doctor and a relevant plan or strategy has to be worked out together.

Medications

For alcohol detoxification, benzodiazepines are the mainstay of treatment along with vitamins. Depending on what is available lorazepam, chlordiazepoxide or diazepam can be used. Lorazepam has the advantage of being relatively safe in liver problems, but chlordiazepoxide and diazepam may have smoother withdrawal control due to their longer half lives. Any available B complex formulations can be used.

It is useful to fix specific times in the day when all patients should receive medicines. This makes it easier for the field workers on duty and thus helps to avoid mistakes due to complicated regimes. Here we do it thrice a day (morning, afternoon and night with additional medicines if required SOS).

Drugs to manage withdrawal symptoms

The doctor would have to decide the starting doses and gradually taper by assessing each patient daily. A general starting strategy for a patient without complicated withdrawal could be 40 to 80 mg of chlordiazepoxide (or 4 to 8 mg lorazepam) in 3 or 4 divided doses over the day, with a larger proportion at night to help with sleep. Patients with severe withdrawal symptoms might need larger doses. However, patients requiring more than 120 mg of chlordiazepoxide might require transfer to the base hospital for safer monitoring. With careful monitoring of withdrawal symptoms, the dose of chlordiazepoxide or lorazepam can be reduced by 20-25% every 1-2 days and stopped within 7-10 days in most cases.

Vitamins and other tablets

B complex tablets should be given daily; if it is feasible to give intramuscular B complex injections this can be done. Chronic alcohol use damages the lining of the stomach and intestines, thus hampering absorption of many vitamins. Also, patients who drink large amounts of alcohol rarely eat balanced diets. As a result, severe B vitamin deficiencies can result, sometimes with permanent damage to the nervous system.

Other tablets may be given for symptomatic relief, for example ranitidine for gastritis or paracetamol for headaches. If a patient is on tablets for another chronic medical condition, these should also be given.

Group therapy

Depending on the team and available resources, these can be taken by the doctor, the coordinator or trained lay workers. Although it is ideal for a mental health professional to take these if available, absence of such a professional should not be a hindrance as the sessions can and should be structured in as simple a manner as possible. At Padhar the psychiatrist, coordinator and field workers all take different group sessions. It is important that the therapist, team and patients work together as a cohesive unit with a common aim and direction, regardless of who actually takes the sessions.

It is important to make sure all members of the group get chances to speak, and are encouraged to share and engage with the rest of the group. Detailed discussions on motivational counselling and cognitive-behavioural strategies can be found elsewhere. However, some simple strategies that can easily be incorporated into therapy even by untrained non-mental health professionals include:

Motivational counselling: (1 or 2 sessions)

- Build rapport within the group after introducing everyone. Allow each member to speak, and prevent any dominant persons from 'taking over' the group.
- Remember it is counterproductive to argue. Allow members to voice their opinions, even if they are negative. Appreciate their honesty if they voice negative comments about the treatment or their ability to remain abstinent.
- Focus on eliciting various motivating factors within the members of the group. Ask each member to think of the reasons why he decided to join. Collect the answers together and classify them in broad heads such as medical complications, financial issues, interpersonal issues, social issues, family issues, legal issues etc. These are more effective if they come from the members themselves rather than it being told to them by the therapist.
- Ask how many of them have attempted to stop the substance in the past: if so, how successful were they? Do they feel something is odd in the fact that they seem to want to stop (for all the reasons they have said above) but have still continued to repeatedly drink?
- Encourage them to take up the responsibility of change. Emphasize that the agent of change in therapy is themselves, and medications are only supporting through withdrawal. Tell them that the fact they are in the camp itself shows they have the inner potential to fight their addiction.

Brief cognitive-behavioural strategies for relapse prevention: (3 or 4 sessions)

- In the first session focus on finding out what are the common triggers or cues of drinking behaviour among the group members. It is useful to classify them into major heads such as visual cues (eg. seeing alcohol in a movie or passing by a liquor shop), social cues (eg. in parties or festivals etc) and emotional cues (eg. anger, anxiety, fear, sadness or boredom).
- Once these are classified, different sessions can focus on one or more major group of cues. The most important aspect is to come up with easy and relevant solutions within the group as to how best to combat a particular cue. Anger management strategies, relaxation techniques or meditation, practicing how to say no in a polite manner, developing a daily routine in order to keep oneself occupied throughout the day and choosing social contacts appropriately are some of the areas which may need to be discussed, among others.
- Lifestyle modification strategies like regular exercise, healthy nutritious eating habits and adequate leisure and family time must be woven into the discussions. During the camp itself, a regular routine of activities should be designed and pasted on the wall so that all are aware of it. The routine should be something feasible that mirrors their daily routine, so that they can easily adapt a similar structure after discharge.
- If a particular member seems to have certain specific or confidential issues, the therapist or another team member may have to spend time separately with him to discuss these.

Self help group formation

- One of the aims of the camp is to form the members into a self help group that can meet at regular intervals. Such self-help groups have long been known to promote long-term abstinence, as classically seen with Alcoholics Anonymous (AA). In our particular rural setting we have no AA chapters nearby, so our self-help group system operates independently. However, in settings where such groups are already available, an option might be to facilitate camp patients to join them after undergoing detoxification.

- These groups should be independent and should plan their own meetings and future; the treating team should not interfere in their functioning except to monitor and facilitate. They should act as a support system for each other. In case of relapses, the group can contact the treating team regarding those individuals if they desire.
- A powerful strategy is to allow members of previous detox camps to interact with new patients during the detox camp. If possible, a session can be fixed for such interactions.

Follow up

The treating team needs to monitor the frequency and regularity of the self-help groups, and also what the drop-out rates are like. The best outcome measure to ascertain the success or failure of a particular camp is the regular membership of the self-help group. Continued and regular membership is an indicator of continued motivation to maintain gains. If feasible, a grand meeting of all the various self-help groups can be organized at a specific interval (eg. once in 6 months). This could provide an opportunity to strengthen each other and motivate others to take part in similar camps.

Appendix

- i) Padhar Community Mental Health Screening Instrument (PaCoMSI)
- ii) Padhar CMH outcome evaluation tool
- iii) Padhar CMH clinical record sheet

Padhar Community Mental Health Screening Instrument (PaCoMSI)

- **Interview the head of the family.** If not possible, any responsible family member can be interviewed (preferably the next senior most after the head).
- Questions apply to the **ENTIRE FAMILY living in the same cluster of villages, not just those living in his/her house.**

Name of the village:		Name of inter-viewer?	
Name of the person interviewed:		Position in family:	
Name of the head of the family:		Occupation of head of family:	
Number in house	Total:	Males:	Females:
Religion	Ethnicity		

	Screening questions:	Screening for
1	Does anybody you know in the family talk to himself, smile to himself, laugh without reason or talk "like a mad person"? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Psychosis</i>
2	Does anyone in the family unnecessarily or unreasonably have suspicions or doubts against others? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Psychosis</i>
3	Is there anybody in the family who becomes uncontrollably violent or excessively angry/excited, or becomes verbally or physically assaultive, or wanders about the village unnecessarily? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Psychosis/mania</i>
4	Is there anybody in the family who neglects his or her personal hygiene and does not do any work for the entire day for many days? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Psychosis/depression</i>
5	Is there anyone in the family who cries all the time, feels sad or looks dull, lacks energy or has no interest in activities/work for 2 weeks or more? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Depression</i>
6	Is there anyone in the family who says he or she wants to die or has attempted suicide in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Suicide</i>
7	Is there anyone in the family who suffers from "tension", or repeats the same action several times and finds it difficult to stop? Or has recurrent headaches or is unable to sleep well for several days? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Anxiety/OCD</i>
8	Is there anyone in the family with demon/ghost/spirit possession or related problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Local cultural expression of ?mental illness</i>
9	Is there anyone in the family with epilepsy/seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Seizures</i>
10	Is there anyone in the family who has had any of the above problems at any time in the past, or keeps getting them again and again? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	-
11	Is there anyone in the family who has ever been evaluated or treated by a psychiatrist anywhere? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	-
12	Is there anyone in the family who <u>FROM BIRTH OR FROM VERY EARLY AGE</u> has had delayed speech or no speech, or delayed walking, or cannot perform activities as should be expected for his age or has had poor academic performance compared to others of his age? <input type="checkbox"/> Yes <input type="checkbox"/> No Name if yes:	<i>Developmental delay</i>

Padhar Community Mental Health (CMH) Project outcome evaluation sheets*Please complete 'For all patients' and then for each disease as relevant***WITHOUT
developmental delay****For all patients****1) Modality of intervention**

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Medications in the field	Referral to base hospital for evaluation/intervention	Other

5) Attended psychiatry OPD at base hospital at least once if referred to hospital

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
No	Yes	Not referred

2) Compliance

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	d <input type="checkbox"/>	e <input type="checkbox"/>
Good compliance (takes medications daily)	Fair compliance (misses some tablets occasionally)	Poor compliance (was very irregular, did not take most tablets)	Non-compliant (did not take any medications at all)	Not prescribed medications in the field

3) Occupational Function

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Non-functional / no change in status	Partial improvement (doing some work in home/fields/other, but not at pre-morbid levels of functioning)	Fully functional (working at home/fields/ elsewhere at pre-morbid level of functioning)

4) Community re-integration

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
No change from baseline	Some change from baseline, but not at pre-morbid level	Completely re-integrated i.e. at pre-morbid level

Epilepsy**1) Seizure remission**

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	d <input type="checkbox"/>
No improvement	Some improvement (fewer seizures/month than baseline, but more than half)	Good improvement (half the number of seizures/month or less)	Complete control (no seizures since last outreach visit)

Severe mental illness (psychosis/bipolar disorder/psychotic depression)**4) Remission of positive psychotic/mood symptoms**

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
No improvement	Some improvement	Complete control improvement

Common mental illnesses (depressive illness/anxiety/neurotic/substance/others)**4) Symptom reduction**

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
No improvement	Some improvement	Complete control

Headache syndromes & other non-epileptic neurological disorders**4) Symptom reduction**

a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
No improvement	Some improvement	Complete control

Padhar Community Mental Health (CMH) Project outcome evaluation sheets*Please complete 'For all patients' and then for each disease as relevant***WITH
developmental delay****Developmental disorders****1) Seizure remission**

a <input type="checkbox"/> No improvement	b <input type="checkbox"/> Some improvement (fewer seizures/month than baseline, but more than half)	c <input type="checkbox"/> Good improvement (half the number of sei- zures/month or less)	d <input type="checkbox"/> 100% control (no seizures since last outreach visit)	e <input type="checkbox"/> Not relevant
--	--	--	--	--

2) Remission of positive psychotic/mood symptoms

a <input type="checkbox"/> No improvement	b <input type="checkbox"/> Some improvement	c <input type="checkbox"/> 100% improvement	d <input type="checkbox"/> Not relevant
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3) Remission of stereotypies/movement disorders/self-injury

a <input type="checkbox"/> No improvement	b <input type="checkbox"/> Some improvement	c <input type="checkbox"/> Complete remission	d <input type="checkbox"/> Not relevant
--	--	--	--

4) Remission of overactivity

a <input type="checkbox"/> No improvement	b <input type="checkbox"/> Some improvement	c <input type="checkbox"/> Complete remission	d <input type="checkbox"/> Not relevant
--	--	--	--

5) Remission of aggression

a <input type="checkbox"/> No improvement	b <input type="checkbox"/> Some improvement, but still not manageable	c <input type="checkbox"/> Manageable at home	d <input type="checkbox"/> Not relevant
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6) Compliance

a <input type="checkbox"/> Good compliance (takes medications daily)	b <input type="checkbox"/> Fair compliance (misses some tablets oc- casionally)	c <input type="checkbox"/> Poor compliance (was very irregular, did not take most tablets)	d <input type="checkbox"/> Non-compliant (did not take any medica- tions at all)	e <input type="checkbox"/> Not relevant
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7) Functional improvement

a <input type="checkbox"/> No change	b <input type="checkbox"/> Some change: some degree of change in self care or milestones or supervised work	c <input type="checkbox"/> Significant change in self care/milestones or supervised work
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8) Community re-integration

a <input type="checkbox"/> No change from baseline	b <input type="checkbox"/> Some change from baseline, but not at pre- morbidity level	c <input type="checkbox"/> Completely re-integrated (at pre-morbidity level)
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Padhar Community Mental Health Clinical Records

Name		Age		Gender		Patient number	
Address/ village							
Diagnosis							

Date		Weight		Blood Pressure	
Clinical status				Drug side effects	
Compliance					
Functional status and re-integration					
Special issues					
Plan					

Date		Weight		Blood Pressure	
Clinical status				Drug side effects	
Compliance					
Functional status and re-integration					
Special issues					
Plan					

Padhar CMH Clinical Records		Name			Patient number		
Date		Weight			Blood Pressure		
Clinical status					Drug side effects		
Compliance							
Functional status and re-integration							
Special issues							
Plan							
Date		Weight			Blood Pressure		
Clinical status					Drug side effects		
Compliance							
Functional status and re-integration							
Special issues							
Plan							
Date		Weight			Blood Pressure		
Clinical status					Drug side effects		
Compliance							
Functional status and re-integration							
Special issues							
Plan							