CHLP LEARNING

As a private mental health professional I always felt a void within me. I was not able to dismiss the fact that the gap between the public sector and private sector was huge. Community mental health needs were only attended to when the crisis was too difficult to handle. It was a glaring truth we chose to neglect. Even in crisis like violence or suicide attempt, access to services like ambulance was difficult. Most of the time people don't know how to navigate the situation. Situations in places like dargah were also concerning. Even though I had no idea about how community based interventions work, I wanted to look into the possibilities. And hence CHLP happened .

Through CHLP, I wanted to learn how to define the goal. How to make it a replicable model? How to come up with a cost effective interventional plan? How to connect the dots between government agencies, NGOs, families, caregivers and patients?

My learning in this journey is beyond what I expected. People I met during the course changed the way I looked at life.

Each module took us through a journey of UNLEARNING. It was surprising to know how we have learnt many things wrong .

All the modules made us accountable and realize that we are all in an effort to build a system in which health for all becomes a reality. Our first assignment with Axioms of community health with a different NGO was an eye opener. Dr Kiran Martin's inspirational work through Action for securing health for all [ASHA] motivated me to think big. Her learning through slum people made me think how we are missing out on so many learning opportunities. Improving the community participation, working on the partnership for expansion which was insisted by the community, bringing in the basic developmental activities which were the contributors for better health, women leading the game were the takeaway from the assignment. Another organization which caught my attention was SANGATH working on mental health at ground level. Working on Equity which is the inclusion through awareness, social accountability and community based participatory research made a huge impact on my learning journey.

Solidarity from below is the ingrained message which was being told. Converting science to service, empowering the community by improving capacity, task sharing, training lay counselors are some of the interventional plans learnt.

It was interesting to understand how Alma Ata declaration 1978 evolved. WHO started giving attention to social determinants after the World War. CHC was established in 1984 and then called SOCHARA focused on the social paradigm of health and worked on rights and responsibility. Achieving equity through establishing PHCs in 2005 was a milestone.

Politics and medicine can't be kept apart. There is a need for a local solution for challenging and changing health needs. Equity is the unequal treatment of inequalities to equalize the opportunity which is social justice. Social determinants of health focusing on intersectoral policies and programmes which guide the epidemiology in public health and community health. Improving individual health outcomes, improving community health outcomes and health outcomes at all levels. Improving social cohesion and social capital increases community participation. Trust, belonging and reciprocation helps in better community participation.

Nutcracker effect where there is a top down and bottom up action for health equity. There is a need for a social vaccine which works on starvation, malnutrition, illness and debt bondage. We were left with a lingering question: are you a tap turner or a mop cleaner? One who needs the most gets the least. This is so true with the insurance facility. During catastrophic situations, there is no plan in place. There is a need to look into promotion, prevention and palliative care.

Public health is not just above technical activity but is to be seen as a way of doing justice, as a way of asserting the value of human life. Politics is to search for common good and just society. Medicine is a social science and politics is nothing but medicine on a grand scale.

Social gradients in health shows disadvantage in terms of health in people from low economic status. Hence only with prioritizing health, demanding for rights and pressurizing leaders we can achieve health for all. Policy implementation is only in papers.

Working on the CSDH framework helps us get more clarity on locating the structural and intermediary determinants of health in society. It helps us explore the hidden power dynamics at play. Map out mechanism to know the interactive pathway and feedback loop between SDH. Reflect on entry points at which action on the SDH can be taken using community health approach. Overall improve the daily living conditions, tackle the inequitable distribution of power, money and resources, measure and undertake the problem, knowledge gap, workforce, macroeconomics, social policies, public policy and build evidence and influence the policy change. Understanding the perceived needs of patients, understanding their rights and its relevance, barriers and priorities.

GOBI: Growth monitoring, oral rehydration, breastfeeding and immunization, access to emergency medicines, Ayushman bharath, NHM, CAH [Community action and health] were the result of selective primary health care.

Self reliance and social awareness are key factors in human development. Community participation encourages people as participants and not beneficiaries, becoming planners; Not work for people but work with and through people. The people do not mean only the formal leaders but includes women, youth, children, local healers, farmers and teachers. Care should be taken to focus on those marginalized. Appropriate health technology is used. Start with a problem and develop technology that is relevant to local conditions and resources, like use of herbal and home remedies, nutritional bangles.

Intersectoral collaboration: PHC involves all related sectors such as education, agriculture, food and nutrition, housing, women and child welfare and others. It demands for coordinated efforts of these sectors. Local capacity building is the key.

But it is observed that there is a fragmented care. There is an increased burden on secondary and tertiary facilities, compromising the quality of care.

WEAKNESS AND THREAT OF SECONDARY HEALTH CARE SYSTEM

INTRODUCTION

Secondary Health Care is the specialist treatment and support provided by doctors and other health professionals for patients who have been referred to them for specific expert care, most often provided in hospitals.

Usually, patients are referred from primary healthcare centers to hospitals when local health staff lack the knowledge, resources or specialization to treat them. Secondary healthcare includes a wide range of specialists, such as psychiatrists, cardiologists, obstetricians, dermatologists, pediatricians and gynecologists.

FEATURES OF SECONDARY HEALTH CARE

- Focus on early disease detection and treatment
- Prevent progression of diseases
- Multi- functional care
- Act as a link between primary and tertiary health care
- Provides assistance, supervision and educational function and research

WEAKNESS OF SECONDARY HEALTH CARE

a) EQUIPMENTS

- There is acute shortage of basic equipments
- Most of the equipments are obsolete and not produced according to the needs and technical specifications.
- Poor maintenance culture.

b) DRUGS & SUPPLIES

- Unavailability of adequate essential drugs & consumables
- Inadequate funds
- Fake and sub standard drugs

c) HUMAN RESOURCES

- Shortage of skilled staff
- Lack of capacity building
- Poor incentives
- Wrong distribution

d) **BASIC AMENITIES (Utilities)**

- Basic amenities are lacking in most of the facilities especially in the rural areas.

e) **FUNDING**

- Poor funding of SHC
- The untimely & irregular release of funds make planning difficult.
- Non implementation of Budgets

f) **MANAGEMENT**

- Lack of managerial skills for Secondary Care Health Professionals
- Limited available Health Human Resources is ineffective and inefficient for service delivery
- Culture of corruption and self- interest in management

g) **HEALTH MANAGEMENT INFORMATION SYSTEM**

- Poor data collection
- Inadequate planning
- Where data is available it is not used in planning & decision making at the Hospital

THREATS OF SECONDARY HEALTH CARE

WRONG SPECIALIST

Sometimes, doctors refer people to the wrong kind of specialist. That can happen because symptoms often overlap between a variety of health conditions. So, at times symptoms may suggest one problem when, in reality, it is another condition that requires a different specialist.

COMMUNITY PARTICIPATION

- Lack of involvement of host communities in the establishment and running of Secondary Health Care facilities.
- Lack of awareness, commitment, enlightenment and knowledge on the part of communities towards how to properly make use of the Secondary health care services.

PRIVATE SECTOR INVOLVEMENT

- Inadequate involvement of private sector participation in SHC delivery.

REFERRAL SYSTEM

- Poor and uncoordinated referral system.
- Lack of feed back mechanism in the referral system.

Under the universal health coverage, Ayushman bharath is introduced. It helps with the health and wellness center, pradhan mantri jan arogya yojana. Focusing on mid level providers, to offer

expanded range of services close to community, improve clinical care, care coordination, Capacity building done through ECHO, MOOC.

Dr Regi George model of THI where the community looks after itself was an eye opener. Instilling our knowledge into the collective community memory is the takeaway: Giving health in peoples hand, reaching community the choice .

There is no path for the traveler, paths are made by walking. Until you walk with the community you don't realize where they want to go.

JHAMKED programme in india is an example of political will which translated into results. There was a combined effort of politics and medical science.

Nicolas Rebello emphasized on the quality of being fair and impartial for equity in health. Emphasizing on the disability persons organization [D.P.O], he emphasized on the CBR [Community Based Rehabilitation].

Caregivers worldwide gave us the other dimension of the problem. Well Being of caregivers and their empowerment.

Discussion on the health system gave us a better understanding of issues at ground level. A peek into the traditional health system gave us a better understanding of stories from different systems of medicine. Learning that collaboration is the only way ahead. We are looking at a health system which is responsive, financially fair and respectful with good infrastructure, human resource, pharmacy, leadership and governance. A system is a set of things, interconnected and organized to achieve something. Different elements connect for a purpose. We have to strengthen the health systems to improve the health outcomes.

We are looking at comprehensive, continuous, patient-centric, integrated quality, accessible, affordable, available, acceptable and polyvalent.

Competent, interdisciplinary, information system, referral, community participation , intersectoral collaboration, close to the community, robust finance mechanism, accountable and team approach. Because the barriers to access secondary healthcare weakens and threatens the system.

As far as the traditional health systems are concerned prejudice, ignorance, and self interest have prevailed over open minded scientific approach in this important area of medical care. TCAM [Traditional,complementary ,alternative medicine]

Faith healers have a huge role to play. DawaDuwa project personifies the need for integration. Trans disciplinary health science helps in better integration.

Asthana declaration, biodiversity act worked on the geography and community better. Building trust, being a part of community and cultural experiences. There is an emphasis on pluralism,

getting to know the community, speaking to the leaders, healers and knowledge holders, building health resources, human nature relationship, self reliance, and bringing everyone together.

Having the connection with nature gives us better access to naturally available ingredients. Botanical survey helps us understand this. Involvement of other experts in the various field. Wildlife, ecosystem protection, community resource mapping.

Pacchamarundu is a popular home remedy which is utilized extensively in rural set up.

Mentally ill are not a part of us, they are US echoing in my mind as I go through the module of mental illness. Psychological first aid was a major takeaway. Bharath munis sadharanikaran theory of communication from natyashasthra and a part of rural mental health programme called ATMIYATA meaning shared compassion is changing the conversation around emotional wellbeing in villages. The idea was to equip the community to define their own narrative of mental health.

Champions and mitras are community leaders trained to provide low intensity counseling to those facing psychological distress. They could be school teachers, a shopkeeper or members of small informal group. We tap into people who already get approached for problem in the community. They need to be sensitive, empathetic, and willing to improve the mental health conditions in the village. Mitras on the other hand acts as eyes and ears of the champions. They receive less training but are taught to spot distress among community members and refer them to champions.

Universal Health coverage

It was interesting to compare between different countries with respect to accessibility, insurance, tax payers, intentions, prioritization, monetization and product. Cuba's model of work is well appreciated due to the district being responsible for administrative units. India is a federal country. 2015; health was considered as state subject; 2017; Niti ayog legislated right to healthcare. Under Niti Ayog, Ayushman bharath insurance is a subsidy for the private sector.

Role of Volunteers

With right ATTITUDE

SKILL

KNOWLEDGE

Social prevention, rural involvement, coordinated son training is possible; Monastic approach in many volunteers who work far more than their abilities create transformations at ground level. Being watchful within, dividing labour and better communication volunteers contribution is invaluable.

Civil   societies

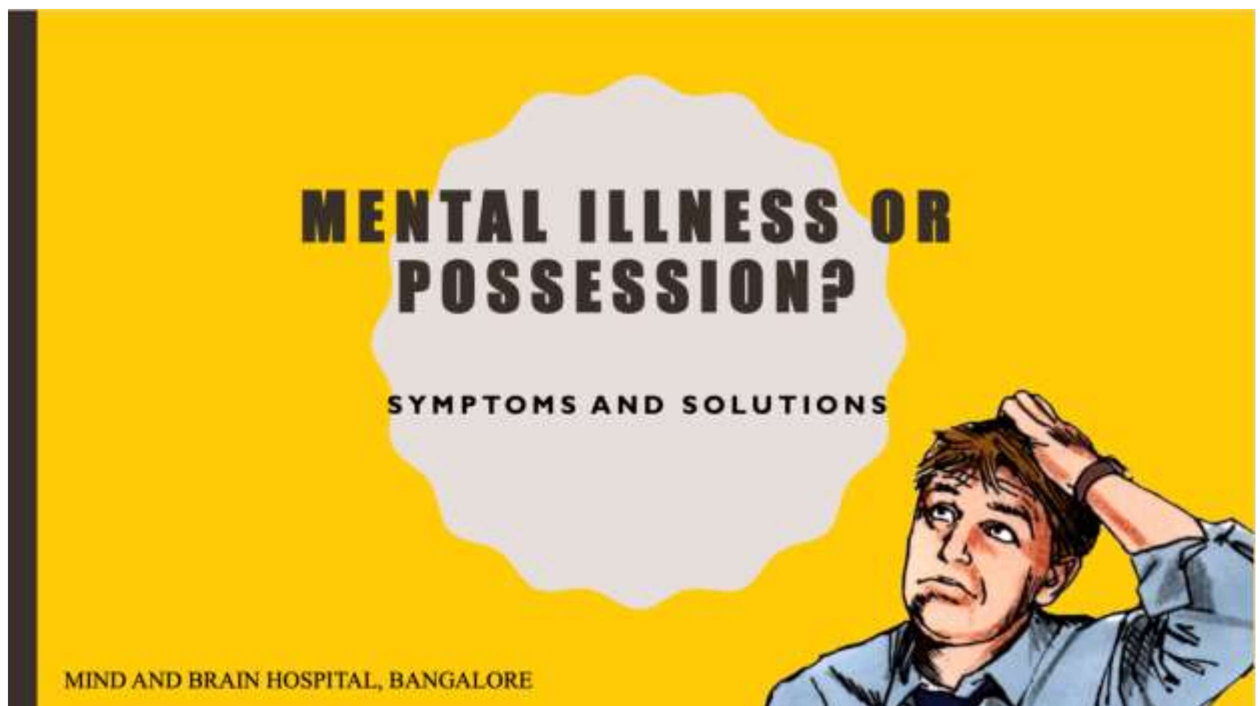
Organisations within a society that works to promote the common good, usually taken to include state run institutions, families, charities and community groups

Jan swasthya Abhiyan is people's health movement in the country which is aimed at establishing health and equitable development through comprehensive primary healthcare and action on the social determinants of health.

It is a worldwide network of peoples organizations, ngos, social activists, civil society organizations, health professionals, researchers etc

With better communication, dialogues, and learning from each other we can bring in change at rural level.

DAWA DUWA model, PPP MODEL are examples of partnership and work at community level to integrate health.



Case Study - 1

Should I marry a JINN or Human?

- Admitted due to psychosis
- Pattern in psychosis.

Case Study - 2

Anger outburst

- Unable to forgive
- ABC model (Chart)

Case Study - 3
Crying spells

- Memory disturbance
- Difficulty to Forgive
- Guilt
- Acceptance
- Building relationships
- Changing self

Case Study - 4
Financial loss

- Blaming the family member
- Poor organization skills
- Poor negotiation skills
- Poor emotional regulation
- Become accountable
- Take ownership
- Start new

Case Study - 5

Afflictions

- Multiple physical symptoms/ Miscarriages
- Body pain
- All investigations normal
- Psycho somatic illness
- Oppressed feelings
- Self care

Video of common practice in India

https://www.youtube.com/watch?v=RWkQH-NTj5Y

Case Study – 6
Self care is not selfishness
Attachment
Awareness
Accountability
Perception
Care
SELF

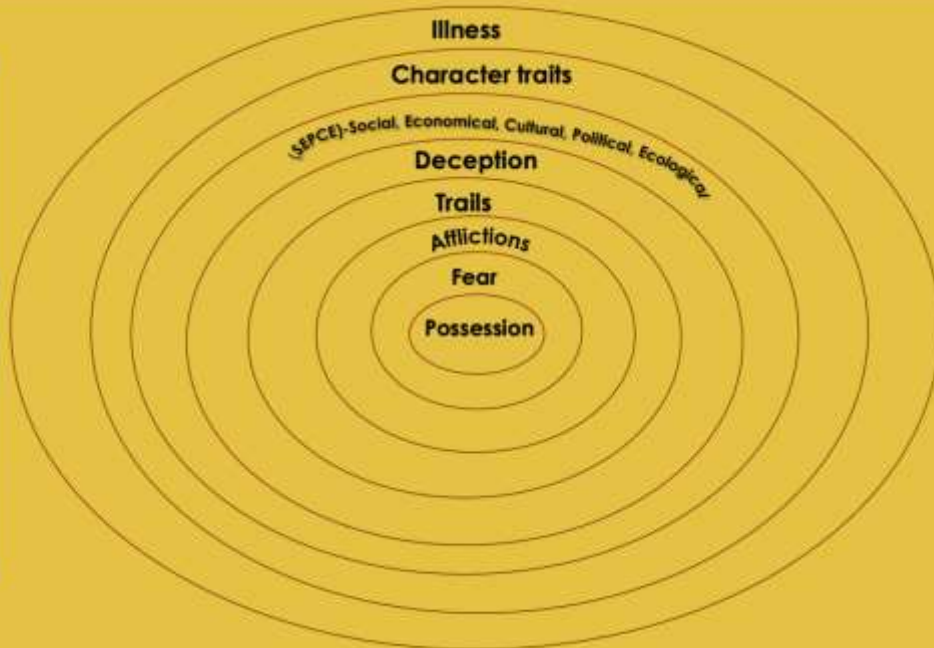


Chart of possession
Illness
Character traits
(SEPCE)-Social, Economical, Cultural, Political, Ecological
Deception
Trails
Afflictions
Fear
Possession

DIFFERENCE BETWEEN JINN AND HUMAN

JINN	HUMAN
Smokeless fire	Mud
Travelling any where is possible	Man has limitations
Power of being concealed from naked eye and being able to be hidden	Power of mind

MENTAL ILLNESS

- 1 in every 8 people in the world live with a mental disorder
- Mental disorders involve significant disturbances in thinking, emotional regulation, or behavior
- There are many different types of mental disorders
- Effective prevention and treatment options exist
- Most people do not have access to effective care

NEUROLOGICAL ILLNESS

Neurological disorders are medically defined as disorders that affect the brain as well as the nerves found throughout the human body and the spinal cord.

POSSESSION

- **Spirit** possession is an unusual or altered state of consciousness and associated behaviors
- Caused by the control of a human body by spirits, ghosts, demons, or gods.
- Cultural context

Symptoms

Mental illness

- Feeling sad
- Confused thinking
- Extreme mood changes
- Detachment from reality
- Low energy
- Excessive anger
- Changes in sex drive

JINN

- Yipping and howling
- Fits and screaming
- Vomiting
- Pain in the womb
- Insomnia
- Head ache
- Back pain
- Poor memory
- Speaking in incomprehensive language

Neurological illness

- Sudden onset of a headache
- Loss of muscle strength
- Memory loss
- Impaired mental ability
- Tremors and seizures
- Lack of coordination

Types of Mental Illness

- **Anxiety disorders.**
- **Mood disorders**
- **Psychotic disorders**
- **Eating disorders**
- **Impulse control and addiction disorders**
- **Personality disorders**
- **Obsessive-compulsive disorder (OCD)**
- **Post-traumatic stress disorder (PTSD)**

Communities Perception On Mental Illness

- Varies across the culture
- Myths and beliefs regarding mental health.
- Perceived cause of mental illness vary from community to community.
- Different names in different societies
- Strong beliefs about the mental illness
- Stigma
- Tends to change

Some Of The Views Of Community Towards Mentally Ill

- Mental illness is a curse of god
- There is no complete cure for mental illness
- People who are mentally ill cannot make friends
- People with mentally illness are commonly dangerous
- People with mental illness are insane
- The mentally ill are burden for the society
- Mentally ill should not be given any responsibility

DIFFERENCE BETWEEN POSSESSION AND MENTAL ILLNESS

POSSESSION	MENTAL ILLNESS
Sudden/ Unexplained	Patterns
Bizarre	DSM/ ICD
New language/ Without past history	With past/ family history
No determinants	Social determinants

LOCAL LANGUAGES/ MYTH IN MENTALLY ILL

- Mental patient', 'nutter', 'lunatic', 'psycho', 'schizo', 'deranged', 'mad.
- Pareshani
- Ghabrahat
- Pranth, Vatt (Malayalam)
- Paithyam (Tamil)
- Shytan's wisper (Waswas)
- Weak Iman lead to depression
- Seher/ Black magic
- Evil eye
- Evil Magic
- Voodoo
- Majnoon/ wushra (Psychosis)
- Bizarre

Hopkins Symptom Checklist (HSCL)

The Hopkins Symptom Check List-25 (HSCL-25) is a screening instrument designed to identify common psychiatric symptoms.

#	Item tag	Item content	Responses (%)			
			Not at all	A little	Quite a bit	Extremely
1	a1	Suddenly scared for no reason	80.0	15.8	3.3	0.8
2	a2	Feeling fearful	54.1	32.7	10.0	3.2
3	s1	Faintness, dizziness or weakness	52.0	34.4	10.8	2.8
4	a3	Nervousness or shakiness inside	38.9	42.1	14.5	4.4
5	s2	Heart pounding or racing	69.7	22.9	5.9	1.5
6	s3	Trembling	78.6	16.9	3.5	1.0
7	s4	Feeling tense or keyed up	44.4	38.9	13.3	3.3
8	s5	Headaches	37.7	41.8	15.3	5.2
9	a4	Spells of terror or panic	83.6	11.7	3.6	1.0
10	s6	Feeling restless, can't sit still	44.5	38.3	13.5	3.7
11	s7	Feeling low in energy, slowed down	20.2	45.8	23.3	10.6
12	d1	Blaming yourself for things	43.7	30.5	17.1	8.7
13	d2	Crying easily	57.7	26.9	10.3	5.1
14	s8	Loss of sexual interest or pleasure	64.9	24.3	7.3	3.5
15	s9	Poor appetite	64.0	26.4	7.3	2.3
16	s10	Difficulty falling asleep, staying asleep	37.5	36.4	17.3	8.8
17	d3	Feeling hopeless about the future	45.1	33.2	13.7	8.1
18	d4	Feeling blue	38.0	42.0	14.1	6.0
19	d5	Feeling lonely	52.8	30.8	10.9	5.4
20	d6	Thoughts of ending your life	91.6	6.1	1.5	0.8
21	d7	Feeling of being trapped or caught	76.1	16.7	5.0	2.2
22	d8	Worrying too much about things	28.8	37.4	21.9	11.9
23	d9	Feeling no interest in things	60.8	26.6	8.6	4.0
24	d10	Feeling everything is an effort	49.6	31.2	12.7	6.5
25	d11	Feelings of worthlessness	74.3	16.9	5.6	3.2

HELP SEEKING BEHAVIOUR

- Traditional faith healers
- Amuletes
- Taweez
- Ruqyah
- Exorcism

SIHIR/ BLACK MAGIC

- Sorcery
- People who are sold their souls become slave to the devils.
- Evil practices and evil ways
- Mysterious lemon and eggs
- Mysterious chicken heads
- Harry potter and Ouija board

DECEPTION OF SHAYTAN

- **Waswasa**
- **Shaytan whisper**
- **Power of tempt mankind**
- **Shaytan enters a person's heart through his weaknesses**
- **Shaytan makes false promises and arouses high hopes**
- **Shaytan commands mankind to argue and make statements about Allah without knowledge**

Preventive steps

PHYSICAL ILLNESS

- Talk about your feelings
- Get a good night's sleep
- Eat well
- Stay active
- Practice mindfulness
- Keep in touch
- Care for others

SPIRITUAL ILLNESS

- Free of sin
- Improve self esteem
- No haram
- Adhkaar
- Dikhr
- Bismillah

Value based practice, professional ethics is becoming an exception. Value based work based on equity, gender, rights, integrity and quality is becoming scarce.

Uneven quality, substandard treatment, and financial exploitations is making health a commodity for exploitation. Statutory regulations, maintaining minimum standards, helping them create standards. Creating partnership helps us move more towards equity.

World is increasingly becoming hedonistic and sometimes its important to question the intent. It was interesting to note that there was a questionnaire to assess the value system.

Topic on food and nutrition gave us an insight into ICDS (integrated child development services); one of the flagship programmes of Government of India and represents one of the largest and unique programmes for early childhood care and development. Anganwadi centers deliver early education, health and nutrition services as a part of ICDS schemes. Child's early years have a disproportionate impact on the rest of their lives. Experiences early in life can have a lasting impact on later learning, behavior and health.

Every country looking to make investments can learn something from ICDS. The program is unusually ambitious in its drive to deliver high quality health, nutrition, community education and preschool education. Below 18 years is a child and comes under the child welfare committee. Protection and care of the child and also aiming at juvenile justice.

Following child and nutrition we spoke on women's health. Financial literacy, inheritance and inequality were topics discussed. Inequality driving violence and work around it caught our attention. SEHAT ngo work was understood in detail. Gender stereotypes and how it impacts the decision making was looked into in detail.

Modules on mental health gave us a perspective on the ground realities.

Mentally ill are NOT a part of us

They are US

Was the loud message

We need to be extremely sensitive as everybody is fighting their own battles. Self help groups, therapeutic community concepts are way ahead to deal with mental health issues at ground level. BNI working on rehab camps partnering with locals is the best example of the community.

Mental health issues are becoming Syndemic.

Under national health policy DMHP, a district mental health programme was designed. In 1982 bellary model was incorporated. After more than a decade in 1996; it was incorporated in 4 districts; in another 2 decades it was present in more than 100 districts in around 757 districts in india.

Ayushman Bharath also saw the need for insurance for people with mental health issues. In 2017 the Mental Health Act created a paradigm shift in the way mental health issues were perceived. MHA 2017 gave a lot of emphasis on patient centric approach. Patient had a choice to make.

Nominated Representative and Advanced directives are given emphasis, the Mental health review board involving the magistrate, advocate and mental health professional was set up to protect the rights of people with mental health issues.

Screening tool is given in all the PHC to screen people with mental health issues. Medical officers are trained to screen and treat the common mental health issues.

Bal swasthya karyakram and Rashtriya kishore swasthya karyakram looking at adolescent mental health. There has to be intersectoral convergence to reach better.

Adolescent and child mental health needs attention as the issues with substance abuse are rising. Human beings are good by nature.

COMMUNITY BASED ACTION PROJECT .

THRUST AREAS OF DMHP

INTRODUCTION

Mental health disorders have a significant impact on health. At some point in their lives, one in four people will experience a mental health problem. Similarly, around one in ten children have some mental health problems. An estimated 1% of the country's population (about 10 million people) suffers from mental illness. In Karnataka, less than 700 healthcare professionals, doctors, and social workers support more than 50 lakh people with mental illness and mental retardation.

OBJECTIVES AS PER DMHP

- ❑ To provide sustainable basic mental health services to the community and to integrate these services with other health services.
- ❑ Early detection and treatment of patients within the community itself.
- ❑ To reduce the stigma of mental illness through public awareness.
- ❑ To treat and rehabilitate mental patients within the community.

OUR OBJECTIVES

- ❑ Training
- ❑ Capacity building
- ❑ Community awareness
- ❑ Enable Community participation

WHAT WE DO?

The Community Mental Health project at Mind and Brain Hospital, Bengaluru aims to address the problems faced by the people who are having mental illness in the communities, religious and other educational institutions. The team consists of psychiatrists, psychologists, psycho-social worker, community field workers (ASHA workers) and interns.

Our main mode of the activity is by training ASHA Workers, volunteers , religious priests, traditional healers, NGOs etc. to make a better community.

OUR COMMUNITIES

The Kodigehalli community has a total of 51836 population. Total number of males are 27663 and the total number of females are 24173. A good number among these population are daily wage workers. Total of 7 ASHA workers are working under the PHC for health and hygiene related matters. Regarding the religious perspective the community has a total of 19 temples, 1 masjid. Since the presence of Christian community is very less, there is no Church in this community.

Coorg and Chintamani are the next communities that have chosen for the spirituality mental health purpose. These are the places where the Dargahs are in a large number. So, that there will be a good connectivity for community intervention towards the people who are associated with the Dargahs.

OUR COMMUNITY BASED ACTIVITIES

July

Received permission from MLA and District medical officer to carry forward the project.

Aug -Sept

Trained ASHA workers to identify the patients from the community.

Oct

Took the case histories of each patients and regular home visits.

Nov- Dec

Provided family counselling,

Medication and Follow ups.

COMMUNITY AWARENESS & COMMUNITY PARTICIPATION

- PHC
- Dargah/ Masjid movement
- NGOs

COMMUNITY PERCEPTION

FLOW OF THE PROJECT

STUDY PARAMETERS

Capacity Building | Awareness | Diagnosis | Treatment | Referral | Drugs | Budgets

TITLE :
THRUST AREAS OF DMHP

COMMUNITY:

- Local PHC, Kodigehalli
- Dargah in Coorg

THE LOCATION

KODIGEHALLI

- Kodigehalli is the place I work so that my staffs as well as me have an easy access towards the place and easy monitoring.
- Identified cases can choose our hospital for treatment purpose.

COORG

- Coorg is my native and very strong base of community health workers.
- Good connectivity to Dhargah.
- Access to any kind of community intervention as we are familiar to most of the people.

UNDERSTANDING OF COMMUNITY CONTEXT

KODIGEHALLI COMMUNITY CONTEXT

- Lower middle-class family.
- Majority Hindu population.
- People from different backgrounds.
- Daily wage workers, Business men
- Urban population

COORG COMMUNITY

- Rural population
- Middle class families
- Majority Muslim population
- Coming from North Kerala and Tamil Nadu for spiritual healing

DIALOGUE AND RAPPORT BUILDING PROCESS

KODIGEHALLI

- Started with training ASHA Workers.
- Working on the preparation of ASHA Workers.
- Three patients were referred to the hospital.

COORG

- Spoke to Dhargah and Mental Health authority
- We are planning to work with local district health hospital and local medical college and the community health workers.
- Permission is given to set a clinic in Dhargah
- Free clinic is initiated near the Dhargah.
- Woking out on selecting the volunteers and connected with CMC Velloor team to train our volunteers as a formal training program
- Ngo are willing to work in association with us.

COMMUNITIES FELT NEEDS

- To understand spirituality better
- To get access to doctor and medication better

COMMUNITIES' PRIORITY

- Not to have a stigma
- Not identify themselves as mentally ill
- Not to take medication
- Spiritual connections

STAKEHOLDERS AS A PART OF COMMUNITY

- Anganwadi workers
- ASHA workers
- School principals
- Dhargah management
- Local NGO
- District hospitals
- Government medical college

THE MAJOR ISSUES

- Stigma in mental health
- Spirituality in mental health
- Medicine in mental health

ADDRESSING THE ISSUES

- Giving talks
- Awareness program
- Social media
- Camps
- Training ASHA workers, Volunteers, Spiritual healers

REVIEW OF LITERATURE

1. Kangkan Pathak, The Central Government launched the District Mental Health Program (DMHP) as a 100% centrally sponsored scheme for first five years, at the national level during the 9th Plan as pilot project. It was launched in 1996-1997 in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu, with a grant assistance of 22.5 lakhs each. DMHP was implemented in 27 Districts across 22 states/UTs in the 9th Plan. The DMHP was extended to 7 districts in 1997-1998, five districts in 1998 and six districts in 1999-2000. During the Tenth Five Year Plan, the DMHP was extended to 127 districts in the country. During the 10th Five Year Plan, NMHP was restrategized and it became from single pronged to multi-pronged programme for effective reach and impact on mental illnesses. DMHP was redesigned around a nodal institution, usually the zonal medical college. The **thrust areas** were to expand DMHP to 100 districts all over the country, modernization of mental hospitals in order to modify their present custodial role, upgradation of Psychiatry wings of Govt. Medical Colleges/General Hospitals and enhancing the psychiatry content of the medical curriculum at the undergraduate as well as postgraduate level, strengthening the Central and State Mental Health Authorities with a permanent secretariat, IEC Activities and Research & Training in the field of community mental health, substance abuse and child/ adolescent psychiatric clinics for improving service delivery.

(Source: L.G. B. Regional Institute of Mental Health, Tezpur, Assam/ Future of District Mental Health Programme/ Kangkan Pathak/ September 2021)

2. Harish M. Tharayil et. al District mental health program (DMHP) is the flagship program of Government of India to deliver mental health-care throughout the country. Being an out-reach program, it is likely that elderly people with mental health programs are accessing it more frequently. If this is the case, there is potential for including additional components in this program so that something more than the generic service is offered to them. The result of this study indicated that a significantly higher number of elderly people are attending the clinics of the DMHP compared to the outpatient service of a teaching hospital. This is important in view of the increasing number of older people who may need these services in future. There has to be a strong link with the existing outreach services. DMHP should take up the task of supporting and guiding community-based initiatives as well as other outreach services. Community clinics run by DMHP can support and supervise other community-based initiatives. Collaboration with palliative care initiatives has the potential for wider application in the community. It is concluded that DMHP can be further strengthened by adding additional components like service for the elderly.

(Source: Tharayil, Harish M., et al. "Mental health care of older people: can the district mental health program of India make a difference?" ***Indian Journal of Psychological Medicine*** **35.4 (2013): 332-334.)**

3. Ng, Chee, et al. District mental health programme (DMHP) activities with the core clinical team were centred on early diagnosis and treatment, PHC staff training, and information, education, and communication initiatives. A management team for conducting various DMHP activities has been added, along with mental health promotion initiatives such life skills teaching and counselling in schools, counselling services in colleges, workplace stress management, and suicide prevention programmes. The creation of community mental health services in the most underserved communities has been one of the program's primary successes. In terms of challenges (areas where improvement required), the training needs for PHC staff are enormous due to the large numbers of PHC workers in India. A shortage of qualified mental health human resources, as well as little involvement of other primary care health workers in the mental health services has meant difficulty in recruiting the district mental health teams. Lack of coordination between Health and Medical Education Departments has resulted in conflict in program implementation. Stigmas attached to mental illness remain widely prevalent, and still pose formidable barriers between the mentally ill and community mental health services. Mental health remains a comparatively neglected area, given the lowest priority in social and development planning. There is still much to be done to integrate mental health into the mainstream public and general health.

(Source: Ng, Chee, et al. "Integrating mental health into public health: The community mental health development project in India." Indian Journal of Psychiatry 56.3 (2014): 215.)

4. Van Ginneken, Nadja, et al. In India very few of those who need mental health care receive it, despite efforts of the 1982 National Mental Health Programme and its district-level component the District Mental Health Programme (DMHP) to improve mental health care coverage. The aim of this study is to explore and unpack the political, cultural and other historical reasons for the DMHP's failures and successes since 1947 (post-independence era), which may highlight issues for today's current primary mental health care policy and programme. Oral history interviews and documentary sourcing were the methods used for this study which was conducted in 2010–11 with policy makers, programme managers and observers who had been active in the creation of the NMHP and DMHP. The results suggest that the widely held perception that the DMHP has failed is not entirely justified, insofar that major hurdles to the implementation of the plan have impacted on mental health coverage in primary care, rather than faults with the plan itself. These hurdles have been political neglect, inadequate

leadership at central, state and district levels, inaccessible funding and improperly implemented delivery of services (including poor training, motivation and retention of staff) at district and community levels. At this important juncture as the 12th Five Year Plan is in preparation, this historical paper suggests that though the model may be improved, the most important changes would be to encourage central and state governments to implement better technical support, access to funds and to rethink the programme leadership at national, state and district levels.

(Source: Van Ginneken, Nadja, et al. "The development of mental health services within primary care in India: learning from oral history." ***International journal of mental health systems*** **8.1 (2014): 1-14.)**

5. Roy, Sushovan, and Nazish Rasheed. The Ministry of Health and Family Welfare, Govt. of India formulated District Mental Health Programme (under National Mental Health Programme) as a fully centrally funded 5-year pilot scheme. The programme was to be implemented in two phases, the Phase I was to be taken up during 1996-97, and the Phase II was to be a continuation of the programme during the IX Five Year Plan period (1997- 2002). This study indicates the major draw backs and also the areas that need further improvement in the perspective of DMHP. Lack of an inbuilt and dedicated monitoring and implementing mechanism for programme, Shortage of skilled manpower in Mental Health, this is a major constraint in meeting the mental health needs and providing optimal mental health services at the community level. Due to shortage of manpower in mental health, the implementation of DMHP suffered adversely in previous years, lack of awareness /stigma about Mental Illness, Lack of facilities for treatment of mentally ill, lack of coordination between implementing departments of DMHP, lack of Community involvement, protocol for early detection & treatment of mentally ill patients within the community was inadequately disseminated, there was very little provision to treat & rehabilitate mentally ill patients discharged from the mental hospitals within the community, main emphasis remained on the curative services for the mental disorders and preventive measures were largely ignored. In the absence of reasonably sensitive and specific indicators of the effectiveness of the DMHP, one has to rely on the crudest. If one looks at the number of districts currently covered by the DMHP out of the aimed 500, the figure is 241(2014-2015). So, one may be tempted to state that even after 18 years of existence the program has achieved less than 50% of its goals and objectives. But what is not immediately apparent is the natural and expected 'learning curve' phenomenon. Currently, the bulk of the 'learning' has been done and corrective changes identified for implementation as evidenced by the latest health ministry report. So, one can take satisfaction in the fact that some comprehensive course correction has been made. But no concrete mechanisms of monitoring the programme by valid indicators have been incorporated in any significant quantum.

(Source: Roy, Sushovan, and Nazish Rasheed. "The national mental health programme of India." ***Int J Curr Med Appl Sci*** **7 (2015): 7-15.)**

6. Johann Alex Ebenezer Patients with mental disorders/epilepsy in rural settings across South Asia face stigma and persecution, and often undergo painful and dangerous rituals as religious "cures" due to superstitions. Remote locations, poverty, and lack of adequate transport facilities

make access to the hospital difficult, and the problem is compounded by a lack of trained mental health professionals. Project "Shifa" is the Community Mental Health project at Padhar Hospital which aims to address these problems. The team consists of a psychiatrist, a coordinator, 10 community field workers, and nursing students posted in the psychiatry department, covering a target area of 75 tribal villages. The main objective of this project was to identify patients with mental disorders and epilepsy and facilitate treatment, rehabilitation, and community reintegration. The 75 target villages are divided into 11 clusters, so that each cluster gets re-visited approximately once in 3 months. Home visits are available for selected patients who are too sick or too far to come to the location. To date, a total of 523 patients have registered and evaluated under this project. 200 of these patients have received medications in the field. Currently, after excluding those whose courses are completed or who refused further treatment, 114 are on long-term follow up in the field.

(Source: Johann Alex Ebenezer, Community Mental Health Project of Padhar Hospital, India, March 2017)

7.Addressing ASHA well-being And burnout for improving Depression care (Project AANAND)

Sangath is a non-governmental, not-for-profit organisation working in Goa, and other Indian states, for 25 years. The organization is committed to improving health across the life span by empowering existing community resources and address the psychological and social needs of people through comprehensive interventions. The people within Sangath are committed to bring positive change in the society by amalgamating humanitarian approaches with science and innovative technological solutions. Burnout and poor wellbeing are prevalent among rural health workers in India. These health workers are responsible for providing last mile care in various areas such as pregnancy care, vaccinations, child care, as well as basic mental health services. The objective of this project was to provide coaching program for ASHAs based on the use of character strengths grounded in Indian spiritual values, to negotiate stressful work situations and relationships, and improve mental wellbeing. This intervention will be added on to the routine supervision that ASHAs already receive. The project aim to deliver this coaching program to a randomly selected group of ASHAs (or 'intervention arm') from Raisen district in Madhya Pradesh, and measure its effectiveness on ASHA wellbeing, compared to another randomly selected group of ASHAs who will receive routine supervision only (or 'control arm'). The duration of the project is from October 2021 to September 2024.All ASHAs will be comparable in their baseline characteristics and previously trained on HAP. First identify their character strengths and understand their routine work problems. Then develop the intervention, and deliver the character-strengths based coaching to ASHAs in the intervention arm. The control arm ASHAs will continue to receive routine supervision as usual. The coaching program will begin with a 5-day residential 'baseline' workshop to orient ASHAs into the use of character strengths in their routine work, rooted in concepts from Indian Psychology/spirituality. As ASHAs resume field work and face problems and stress-inducing situations, we will reinforce the concepts learned in the workshop, through once-a-week telephone calls between the coaching team and each of the ASHAs over an 8-week period. The project measures wellbeing, burnout and motivation of ASHAs in both arms for comparison, at 'baseline' or before the intervention, and at 1, 3 and 6 months after baseline. Study outcomes will also include ASHA work performance measures. Finally, we will compare the client's satisfaction with ASHA's HAP, and client's

improvement in depression symptoms between both arms. This study will enrol 244 ASHAs, and 240 individuals identified with depression, for meaningfully explaining our results.
(Source: https://sangath.in/aanand/)

8. Banyan project: The Banyan addresses the issue of mental health among marginalized groups, primarily persons affected by homelessness and poverty. Statistics on homelessness in India from the 2001 census reported 1.94 million homeless people in India, of whom 1.16 million lived in villages, and 0.77 million lived in cities and towns. To address the lack of access to comprehensive mental health care in both urban and rural areas, The Banyan was established in 1993 to provide comprehensive services for people with mental illness living in poverty and homelessness and their families. The organization adopts a multi-interventional approach toward mental health, combining clinical services (psychiatric reviews, medication, counselling) and social services (employment, disability allowance, social benefits facilitation, education/health support). The Banyan currently operates two programs in Chennai and Kancheepuram:
The first one is Urban mental health program
Adaikalam: A transit care center with 160 beds for homeless women with mental illness. Through a biopsychosocial model of care, Adaikalam enables various options for reintegration back into the community including, reunion with family, employment, open cottage-style community-based facility, group homes and supported housing for federated/non federated persons.
Outpatient services: Mental health clinics are operated at four locations in urban areas: a transit center in Mogappair; a state-run resource center for disability in KK Nagar; a Corporation of Chennai clinic in Santhome; and a college in Choolaimedu. Services include:
Day care center, home visits, Disability allowance, Employment/other social benefits.
Open shelter: A 25-bed facility for homeless men with psycho-social disabilities, providing treatment and rehabilitative services run in partnership with the local government, the Corporation of Chennai.
The second one is Rural Mental Health Program:
Health center: Mental Health Clinics are run in tandem with General Health Services in Thiruporur Block with 50 villages. Services include: 12-bed inpatient service, Vocational training, home visits, Disability allowance, Employment/other social benefits
Community living: An open cottage-style long-term facility enables up to 60 women to live close to the community.
Rented housing: 22 women live independently in Kovalam, in rented housing, and receive additional support through self-help groups.

(Source: https://www.mhinnovation.net/organisations/banyan)

9. SCARF Tele-psychiatry in Puddukottai (STEP): India has 4,000 psychiatrists to serve a population of 1.3 billion people. 70% of these psychiatrists are located in urban areas. The aim of SCARF's mobile tele-psychiatry innovation (STEP) is to provide accessible and affordable mental health care services in Pudukottai – a rural community without access to mental health care – through the integration of mobile clinics and tele-medicine.
Mobile tele-psychiatry service is provided on the STEP bus containing a consultation room and a pharmacy, consultation takes place between a psychiatrist based at the SCARF office in Chennai and the patient in Pudukottai through electronic means on the STEP, prescription is dictated by

the psychiatrist to the tele-psychiatry clinic facilitator in the bus and filled by the on-board pharmacy; medication is provided free of cost etc bus were the major process delivered through STEPS. 1500 clients treated for severe disorders, number of severely disabled clients who are certified and will receive benefits increased by 10% (from 0 to 138), cost of care is $12 USD per capita per month etc were the major impact summary of the project.

(**Source**:https://www.mhinnovation.net/innovations/scarf-tele-psychiatry-puddukottai-step)

10. ATMIYATA: A community-led intervention in rural India: The Atmiyata is a distinct approach from the health sector approach but complementary, as it is a community led innovation for the detection, support and referral for persons with common and severe mental disorders.

The innovation involves a two- tier community led mental health model that develops capacity of community volunteers (*Atmiyata* champions and mitras) to detect and provide primary support and counselling to persons with common mental disorders. The innovation also uses digital approaches that promote capacity development and raise community awareness of mental health. Each champion is provided with a smart phone that includes capacity development and community films. The second innovative aspect of the *Atmiyata* intervention is its integrated care approach: Horizontal integration (integration of care between mental health and social care); vertical integration (integrating professionals working at the community level, primary care level and tertiary care level), and between preventive and curative services. 14000 population screened with 7,600 reach of the programme.1350 people with mental health issues helped with mental health care and 1350 people helped with social benefits, There was a 27.5% (from 63.8% to 36.3%) reduction in proportion of cases. Pre 14.2% with GHQ score 6+ (n= 120) and post is 9% (n=76), 80% improved wellbeing outcome after intervention were the impact summary.
(Source:https://www.mhinnovation.net/innovations/atmiyata-community-led-intervention-rural-india)

11. Nae Disha Project: Mental ill-health is a leading cause of the disease burden among young people. In India, young people with mental health problems often experience social exclusion, impacting their ability to meaningfully participate in their communities, with peers or seek care. The risk of mental ill-health also increases with poverty, adversity, low skills and knowledge. Nae Disha is a peer-led mental health intervention that aims to increase and strengthen key psycho-social assets in adolescents to moderate the impacts of adversity and has been implemented primarily in Uttarakhand state. It consists of an 18-module youth development and positive psychology curriculum which is implemented in groups weekly by peer facilitators. The project demonstrated that young people’s social inclusion and mental health can be improved through a low-resource short term peer-led intervention involving group discussions and a supportive curriculum. A total of 1900 adolescents have participated in the intervention to date, reported a decrease in the proportion of adolescents scoring in the ‘abnormal’ range of Strengths and difficulties by more than half (from 42.6% to 20.3% (p<0.001) were the impact summary.
(Source:https://www.mhinnovation.net/innovations/building-youth-resilience-and-mental-health-india-nae-disha)

12. Care for People with Schizophrenia in India (COPSI): In low- and middle-income countries, most services for people living with schizophrenia are located at psychiatric hospitals

and other centralized facilities. Lack of human and financial resources inhibits the development of more accessible services. COPSI (Care for People with Schizophrenia in India) was designed to provide evidence for a feasible model of community-based rehabilitation for people with schizophrenia in low- and middle-income countries. The COPSI trial tested a community-based collaborative care (CBCC) intervention using lay community health workers to provide rehabilitation services alongside facility-based specialist care. Structured needs assessments and clinical reviews to tailor treatment plans, individualized rehabilitation and adherence management strategies, strategies to address physical health problems in participants, linkages with community agencies and self-help groups, psychoeducational information for both participants and caregivers etc were the major focus area of the project.

(Source:https://www.mhinnovation.net/innovations/care-people-schizophrenia-india-copsi)

13. Chebolu-Subramanian, Vijaya, et al The Community Mental Health Program (CMHP) run by the Foundation for Research in Community Health (FRCH) is one such program which utilizes CHWs to provide health services in rural areas. The primary intent of the CMPH is to respond to the large gap in mental health care through the delivery of a range of appropriate interventions to persons with selected mental disorders. The project is designed on the lines of a task-shifting model wherein the scarcity of health care personnel is addressed by shifting some of the tasks of a psychiatrist and a psychologist to the primary care doctor and CHWs. Community Health Workers (CHWs) are critical to providing healthcare services in countries such as India which face a severe shortage of skilled healthcare personnel especially in rural areas. The aim of this study is to understand the work flow of CHWs in a rural Community Mental Health Project (CMHP) in India and identify inefficiencies which impede their service delivery. This will aid in formulating a targeted policy approach, improving efficiency and supporting appropriate work allocation as the roles and responsibilities of the CHWs evolve. A continuous observation Time Motion study was conducted on Community Health Workers selected through purposive sampling. The CHWs were observed for the duration of an entire working day (9 am- 3 pm) for 5 days each, staggered during a period of 1 month. The 14 different activities performed by the CHWs were identified and the time duration was recorded. Activities were then classified as value added, non-value added but necessary and non-value-added to determine their time allocation. Home visits occupied the CHWs for the maximum number of hours followed by Documentation, and Traveling. Documentation, Administrative work and Review of work process are the non-value-added but necessary activities which consumed a significant proportion of their time. The CHWs spent approximately 40% of their time on value added, 58.5% of their time on non-value added but necessary and 1.5% of their time on non-value-added activities. The CHWs worked for 0.7 h beyond the stipulated time daily. The CHW's are "dedicated" mental health workers as opposed to being "generalists" and their activities involve a significant investment of their time due to the specialized nature of the services offered such as counselling, screening, and home visits. The CHWs are stretched beyond their standard work hours. Non-value added but necessary activities consumed a significant proportion of their time at the expense of value-added activities. Work flow redesign and implementation of Health Management Information Systems (HMIS) can mitigate inefficiencies.

(Source: Chebolu-Subramanian, Vijaya, et al. "A time motion study of community mental health workers in rural India." BMC health services research 19.1 (2019): 1-7.)

14. Gramina Abyuday Seva Samsthe (GASS) - Since 1996, GASS has been known in Bangalore Rural and Urban, Chikkaballapur, Tumkur, Kalburgi, Chamarajanagar and Kolar districts as a leading implementor of services for the Persons with disabilities (PWDs). The focus on mental health and creating empowerment opportunities has impacted several thousand lives in a positive way. The programs, implemented through staff members and community volunteers are designed with empathy and service delivery as core values. Covering vital social development domains like Health, Education, Livelihoods and Environment, our work reaches vulnerable populace including Children, Women, Youth and Seniors from marginalised communities. The various programs of GASS are supported by different funding partners. GASS has been a preferred partner for the Government of Karnataka for the protection of children and women in difficult situations. Child helpline, shelter for senior citizens and women short stay homes are supported by the government. It is equally recognized by leading corporate sector for reaching out to the marginalized through their CSR funds. GASS also enjoys international partnerships with renowned organizations for specific theme-based interventions. During the Covid19 pandemic the organisation had the support from all sectors to reach out to the most vulnerable at the most remote areas. GASS also serves as the center for global research, training and exposure for interns and students from various universities. Working in Mental Health and community wellbeing has been our forte since inception. From operating PHC and Mobile Health clinics to implementing health screening, tertiary referrals, counselling and provision of medicines the organisation ensure the wellbeing of people in the areas of operation. The programs work on increasing awareness in communities about general and mental health.

(Source: https://gassindia.org/programs/#health)

15. UDAAN- Udaan is an innovative health initiative that has taken flight under the aegis of the Trusts. Meaning ‘flight’ this is the Trusts’ most recent and perhaps most ambitious health initiative to develop and implement mental health programmes. Udaan has recently undertaken two large and path-breaking programmes in collaboration with the Government of Maharashtra.

The first of these — psychiatric hospital reform — was initiated in 2016. It was introduced in the Regional Mental Hospital of Nagpur, which serves 24 million people across 11 districts of Vidarbha in Maharashtra. This hospital, established in 1864, continues — like other psychiatric hospitals in the country — to have abandoned persons with chronic mental illness who have become institutionalised. Through Udaan, the Trusts’ effort is to offer an alternative narrative in the global mental health space through systematic and evidence-based reforms, repurposing the role of a psychiatric hospital to offer vulnerable people an important element of care that is otherwise not available in low-resource settings.

The second collaborative programme launched by Udaan is a district-wide community mental health programme for the district of Nagpur. This ambitious programme directly covers a population of five million people, providing mental health services at their doorstep. It aims to work with communities to build awareness on mental health, early detection of illness and to provide care closer to home.

(Source: https://www.tatatrusts.org/our-work/healthcare/mental-health)

16. Mental Health Care (2017-18), Sambandh Health Foundation is a charitable trust dedicated to understanding mental illness and addressing mental health issues in India. The objectives encompass building the capacity of people living with mental illness and their families to lead fuller lives, raising awareness about mental health and mental illness while advocating for improved treatment and community supports. Sambandh Health Foundation is successfully running a community mental health program in Gurgaon for the last four years. The program draws upon the recovery research, strengths-based practices, and the principles of community development. The programs and activities facilitate the capacity of to gain life skills, make social connections, and rebuild bonds with their natural communities. This is accomplished by building social skills, confidence, facilitating social inclusion and the independence to choose desired life paths. Sambandh initially initiated such activities from a Community Integrated Center (CIC) from a government polyclinic in Gurgaon. CIC is a day support center designed to help people suffering from mental illness to recover and get back to normal society. CIC is being run successfully for past several years. In the financial year 2016-17 Sambandh also started this project in 2 villages in the vicinity of Gurgaon with the goal of expanding recovery based supports to semi urban area, wherein community workshops, street plays, educational & awareness sessions, mental illness screening camps etc. are being organized with the objective of generating awareness on mental health, its myths and symptoms and encourage the person suffering with mental illness to gradually adopt the recovery based techniques. The Company's contribution to this Project is in accordance with the requirements of Section 135 of the Act, read with Companies (Corporate Social Responsibility Policy) Rules, 2014, and Schedule VII to Act. During the financial year 2017-18, the Company contributed an amount of INR 33.66 lakhs towards this Project.

(Source:https://csrbox.org/India_CSR_Project_MPS-Limited-Mental-Health-Care-Haryana-_15568)

17. JANAMANAS PROGRAMME Anjali Mental Health Rights Organisation, a Kolkata based Non-Governmental Organisation, launched a community based Janamanas programme in 2006 to target mental illness. Overall, the organization is working towards bringing in systemic reform in mental healthcare and advocating for the rights of people with psychosocial disabilities. The programme implemented by Anjali Mental Health Rights Organisation aims to: · De-institutionalise mental health services and make it accessible to 'last mile communities. · Demonstrate a model of community based mental healthcare that is driven by resource poor women from within the community. · Integrate mental health in the District Development Plan of the government of West Bengal, which is followed by all the municipalities of the state. The implementation design of Janamanas programme reflects the core value of the organization in addressing the broader paradigm of mental wellbeing and right to positive mental health by advocating for quality mental healthcare. Janamanas programme was launched after conducting a needs assessment exercise in Khardah, Kamarhati and Rajarhat-Gopalpur municipalities of Kolkata Metropolitan Area, where a significant proportion of population lived in slums and did not have access to basic amenities. The study facilitated understanding of existing mental health care services, helped in mapping existing healthcare facilities in the area and identified constraints effective delivery of public mental healthcare service.

(Source: https://www.anjalimhro.org/wp-content/uploads/2020/03/janamanas.pdf)

18. Ramakrishna Mission: Ramakrishna Mission (RKM) has been providing health care services through its village medical camps in 9 villages spread over 7 blocks of Mirzapur and Sonbhadra districts since 2006. These villages range from 40 to 130 km from RKM, Varanasi. The total population covered is around 70,000, with most people engaged in agriculture, and 40% of the population being Below Poverty Line. In 2013 mental health services were integrated into the community-based primary health programs of (RKM) as part of the Jan Man Swasthya Pariyojana (JMSP). The programme focused on the treatment needs of people with Common Mental disorders (CMD), Severe Mental Disorders (SMD) and convulsive epilepsy. At that time, no psychiatric facility existed in the area in the government or private sector. Psychiatric patients had to go to Allahabad or Buxar (50-120 km) for treatment. Dr. Amiya Banerjee has been the Mentor and Consultant psychiatrist for the mental health services at RKM since the inception of the mental health programme in 2013. In 2018, this programme was further scaled up to include telemedicine and telepsychiatry services. Dr. Bannerjee regularly conducts onsite hands-on training for the middle-level team and the doctors, provides his supervision and clinical expertise for the treatment and clinical monitoring of patients, develops booklets, manuals, and videos for training along with conceptualizing research design and data analysis for scientific publication of results and insights gained from the program. The mental health services were integrated into the 3-tier primary care system, with: the physician being available in-person in the Mobile Medical Units (MMU) or available virtually at the Telemedicine Units (TMU), the Community Health Workers (CHW) providing door-to-door coverage, the Middle Level Team (MLT) working as 'physician substitutes and trainers of CHWs.

(Source: https://manas.org.in/mansik-soundarya-varanasi/)

19. COMMUNITY BASED MENTAL HEALTH INITIATIVES: The population of India has crossed the billion marks but the state of services for mental health is yet to make strides with equal pace. Given the rate of occurrence of major mental disorders being as high as 1-2% the resultant situation is that there exists a huge gap in supply and demand for mental health interventions. With the objective of creating access to mental health care and treatment for those are socially, economically, and geographically marginalized Ashadeep initiated a Psychiatric OPD in Guwahati in 2006 and undertook outreach mental health camps from 2006-12 in 8 remote regions of Assam including conflict areas such as Chirang, Baksa and Kokrajhar in Bodo Territory areas. The outreach camps consisted of psychiatric treatment for persons with mental illness and training of local NGOs who would continue to secure mental health needs for the community they were serving. The outreach mental health camps have been shaped as 'Community Mental Health Programmes' (CMHP) in the year 2012. These programmes include creating access to mental health interventions and developing sustainable measures for empowering the community on mental health. During 2012-2016, these programmes were implemented in one block each in the districts of Darrang, Morigaon, and Kamrup (rural) in Assam with funding support from the Tata Trusts. A total of 1906 persons in the three blocks had been intervened through this programme. The major aim of this programme is to facilitate mental

health interventions from the Government Health Care facilities within the block along with home-based psycho-education by trained Community Health Worker. To sustain these efforts partnership and capacity building of local Civil Society Organizations and Government Health delivery systems are undertaken. Currently, the program is implemented in Rangjuli Block of Goalpara district, Bhurbandha Block of Morigaon District in collaboration with Morigaon Mahila Mehfil and Chumukedima Block of Dimapur District, Nagaland in collaboration with Prodigals' Home. The program is supported by Azim Premji Philanthropic Initiatives Pvt. Ltd. Bangalore for a period of three years from June'2020.

(Source: https://www.ashadeepindia.org/community-based-mental-health-initiatives/)

20. PROJECT MAANASI -The "Project Maanasi" is a mission to deliver mental health and primary care services to poor rural women and children in southern India. The goal of the program has been to provide low cost or free care to villagers, sustained outreach to those who cannot access the clinic, and educate patients and others about seeking care to improve their lives.

The Project sets out a number of cost-effective strategies to tackle the treatment gap for mental, neurological and substance use disorders in rural southern India. These include: screening of women from villages for psychiatric treatment, bringing treatment near to their homes, bringing medicine and medical assistance to women with varying degrees of mental illness. The project relies on partnerships to scale up services with the objective of reducing the burden of mental, neurological and substance use disorders.

The Project is running under the care of Department of Psychiatry and Community Medicine at the St. John's Medical College, Bangalore, who provide a dedicated team of doctors under the leadership and compassionate care of Dr. Ramakrishna Goud, and Dr. Pradeep Johnson of St. John's Medical College.

In the year 2002, the first "Maanasi Clinic" was established at Mugalur (as the Pilot Project), a tiny village 30 km outside Bangalore to provide integrated primary health care, depression, anxiety and other mental health care in the villages nearby. The centre also serves as a centre `for all community services including a general health clinic, antenatal and postnatal care, childcare, services for the elderly, and for the blind and deaf. The centre serves more than 30 villages as the nearest other medical care is 10 km away.

(Source: https://www.projectmaanasi.org/project_maanasi.html)

21.VENDA – Say no to drugs The menace of drug abuse in the younger generation has been rising all over the world and India is no exception. Addiction to drugs and alcohol not only affect the individuals involved but also disrupts the family and society. Addictions seem to have affected all classes of society, and there are no age barriers either. The worst affected are the adolescents. They use drugs for many reasons: Peer pressure, academic failure, ignorance of the consequences, curiosity and fun, easy availability of the drugs, stress, lack of communication with parents, low self-esteem, free money, Depression- the list is endless.

The results of a study done by National Drug Dependence Treatment Centre and the All-India Institute of Medical Sciences, sites that alcohol, tobacco and inhalants are common initial substances of abuse and have been described as 'gateway substances. These substances are easily available to the children, according to the revelations in the research and are a reason for concern.

In this context, project Venda empowers the teenagers to say 'NO' to substance abuse and help to rehabilitate addicted and affected teenagers. Project Venda also aims at equipping various stake holders with information, skill and knowledge to broach and discuss the topic of drugs with children and young adults. These Partnerships with parents and communities would indeed help to integrate consistent and relevant messages into the home and society, thus improving the student health of mind and body.

(Source: https://www.fourthwavefoundation.org/project/venda/)

22.SHRADDHA REHABILITATION FOUNDATION Shraddha Rehabilitation Foundation was founded in the year 1988, to deal with the tragedy of the mentally ill, destitute wandering aimlessly on the streets of India.
Shraddha does not take in patients brought by family members or whose family antecedents are known. Shraddha is a fully charitable, secular, social, apolitical and registered Non-Government Organization (NGO) wherein all the services are provided free of charge.

Shraddha rescues wandering mentally ill destitute, brings them to their institute and provides them care, food, shelter and appropriate psychiatric treatment. Once psychiatric wellbeing is achieved (often taking 2-3 months), these destitute are helped in tracing out their antecedents, from wherein the reunion with the original family and native home takes place in the farthest corners of India and nearby countries. All these services, from the moment they are rescued from the streets till the time they are reunited with their families in their native village, are rendered absolutely free of cost.

Shraddha stands strong proving itself to be a time-tested and a very hopeful humane experiment in itself, providing treatment, protective care and rehabilitation to a neglected group of wandering mentally ill roadside destitute and reuniting them with their lost families (loved ones) and correspondingly spreading awareness in the farthest corners of India. This model has spearheaded more than 9,000 reunions and seems to be capable of replication at a national level vide shelters run by government and NGOs, addressing the very much existent issue of homeless destitute roaming around aimlessly on the streets of India and other neighbouring countries as well.

(Source: https://www.shraddharehabilitationfoundation.org/)

Our journey through CHLP project .Finding Thrust areas of DMHP

PLANNING PHASE

Planning to initiate Community Mental Health Project

Prepared and studied upon the initiatives and various activities that come under District Mental Health Programs.

Spoke to various NGOs (SHAMA, Masjid one, BIRDS) for providing volunteers for the Community Mental Health Project.

Visited PHC Kodigehalli as part of the Community Mental Health Project.

Created poster as part of Community Mental Health care.

Created letters to BBMP Kodigehalli, Health Officer Yelahanka and also to The MLA Sri. Krishna Byre Gowda based on assistance like volunteers, food kits etc.

18.07.2022- Dr. Safiya held a meeting with the staff of the organization on how to proceed with the NGO activities and staff presented their opinions and suggestions.

19.07.2022- Spoke with various NGO personnel on how to go forward with the community mental health program.

20.07.2022- Dr. Safiya M.S (Psychiatrist) and Mr. Allen A. Marattil (Psycho- Social Worker) visited MLA Sri. Krishna Byre Gowda's office to get the support from Asha workers and link workers, to identify the people with mental illness from the communities. MLA also gave permission to collect food kits from Indira Canteen.

20.07.2022- Dr. Safiya M.S (Psychiatrist) and Mr. Allen A. Marattil (Psycho- Social Worker) have met the Health Officer in PHC Kodigehalli. The Health Officer agreed to provide five Asha workers and one link worker for the Community Mental Health Project.

Photos of Meeting with Health Officer in the PHC, Kodigehalli

22.07.2022- Dr. Safiya M.S (Psychiatrist) and Mr. Allen A. Marattil (Psycho- Social Worker) met MLA Sri. S.R Vishwanath informed him about the Community Mental Health Project to identify the people with mental illness from the communities. Also, the team got permission to do the projects in the various Wards of Yelahanka.

Photos of Meeting with the MLA Sri. S.R Vishwanath

ü 28-07-2022- Dr. Safiya M.S (Psychiatrist) and Mr. Allen A. Marattil (Psycho- Social Worker) met Dr. Lakshmi in Kodigehalli PHC for discussing about the Community Mental Health project. In this meeting, it was proposed that the first training program for the ASHA workers will be commenced from 3rd August 2022 (Wednesday). The venue of the training will be the top floor of Urban Public Health Center Kodigehalli.

Photos of Meeting with Dr. Lakshmi in the PHC Kodigehalli

29-07-2022-Prepared the tentative plan for the Community Mental Health Project of Mind and Brain Hospital.

05-08-2022- Conducted a meeting with Mr. Mani Kalliyath from BNI on a Community mental health project.

08-08-2022- Conducted an online zoom meeting with Dr. Johann Ebenezer from Padhar hospital regarding his experience while carrying out the community mental health project. Also, the Mind and Brain Charitable trust received permission from Dr. Johan in using the outcome tool and screening tool which was used for the Shifa project.

10-08-2022- Dr. Safiya M.S(Psychiatrist) and Mr. Allen A. Marattil (Psycho-Social Worker) visited the PHC Kodigehalli for training purposes of ASHA Workers. The training session for ASHA Workers was started at 10.00 on 10.08.2022 in the PHC Kodigehalli. The keynote speaker of the session was Dr. Safiya M.S. Almost six ASHA Workers, two nurses and the Health Inspecting Officer of the PHC participated in the training session. During the meeting the major focus was given to the concept of Mental illness.

01-09-2022- As part of the community mental health project, first case was referred to Mind and Brain Hospital by the Kodigehalli PHC. The name of the client was Mr. Mallika Arjun and Mr. Allen A. Marattil (Psycho-Social Worker) along with Ms. Ruquiya Jabeen (Psychologist) took the case history from the client. Dr. Sony (Psychiatrist) wrote the prescription for the client and Dr. Safiya verified and went through the whole case as well as the prescriptions.

06-09-2022-Converted the Padhar hospital's screening tool and outcome evaluation tool from English to Kannada for the purpose of understanding among Kannada speaking villagers and ASHA workers.

07-09-2022- Dr. Safiya M.S (Psychiatrist) and Mr. Allen A. Marattil (Psycho- Social Worker) met Dr. Lakshmi in Kodigehalli PHC to discuss the Community Mental Health project. In this meeting, Dr. Safiya discussed how to connect towards the traditional/ spiritual healers. The major reason for the discussion was that many people with mental illness are being taken to the spiritual healers rather than to the psychiatric hospitals. While doing so, the mental stability of the patients is getting worst day by day and the chances of suicides are also high. Dr. Safiya put forward that she will be able to train these spiritual healers and one intervention model will also be taught to these spiritual healers to responsibly take care of the mentally ill cases that are coming to them.

ACTION PHASE

07-09-2022 – As part of the Community mental health Dr. Safiya, Mr. Allen along with Mrs. Uma (staff of PHC) visited one of the villages near to the Kodigehalli PHC. In the visit the team identified two cases with mental illness.

07-09-2022 – As part of taking case history Ms. Ruquiya (Psychologist) and Mr. Allen (Psycho-social worker) from Mind and Brain hospital visited a house near to the PHC,

Kodigehalli. The informant of the case was Mr. Viswanath (husband of the patient). All the concerned information about the client was taken from the husband and the neighbors also gave their input into the same.

08-09-2022- Ms. Ruquiya (Psychologist) and Mr. Allen (Psycho-social worker) from Mind and Brain hospital visited the PHC, Kodigehalli for preparing the list of psychiatric medicines that are available in the PHC.
15-09-2022- Dr. Safiya and Mr. Allen have gone to the PHC Kodigehalli to meet the staffs to make a plan of actions for the mentally ill people who are under the PHC. Dr. Safiya also asked the help from the PHC for identifying the spiritual leaders related to mental health.
16-09-2022 – Mr. Allen A. Marattil (Psycho Social Worker) along with Mrs. Kusumam and Mrs. Uma visited the villages under the Kodigehalli PHC for the purpose of collecting the data of the people who are having mental illness.

27-09-2022 – Mr. Allen A. Marattil (Psycho Social Worker) along with Ms. Ruquiya (Psychologist) visited the villages under the Kodigehalli PHC for the purpose of collecting the data of the people who are having mental illness.

15.11.2022- In collaboration with PHC Kodigehalli, Dr. Safiya initiated the medicine distribution camp for the caregivers of the patients. So, the patients along with the caregivers came to the PHC for taking the medicine and some of the cases were also referred to the mind and brain hospital.

Challenges:

- Lack of medicines in the PHC
- Unwilling attitude of the patients to come to PHC
- Stigma associated with the psychiatric medications
- Lack of hope from the family members

Case history

1. **Priya**

SOCIO-DEMOGRAPHIC DETAILS

Name : Priya

Sex : Female

Age : 25

Education : 10th grade

Occupation :Homemaker

Address : Oil Mill Road, Bangalore

Socio-economic status : Middle class

Religion : Hindu

Mother Tongue : Tamil

Languages Known : Tamil, Kannada, Telugu, English

Presenting Complaints

- Feels lonely and feels like being enclosed in jail
- Feels sad almost all the time
- Missing her children
- No one is supporting me

The onset of Illness :

The course of Illness :

Progress of Illness :

Predisposing Factors :

Precipitating Factors :

Perpetuating factors :

History of present Illness

The patient had conflicts with her husband two weeks back and decided to go to a friend's room to stay away from him. She had not reported the same to her husband or any other family members. After a while when the family realized she was missing they informed the police station. The official on receiving the complaint contacted the individual she has been suspectedly having an extra marital affair with. On searching his phone, as the officials found photographs of her with him, they asked him to contact her on which he did. After talking to the police officials she returned to her home and went with her husband's family. Reportedly none of her family members behaved harshly with her post the incident. But as the family members left the house without her for dinner, she had a suicidal tendency. She attempted suicide by hanging herself and fell unconscious. She was taken to hospital by her family members and was in the hospital for a week. After her discharge from the hospital, in the pretext of an interview her cousin sister brought the patient to the hospital.

Negative History

No h/o crying spells, significant weight loss

No h/o increased talk, tall claims, overfamiliarity

No h/o multiple, variable physical symptoms, additional subjective symptoms referred to a specific organ or system

No h/o repetitive behaviours like washing hands, changing clothes, counting

No h/o of head injury, substance abuse

No h/o Fever, Hypertension, Diabetics

Past Psychiatric History : nil

Medical History : nil

Family History and Family Genogram

The patient belongs to a nuclear family with a mother and a younger brother. The patient's father left her mother when she was 6 years old. Later she remarried her love interest. He used to sexually harass the patient. But the patient did not report it to her mother as she thought she would not be believed by anyone. Later on after a few years a case was filed against him following which he left the house. The patient and her family then learned that he died by suicide. The patient reported that her mother does not share anything with her nor does she share anything with her mother. The patient is more closely attached to her younger brother with whom she shares everything.

Consanguinity : No

Type of family : Nuclear

Family History with any problems : nil

Birth and Development History : Normal delivery.

Developmental milestones were attained as per the knowledge of the patient

Child and Adolescent History

History of Hyperactivity : nil

History of conduct problems :nil

Educational History

The patient completed her education till 7th in Bangalore and later in 8th grade moved to

Tumkur to continue her education. The patient completed her 9th and 10th via correspondence and later had to discontinue her education as her mother did not permit. The patient also mentioned her interest in wanting to complete her education.

Sexual history

The patient reported having faced sexual harassment from her step father from the age of 5 till the age of 14. He used to forcefully make her watch pornography and touch her inappropriately. The patient reported that her husband after being intoxicated with alcohol forces her to indulge in sexual activities. She reported that she lost interest in sexual activity during her second pregnancy. She stated that her husband constantly doubts she is in a relationship with someone and therefore she lost interest. Although the first child was planned, the second child was conceived when the husband forcefully had intercourse with the wife.

Menstrual History

The patient attained menarche at the age of 10. The patient mentioned that she does not face any particular mood changes or difficulties during her cycle. Her menstrual cycles are normal.

The patient reported her last menstrual cycle as 20th February, 2022.

Marital History

The patient was in a relationship with her husband for one and a half years before the wedding. They had met at work. The patient reported her marital life as unhappy. The husband is an alcoholic and often comes home drunk and physically and sexually abuses her. The patient also reported instances where the husband has urinated in his clothes after being intoxicated by alcohol. The husband is often at home except for two weeks a month when he has to travel regarding work. The patient reported that when the husband is in a sober state, he doesn't talk much. She also mentioned that there have been instances where she was asked to leave the house and she had to go to her mother's place. The patient also accepted having an extra marital relationship with a neighbor. She has known him for three years and has been in a relationship with him for the past six months.

History of psychoactive substance usage : No history of psychoactive substance usage

Premorbid Personality :

Attitude towards others :

Attitude towards self :

Moral and Religious attitudes and standards : Moderately religious

Leisure activities and interests: Interested in doing embroidery works and watching television whenever the client used to be free at home.

Reaction patterns to stress : Vents out by crying or reacting back in the same manner as the stressor does if it's a human figure.

EXAMINATION OF HIGHER MENTAL FUNCTIONS

Attention and concentration

Serial test :100-7=93,86,79,62,55,48,31,24,17 -Incorrect

40-3 = 37,34,31,28,25,22,19,16,13,10,7,4,1 -Incorrect

Week days or months backwards -Done

Impression -Easily aroused and sustained

Orientation : Oriented to place, time, person, date/day

Memory

Immediate : Digit span intact

Recent :Intact

Remote :Intact

Abstractability :

Proverb: “All that glitters is not gold”, the patient couldn’t explain the proverb.

Similarities: “Table and chair”, the patient couldn’t explain the proverb.

Differences: “Fly and Butterfly”, the patient couldn’t explain the proverb.

Impression : Concrete level

Judgment : Personal , social, and test intact

General Knowledge : Name of the capital/Chief minister/Father of our nation – Name of the capital and father of our nation not answered.

Impression : Adequate

MENTAL STATUS EXAMINATION [31/03/2022]

GENERAL APPEARANCE AND BEHAVIOR

Consciousness : Alert and Awake

Eye contact : Maintained

Rapport : Easily established and maintained

General appearance : Well-kept and tidy

Hair : Well groomed

Finger nails : Well maintained

Grooming : Well groomed

Dressing : Appropriate

Comprehension : Intact

Gait and posture : Normal gait

Attitude towards examiner : Cooperative

Motor Behaviour : Within normal limits

Speech and Language Ability

Intensity : Audible

Pitch : Normal fluctuation

Reaction time : Adequate

Speed : Normal

Ease of speech : Spontaneous

Relevance of the speech : Relevant

Coherence : Coherent

Goal direction : Goal directed

Productivity : Adequate

Manner : Relaxed

Deviation : Does not divert conversations in between

Form of Thought : Thoughts were coherent and in flow. No loose associations, circumstantial or tangential thoughts

Stream of Thought : The tempo of speech is maintained. No flight of ideas, thought blocking, perseveration or neologisms. The thought processes were relevant to the questions asked.

Content of Thought : Suicidal ideations mentioned, attempted twice; once in childhood and the recent incident. The patient also mentioned thoughts of loneliness.

Possession of Thought : No thought insertion, withdrawal or broadcasting

Perceptual Abnormalities : Nil

Mood : Feels lonely, low mood

Affect : Blunted

Insight : Level I - Complete denial of illness

2. Asmataj

A. Identification

1. Name: Asmataj

2. Sex: Female

3. Age: 29

4. Education:

5. Languages Spoken: Hindi

6. Religion: Muslim

7. Nationality: Indian

8. Marital status: Married (With three children). First child in 2005 after 2004 (Year of marriage).

9. Occupation: Housewife and Tailor (entrepreneur)

10. Referral: -----

11. Previous admission: NIMHANS (84 IQ borderline)

12. Person’s living with client: Husband and children.

B. Chief Complaints

1. Presenting Complaints: Family complaints of violent beating and talking to walls.

2. Informant: Husband

C. History of Present Illness

1. Onset (with life circumstances): Acute Patient seemed to have a very wholesome and peaceful life with family. About 3 years ago, patient left home with money and had disappeared for about 8 days and when found had a drastic change in personality.

2. Progress: Continuous (mostly, patient has some periods of normalcy but never regains Pre-Morbid personality)

3. Precipitating Factors: Questions about patient's behaviour triggers violence and outrage.

4. Perpetuating factors: Insomnia. Eats only once a day and throws away food even then (Doesn’t respond when asked about the taste of her daughter's cooking.). Refuses to take medicine.

5. Predisposing Factors: The patient's grandmother had similar symptoms. Disappeared for more than a week.

6. Pre-Morbid Personality (subsequent changes due to illness also): Devoted to family, loving, religious, introverted, doesn’t talk to people. Had minor arguments with husband. Concerned about kids' futures. Industrious (tailoring work). Drives on her own. Didn’t hide things from husband.

7. Psychophysiological symptoms:

a. Nature and details of dysfunction: Some hand tremors at times. Reports of limbs, organs (kidneys) and hair not her own. “This is not my hair? Where are my kidneys? You sold them right? This is not my hair.” Later shaved her head. Son reported moist hands at times. Patient was reported to be very restless. Couldn’t and didn’t sleep without pills. Woke up family members when they tried to sleep.

b. Pain location, intensity and fluctuation: Severe and constant headaches, usually at frontal lobe area.

8. Level of anxiety: Seems to be episodic. (from informants viewpoint)

9. Anxiety handling: Commits violence and cries frequently. Repeats same event.

10. Use of drugs or other activities for alleviation: Talks to walls as if she’s talking to real people she knows. (Family members)

D. Past Psychiatric and Medical History

1. Emotional or mental disturbances: Admitted at NIMHANS for 4-5 days. Attacked doctor. Later discharged. Took only 2 days of medicine. Illness now prevalent for 3 years since 2019.

2. Psychosomatic disorders:

3. Medical conditions:

4. Neurological disorders: Severe and frequent headaches. Son reports bump on patients head.

E. Family History:

1. Ethnic traditions: Normal.

2. Religious traditions: Namaz

3. National traditions: Normal.

4. Descriptions of other people in home:

Members of home	Descriptions	Personality	Intelligence
Husband	Thin and average height. Has a pepper salt beard.	Agreeable personality. Very cooperative and open.	At least average intelligence
Eldest son (17)	Thin and lanky boy with a mature air.	Composed, agreeable.	At least average intelligence
Middle brother (16)	Thin and lanky boy.	Q little shy Shy and cooperative	At least average intelligence
Youngest daughter (15)	Thin and average height.	Shy and cheerful. Affectionate to mother. Responsible	At least average intelligence

5. Role of illness in family: Husband sometimes hits wife in anger.

Family history of mental illness: Patients grandmother reported to have similar symptoms.

6. Where patient lives: at home, crowded space, single room for sleep, socializing, and kitchen.

7. Sources of family income: Husband works. Patient used to work as a tailor and even travelled to Saudi for nearly a year working as a house helper, to secure her patients future (after returning complained of bad treatment by women and good treatment by men).

8. Child care arrangements: Patient used to take care of children before incident 3 years ago.

F. Personal History (Patient uncooperative and unwilling to continue case history, husband has no knowledge of patients early and middle childhood life before marriage)

1. Adulthood

a. Occupational history: Housewife, tailor and house helper (Went abroad to work in 2015).

b. Social activity: Limited to only family. Little to no communication with neighbours.

c. Adult sexuality

1) Premarital sexual relationships: No info.

2) Marital history: Husband reported no problems.

3) Sexual symptoms: None

4) Attitude towards pregnancy, children and contraceptives: Positive.

5) Sexual practices: None.

d. Military history: None.

e. Value systems: Positive value system. Children are a joy.

Mental Status Examination

A. Appearance

1. Personal Identification: Initially cooperative but unwilling to respond and turning disinterested once questions began to take effort or invade privacy.
2. Behaviour and Psychomotor activity: Preferred to remain lying down to answer questions. Kept glancing down or turning away from facing the examiner. Expressed hostility to husband in tone, facial expression and gaze.
3. General Description: Looked apathetic and slightly irritated. Usually good eye contact except when trying to avoid answering questions

B. Speech

1. Volume: Low
2. Tone: Soft
3. Pace: Normal
4. Quality: Hesitant (almost mumbling)
5. Intensity: Soft but turns intense when speaking to husband
6. Reaction Time: Normal

C. Mood and Affect

1. Mood: Reported as normal.
2. Affect: Apathetic, disinterested and anxious to go home.
3. Leisure: None.

D. Thinking and Perception

1. Form of Thinking:

a. Productivity: Speaks only when asked. (May not answer)

b. Continuity of thought: Evasive

c. Language Impairments: None. Dysarthria absent.

2. Content of thinking

a. Preoccupations about the illness: Wishes to go home

b. Obsessions, compulsions, phobias: Wears men’s clothes.

c. Obsessions or plans about suicide and/or homicide:

d. Hypochondriacal symptoms: Hits and beats people (family and strangers). Burns bikes, things and her own clothes. Attacked husband with knife as well. Breaks phones and kids gadgets. Talks angrily. Leaves home and turns phone off if not supervised so kids have to stay home and can’t go to school.

3. Thought Disturbances

a. Delusions: Claims her family is not her own. Fails to recognise family members. Is suspicious of the family's intentions. Suspects husband sold her kidneys. Becomes physically hostile when questioned.

b. Ideas of reference and ideas of influence:

c. Thought broadcasting:

d. Thought insertion:

4. Perceptual Disturbances:

a. Hallucinations and illusions: Talks to the wall. Calls names of brother, parents etc.

b. Depersonalization and Derealization: Asks if body parts are her own. Claims her limbs are not hers.

5. Dreams and Fantasies: ------

a. Dreams:

b. Fantasies:

E. Sensorium

1. Alertness: Seemed to be lucid and aware.

2. Orientation:

a. Time: Aware of the time period of day but not exact time.

b. Place: Knew general place as hospital but not area.

c. Person: Knew herself and her family members.

3. Concentration and Calculation: Gave up calculation because of fatigue after one calculation. 100-7=93. Misheard questions at first as 100-70= 30.

4. Memory: Uncooperative.

a. Remote memory:

b. Recent past memory:

c. Recent memory:

d. Immediate recollection and recall

e. Effect of defect on patient:

5. Fund of Knowledge: -----

a. Level of functioning:

b. General knowledge:

6. Abstract Thinking: ----

7. Insight: Complete Denial. Evasive, does not respond to relevant questions.

8. Judgment: -------

a. Social judgment:

b. Test judgment:

3. Sana Zainab

1. General Information

Name – Sana Zainab

Sex – Female

Age – 14 years 2 months

Education – 4 th standard (English medium)

Language – English, Hindi, Urdu, (can understand Kannada)

Religion – Muslim

Marital Status – unmarried

Informant – Parents

Reliability and Adequacy of information – The information is reliable and adequate.

2. Presenting complaints –

1. Mobile Addiction

2. Unhealthy attachment with doll from the past one year

3. Negative changes in behavior from the past one month

4. Aggressive behavior from the beginning of May 2022

5. Tearing her own clothes in anger

6. Obsessive thoughts related to pregnancy

7. Inappropriate behavior with the doll from the beginning of May (breastfeeding the doll)

8. Violent behavior; started hitting parents.

9. Lack of eye contact

10. Associating human factors and emotions with doll

11. Fact checks on YouTube or internet on all aspects of pregnancy

12. Engaged in watching porn or related video

13. Breaking things in anger

3. History of present illness

Total duration of illness –For the past 13 years

Age of onset –2 years

Onset - sub acute

Precipitating factors - psychological in nature

Course of the illness - fluctuating

Associated disturbance-

Impairment in ADL

● Sleep

She has problems sleeping, and has an irregular pattern of sleep. During her schooling she followed a schedule to sleep and wake up. She mostly has 7-8 hours of sleep. Before sleeping she stays awake for 1 ½ - 2 hours and repeats what she had seen on her phone and TV to herself.

● Appetite

Increase in appetite since she has started taking psychiatric medicines.

● Weight

Her weight is 92 kgs and is considered as overweight for her age.

● Social life

Doesn’t stay in touch with her friends. Isn't allowed to leave her home.

● Negative history

Had a fever at the age of 1

4. Past history

● Past physical illness - she was diagnosed with PCOS in February

2022.

● Psychiatry illness - she was diagnosed with ASD and ADHD in

2012.

5. Family history

She is the older of the two children, born of a non consanguineous marriage. Her younger brother is 12 years old. Father has had a basic formal education and is a businessman. Mother is an educated housewife. Theirs is a nuclear family. Mother tongue is Urdu.

6. Personal history

Birth history

Mother had history of 2 miscarriages, has a diagnosis of PCOS before the conception of the patient. Was on bed rest for the entire pregnancy, had undergone cervical stitch on the 6 th month of pregnancy. She had gestational diabetes, high

blood pressure and high sugar level for the entire pregnancy. In the 8 th month 1 week, the baby was taken out through cesarean and had a birth weight of 2.2 kg. The patient had no fever, had normal skin tone during birth, had immediate cry and had a history of jaundice which was treated appropriately. Post delivery the mother was admitted to ICU for 3 days and breastfed there. The patient was breastfed for 1 year and 9 months.

Developmental milestone

The patient started walking after the age of 1. Started babbling between the age of 3 and 4. Started walking at the age of 6 years, but has difficulty in speaking in full sentences.

Behavior during childhood

She had tantrums. Parents were scared to take her anywhere. Used to cry when she didn’t get the things that she wanted and broke things at home. She had the habit of bedwetting until the age of 10. She had no issue with mingling with kids of her own age, did not get into a fight with them, had healthy competition with them. She was a good student and used to listen to her teachers but was unable to sit in one place in school.

Physical illness during childhood -

Didnt have physical illness during childhood and had one occasion of a fever at the age of 1 and was treated for it.

School -

She has studied till 4th class. She was regarded as a student with potential to do better according to her teachers. Couldnt sit in one place for a long period of time throughout her school life and due to extreme issues with distractibility her parents couldn't continue her education through the means of online class due to covid19.

Menstrual history -

She got her periods in 2018. For 2 and half years there were no problems with her menstruation and had problems from September 2021, as her psychiatric medicines were started from then. After which she gained weight and had irregular periods. She was diagnosed with bilateral polycystic ovary in February 2022. She has painful cramps for which she has meftal spas. She has heavy flow throughout her periods. Her menstrual cycle usually lasts for 5 days.

7. Premorbid personality

Attitude to others-

She was good to her brother but the past 1 year has been hostile towards him. Has always bet her parents in anger.

Attitude to self -

Wasnt much interested with pregnancy related things earlier on.

Moral and religious attitudes-

She had the habit of praying everyday and could remember Quran verses.

Mood –

Was always adamant about things she wanted. Liked to maintain conversation about her favorite topics.

Leisure activity and interests –

She liked to color, do embroidery, cycling, dancing, singing and painting.

Fantasy life -

Wanted to be a director. Wanted to be a doctor who does scanning for babies in

womb. Wanted to be married and have 1 kid.

Reaction pattern to stress –

Becomes aggressive when stressed, breaks things in anger, had the habit of kicking on things near her and cries when overwhelmed.

Habits –

Had selfcare habits and reading habits.

4. Mallika Arjunan

PERSONAL DETAILS

Name: Mallika Arjunan

Address: Kariyanna Layout, Hebbal Kempepura, Bangalore – 560024

Age: 32

Phone no.: 9019096002

Marital status: Single

Siblings: Five

Educational qualification: SSLC Failed

PROBLEMATIC AREAS

Repetitive thoughts and images.

Anxiety and fear (Fear of hitting by someone)

Consumes alcohol to overcome the fear

5 to 10 years he is undergoing the fear and anxiety

Past 10 years he is not going to work because of this anxiety and fear

Not able to sleep properly

Past 10 years he is consuming alcohol

Sexual thoughts towards ladies after seeing them

Appetite is not proper

Suicidal thoughts occur

Tried to commit suicide by lying on a railway track

PRESCRIPTION

MIND & BRAIN HOSPITAL

CHANGING PERSPECTIVE...

Mallikarjunan, 32y

- OCD
- ADS

C. Fluoxetine 20mg AmOD ✱
T. Diazepam 5 – 0 – 15mg
C. Bensten 1 TID
(Thiamine)
T. Chlorpromazine 50mg HSOD.

10 day.

P/c: ↑ Fluoxetine
↓ Diazepam

Dr. Sony Mathews Lukose
M.B.B.S., D.P.M., M.D (Psychiatry)
T.N.M.C Reg: 89203
KMC 130461

5. **Kalpana**

Name: Kalpana

Sex: Female

Age: 37

Education: 5th grade dropout

Languages Spoken: Tamil and Hindi

Religion: Christian

Marital Status: Married

Informant: Husband

Reliability and Adequacy of Information: The information provided was reliable but not adequate.

Presenting Complaints: (15 years)

- Poor hygiene
- Irregular appetite
- Insomnia
- Self-medication
- Excessive caffeine intake
- Overdosing medication
- Violent outbursts
- Manic episode

History of Present Illness: Detailed and Coherent Account of the Symptoms from the Onset to the time of Consultation.

- Onset: Sudden onset
- Precipitating Factors: Psychological in Nature

• Course of the Illness: Continuous

• Associated Disturbance: Impairment in ADL (Sleep, Appetite, Sexual Life, Social Life, Occupation)

• Negative History: Has High blood pressure

Past History: Absence of physical illness, Psychiatric illness (Yet to be diagnosed)

Family History: Husband is a fruit merchant and had lost his eyesight in 2011.

Personal History:

• Birth and Early Development: Normal; no delay in milestones

• Behaviour During Childhood: Normal

• Physical Illness During Childhood: None

• School: Dropped out after 5th standard

• Occupation: Unemployed

• Menstrual History: Normal

• Sexual History: Not sexually active

• Marital History: The patient has been married for 22 years. The patient is violent towards her husband and her children.

• Substance Abuse: Has the habit of excessive consumption of over-the-counter medication (Vicks action 500)

Premorbid Personality:

• Attitudes to Others: She used to mingle with everyone and had a healthy martial relationship. She was a caring mother and used to love spending time at home.

• Attitude to Self: Self-destructive (Self-medicates and overdoses the said medication)

• Moral And Religious Attitudes and Standards: The patient does not follow rituals or attend any religious gatherings.

• Mood: Normal

• Leisure Activities and Interests: None

• Fantasy Life: None

Diagnosis: Schizophrenia.

Summary:

The patient was unkempt, lacked personal hygiene, aggressive and violent on arrival. The symptoms were first observed in 2007 where her behavior suddenly turned aggressive and this was when she started overdosing on over-the-counter medication. She was also prescribed medication for her condition in NIMHANS. She consumed the prescribed as well as unprescribed drugs. After consuming her behavior turns out to be short-tempered and violent and attacks the people around her. She abuses her family physically and verbally. She has anxiety and gets aggressive if she notices her family as she feels that they are following her, to spy on her. She possibly had a manic episode on her mother's death where she did not cry but instead laughed loudly and uncontrollably. In 2016 she was admitted to Home, Indiranagar for 6 months where she was physically abused by the staff. She was also on a different occasion physically abused by 5 transgender people on the road when she accused them of talking about her. After all this she started going out at odd hours and returned home at 1:00 am. She watches TV the whole night without sleeping. Recently she was taken to Charitable medical Centre who then referred this organization for further treatment.

Plan of action

• Medication

• Psychotherapy (could not be initiated as the patient was uncooperative and aggressive,

rapport could not be established)

Treatment Plan

Injections were induced for starting four consecutive days continuously in order to reduce the aggression.

• Injection Lorazepam, Haloperidol and Phenergan

After 4 days medication was induced and injection was induced on need basis.

• Syrup Oprex and Risnia

After 14-15 days tablets were given.

• Tablet Olanate 20 mg

• Tablet Oprex 20 mg

After 15 days of admission the patient was diagnosed with Hepatitis-B.

6. Bhagya Lakshmi

PERSONAL DETAILS

Name: Bhagya Lakshmi

Age: 46 years

Educational qualification: 9 th standard

Address: Near to PHC Kodigehalli, Bangalore

Pincode: 560092

Marital status: Married

Mobile Number: 9620035618

PROBLEMATIC AREAS

Wandering

Forgetfulness

Self-talk

Aggression

Appetite and sleep are not regular

Poor hygiene

Low eye contact

OCCUPATIONAL HISTORY

Six years before she had quit her job from Columbia Asia Hospital.

PERCEPTION

Her husband suspect that something might have happened to her in the work place.

7. **Gayatri**

PERSONAL DETAILS

Name: Gayatri

Address: Near to PHC Kodigehalli, Bangalore, Pincode: 560092

Age: 18

Phone no.: 8217396926

Marital status: Single

Siblings: One

Educational qualification: Nil

PROBLEMATIC AREAS

Large head because of excess amount of water

The shunt inside the head is not functioning properly

Fluctuations in behavior

Sleep is not proper

8. Guru Raj

PERSONAL DETAILS

Name: Guru Raj

Age: 50 years

Educational qualification: 7 th standard

Address: Near to PHC Kodigehalli, Bangalore, Pincode: 560092

Marital status: Unmarried

Mobile Number: 8884209164

PROBLEMATIC AREAS

- Self-talk
- Does not do the work which is allotted by others
- Aggression
- Wandering around the house
- Poor hygiene

MEDICAL HISTORY

- He was treated in NIMHANS for a duration of 15 years.
- The family members had to give small punishments to him especially
- during covid to control his misbehaviours.

9. Suhas

PERSONAL DETAILS

Name: Suhas

Address: Near to PHC Kodigehalli

Bangalore

Pincode: 560092

Age: 10

Phone no.: -

Marital status: Single

Siblings: One

Educational qualification: 7

PROBLEMATIC AREAS

- The first Seizure attack occurred when Suhas was one year old.
- With the help of medication the seizure attack was controlled but three
- months back it occurred again.

10. Vinod

PERSONAL DETAILS

Name: Vinod

Address: Near to PHC Kodigehalli, Bangalore

Pincode: 560092

Age: 27

Phone no.: -

Marital status: Single

Siblings: One

Educational qualification: PUC

PROBLEMATIC AREAS

- From six year onwards he was paralyzed
- Experienced seizure attacks from childhood
- The level of aggression is very high

11. Dhanush

PERSONAL DETAILS

Name: Dhanush

Address: Near to PHC Kodigehalli

Bangalore

Pincode: 560092

Age: 5

Phone no.: 9964829579

Marital status: Single

Siblings: One

Educational qualification: Nil

PROBLEMATIC AREAS

- No proper growth of brain
- No proper eye contact
- Discontinued the treatment due to financial issues

12. Yahon

PERSONAL DETAILS

Name: Yahon

Address: Near to PHC Kodigehalli, Bangalore

Pincode: 560092

Age: 2

Phone no.: 9964829579

Marital status: Single

Siblings: One

Educational qualification: Nil

PROBLEMATIC AREAS

- No proper growth of brain
- No proper eye contact
- Discontinued the treatment due to financial issues

13. Sathish (Antiha's brother)

PERSONAL DETAILS

Name: Sathish (Anitha's brother)

Address: Near to PHC, Kodigehalli, Bangalore

Pincode: 560092

Age: 57 years

Marital status: Single

Siblings: 2

Educational qualification: SSLC Failed

PROBLEMATIC AREAS

- Aggressive traits
- Wandering around
- Fear
- Aloof
- Constantly searching
  (NB: Could not continue treatment due to family reasons)

Three follow up sessions were given to all the patients.

Home visits were done.

Medications were initiated.

Family therapy was given

Group sessions were organized.

REFLECTION:

The problem is not the accessibility, but the acceptability.

Hence, to improve the accessibility, we have initiated with NIMHANS to improve the community acceptability regarding mental health illness.

LOCAL PROBLEMS, LOCAL SOLUTIONS

Area of interest: to improve community participation, increase the acceptability of the treatment of the mentally ill, and reduce stigma.

Research question: Will community participation reduce stigma?

Potential resources: psychiatrist, psychologist, nurse, driver, and social worker.

Supervisors: Under discussion

Weekly one-on-one visits for case identification, diagnosis, documentation, psychosocial intervention, family therapy, and follow-up.

Follow-up plans: If the patients come to the Dargah for the follow-up, the follow-up will be done in the Dargah itself. If the patients do not come to the Dargah, the follow-up will be done through phone calls. In case the patients do not have phone facilities at home, the follow-up will be done through ASHA workers or Masjid Imams.

Target area: Chintamani-Murmalla Dargah

Beneficiaries: People who predominately seek faith-based treatment.

Outline of the research: To address the global challenge of mental illness within the local context. The prayer treatment model offers a unique opportunity to blend faith and medicine. It allows for medical practitioners and religious leaders to work alongside each other to find viable solutions to help those in need of mental health care.

We want to conduct a prospective, impact-based study. A sample will be collected from the patients attending Dargah. Medications will be prescribed as per the diagnosis. The Quran will serve as a foundation for the DUWA aspect. A few simple Quranic verses will be used for supportive psychotherapy, cognitive therapy, and the grounding technique model.

The objective is to improve community participation and increase the acceptability of the treatment of the mentally ill. The planned activities are to strengthen the rapport, complete clinical assessments, track progress, and evaluate the impact of the therapy with and without it.

We are expecting the compliance to be better and reduce the dropout rate. The outcome at the community level is to reduce the barrier to accessibility for treatment and increase acceptability.

Better follow-up, better compliance, reduced stigma, the reference of other patients, early identification and early intervention, psycho-social rehabilitation, and the prevention of complications due to untreated illness are the main indicators of effective intervention.

Our motive is to work towards proper documentation and future publications to facilitate replications of the model by preparing booklets and training other prayer places and communities to overcome the stigma.

BUDGET

SN	Item head	One Year (In Indian Rupees)
1. Staff	Social worker	300000
2. Non recurring (equipment)	Computer/ accessories, printer, phone, software for analysis	50000
3. Contigencies	Stationary etc	50,000
4. Travel	Travel expenses for Local panchayats, investigator and Research staff travel to Research site	1,00,000
5. Overhead	5% Institute overhead charges	25000
	Grand total	5,25,000

Note: Payment can be done in 3 times installments.

	Budget Requirements Break-up	Full justification
1	Social worker	The proposed study will be conducted across the community. Research staff will go to the community to meet stakeholders and conduct individual interviews and focus group discussions. Here, the research staff will identify all persons disabled in mental health conditions (PDMHC) due to mental illness (MI) or intellectual disability (ID) in each panchayat through the key informant method. The research staff will provide support in the coordination, assessments, data collection, and analysis of the research project
2	Nonrecurring (equipment)	Computers and accessories, storage, phones, software for analysis, one computer for staff (a research fellow), who will be working with computers on review, developing interview schedules, qualitative data collection, and analysis
3	Contingencies	Stationery, and the research staff to get training in qualitative analysis, the process of systematic review, and ethical considerations in research. They can attend workshops and training programs during the project period.
4	Travel	The research team will be travelling across the community for permission, data collection, and intervention delivery.

CENTRE

NIMHANS

National Institute of Mental Health & Neuro Sciences, NIMHANS- Bengaluru 560029
Department of Mental Health Education

GOODBYES ARE DIFFICULT,
EXTEND A HELPING HAND TO HOLD ON

BE A BUDDY FOR SUICIDE PREVENTION

#rethink #reachout #rebuild