# Urban Mental Health Program

STANDARD OPERATING PROCESSES

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UMHP team is doing a splendid job and this document is a tribute to their hard work.

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# Preface

This document describes the standard operating processes of a mental health service delivery program implemented in two urban wards of the city of joy – Kolkata. Access and availability of mental health services are very limited to people in several parts of our country. This is not only a result of lack of such services or distance of a service from the residence of people, it is more a case of sensitivity and efficacy of the service.

People undertake great pains at a high cost to access a service they feel would reduce the suffering of their family members. However, in the face of overcrowded facilities, short contact time with treating team, lack of any follow-up or support service and sometimes poor outcome, they stop utilizing a service. The treatment is thus discontinued. There is no instrument currently to even ask previous users why the treatment was discontinued and make efforts to reorient the services. Services are used only by those who have manifest illness or know that their problems are attributable to an illness, but a large proportion comprises of those people who either do not know that their problems are attributable to an illness or have symptoms that make them withdraw from the family, society, and community thereby suffering silently in isolation. There are also homeless who we have all used to seeing on the roads and do not find anything strange in their predicament in these times.

As health service providers know that clients have a story to tell and they have many such clients to attend. As community health workers know that inside households there are several dynamics at play. Poverty muddles the water in ways that make it difficult to see and understand things, making it difficult to resolve the situation. Interpersonal relations, gender issues and traditional customs and cultural practice all intertwine and interact with mental health problems that people face. It is not an issue therefore of knowledge alone to deal with mental health problems but also of personal commitment and empathy. It is the people who work in programs that make the program, it is the soul and spirit of a health care delivery that improves its efficacy in resolving problems not only the knowledge and skills which although is essential. It is, therefore, a challenge to describe a service that is people-centric in terms of its standard operating processes because processes respond to needs of people which are ever-evolving. However, the document is located in time and space and at that time whatever processes were standard have been documented to the best of the ability of the author. For the reader, it is essential to read the objective or intention of

each process and then choose for themselves how they would like to respond in their context to the problem, they might come to similar solutions, albeit.

# Urban Mental Health Program

**A COMMUNITY-BASED MENTAL HEALTH INITIATIVE**

# Executive Summary

Urban mental health program implemented by Sankalpa is a seamless flow of activities that help to identify a person with mental health problems, bring them into treatment and support them through a range of community-based services to improve their quality of life. The document contains all the processes in the Sankalpa service and describes them for the reader who could then implement these processes. The document distinguishes the work in the clinic of the ward health unit from the community level work that is located more in the houses of the person with mental health problems. The former is called track 1 and the latter track 2.

The prime audience of this chapter is the staff working in UMHP. The chapter is therefore addressed to them or anyone else who would be employed in a similar program. While details are provided and pictures used in some places as teaching aids, no clear staff role boundaries are drawn and it has been left up to the team to decide which staff position would execute a particular task, therefore tasks are defined in detail with reference to member who could do it, but there are no hard divisions.

To describe the program, an explanatory framework has been adopted. This framework explains the evolution of a program; describes UMHP processes in view of the psychosocial problems seen in the clinic and community. It links client wise progress to program indicators to make it easy for UMHP team to track its progress.

The document also discusses some ways of managing high caseloads which have become the hallmark of a popular service. With limited points of delivery of service and a community level identification program going on, many more people than who would go otherwise for treatment are identified and soon enough the clinics are overloaded. Maintaining quality of services, preventing staff burnout and to maintain the satisfaction of the client (who wants adequate contact time with the doctor) is a challenge which has been discussed in the document.

The document is divided into two main sections – the first section is a brief introduction to UMHP and second section details the key processes involved in the program. An overall process map of UMHP is presented. Various scenarios that emerge in the program are discussed in relevant sections. A format has been adopted to detail out each process of UMHP, this format could have some gaps and reader is advised to revert to the author to fill the gaps.

The format of process description has been developed after a review of several formats that have dealt with similar work. Each process is described as one in a sequence of the process chain. The document has attempted to grade each process and suggest ways of further improving it.

The document has a long list of annexures that would add value to the work. It also includes links to several resource material that is useful in implementing and improving the processes.

This document has several lacunae and the reader is advised to point them and write to the author to further improve the document.

# Introduction

If you have recently joined the Urban Mental Health Program (UMHP) team or are currently working in it, then you know that UMHP is aiming to scale up to other wards of Kolkata Municipal Corporation (KMC). This scale up would be in partnership with KMC and of a slightly different nature than what was implemented till date in Wards 78 & 82 of Kolkata. Experience from implementing UMHP is invaluable. Much has changed from 2012 to now when the clinic was initially set up and community work initiated - the clinic is full till its brim and significant positive changes are seen in the community. As time goes by some changes are required both in current operation as well as in its adoption in other settings for efficiency.

The nature of processes changes with goal and vision of services. UMHP's constant challenge between being a community based mental health program to a clinic-based outreach program shows there is no clear line of separation in the two and often in implementation lines get blurred. The needs of the community, past habits, socioeconomic and cultural frameworks change mental health service making each service location unique in itself. This uniqueness is a welcome change from one size fits all approach, but it becomes a challenge when Standard Operating Processes (SOPs) have to be documented for later adoption. New sites may not have to go through the process of evolution as the initial sites and might feel that the program is handed down to them for implementation. However, it must be known that each location will evolve from its starting point and the new sites would be thankful to go up the evolutionary ladder and save resources rather than start with solving all problems on their own. Hence, one must read the SOPs as basic requirements for UMHP and innovate on them as per local realities and need.

# 1. Program Overview

## 1.1 About Project & Problem Statement

Urban Mental Health Program (UMHP), a pilot project was launched in 2012 by Sankalpa in partnership with Kolkata Municipal Corporation, Tata Trusts, and the community. The goal of the Urban Mental Health Program (UMHP) is to improve Quality of Life of a person with a psychosocial disability in municipal Wards 78 and 82 of Kolkata. The Urban Mental Health Program was initiated much after the programs for homeless person with mental illness by Sankalpa. Therefore, borrows its orientation from Sankalpa's work with a homeless person with a psychosocial disability.

5 critical arguments are embedded in UMHP conceptualization, these are:

1. Homelessness amongst person with a psychosocial disability could be prevented by:
    a. Early detection
    b. Optimum & affordable treatment, care and support*
    c. Community awareness helps in early detection
2. Assumption that primary healthcare services are accessible and available to community members
3. Availability of mental health services within primary health care is possible
4. Community awareness and participation is needed to reduce treatment gap, stigma and discrimination against person with psychosocial disability
5. People living in slums face multiple barriers to good health and well-being, therefore, provision of mental health services should be provided them to on priority.

*Optimum treatment, care and support of untreated psychosocial disability would prevent undesirable outcomes such as homelessness, admission into a mental hospital, severe functional limitations, loss of employment, education, etc.

Kolkata Municipal Corporation agrees that mental health services should be provided as part of the general healthcare, but did not know how to do it, therefore they agree on this pilot intervention with Sankalpa, to begin with, in Wards 78 and

82 of Borough IX of Kolkata[1]. A Memorandum of Understanding was signed between the two parties wherein roles and responsibilities of each were defined. **(Annexure 1)**

It was assumed that in these two wards, like other wards of the city, following conditions would hold true and provide a rationale to start work in mental health:

- Poor, inadequate understanding of mental health-related issues in the community;
- Lack of affordable treatment, care, and support for persons with psychosocial problems in both wards
- High prevalence of substance abuse
- Common phenomenon of people suffering frequent headaches, anxiety, stress, other body pains but unable to link them to mental health conditions and continue with suffering
- Untreated psychosocial problem leading to disability, unemployment, and poverty[2]

These assumptions were later validated by:

1. Baseline conducted by Sankalpa before starting UMHP &
2. Experience from Medical Camps organized by Sankalpa in these areas for persons with psychosocial problems

The assumptions mentioned above are however true of most areas of the city, some of which Sankalpa has other programs - Rajabazar, in and around Sealdah station, Entally, etc.

The mental health services in Kolkata are largely restricted to office practice; there is little or no community level support service. It is well known that clients with psychosocial disability require support services and respond better when such a

[1] Iswar Sankalpa, Annual Report 2012-13

[2]Compiled from FGD Reports in Baseline Study done with Mothers of school going children, a youth club, health workers and key persons; Annual Work Plan, FY 2013-14

service is made available. Further, the integration of social services such as Disability benefits, supported housing, education, employment is poor.

The need for a comprehensive mental health program was urgent. No wonder that over the past 5 years, the UMHP has provided treatment, care, and support services to more than 2500 individuals across the two wards.

### 1.2 Project Philosophy / Principles

The main principles on UHMP are:

1. Mental health problems were not identified correctly in clients coming to primary health care clinic hence trained primary health care doctors would be able to identify clients with psychosocial issues who otherwise would not come to a specialist clinic due to an unawareness that their condition was a mental health problem
2. A specialist mental health clinic would compound the stigma already attached to person with psychosocial problems
3. The community is interested in resolving the problems of people with psychosocial problems but does not have awareness and knowledge. Higher mental health literacy in the community would lead to early detection, management of psychosocial problems and improved behavior towards clients with psychosocial problem
4. A service for psychosocial problems should be sustainable for it to make a significant difference in the community. Additional resources required to set up such a service should be least. In the intended UMHP design the only incremental expenditure would be training and supervision by Sankalpa
5. Primary health care system should be strengthened to handle chronic conditions instead of setting parallel structures
6. Primary healthcare strategy is the only approach that can provide mental health services to poor people

With above principles, UMHP was started, however as seen above, the design was changed. This change although undesirable proved to be a blessing in disguise. Sankalpa has gained tremendous first-hand experience in providing mental health services to a community. This experience would strengthen Sankalpa's resolve to implement the intended design in collaboration with KMC across other wards of the city.

### 1.3 Main clients / Beneficiaries of project

The project was focused on people living in slums who face multiple barriers to good mental health. In addition to the person who had a psychosocial disability, the general community was a target to improve mental health literacy. The pre-conceived notion was that person with severe mental disorders would be the main client of the program, but soon it was clear that clients with common mental disorders utilized the clinic far more than those with SMD, not because the former is more common, but because the service was approachable and gave time to clients to share their problems. More women than men were considered to be clients of the program and young adolescents & adults were targets for awareness activities.

### 1.4 Program Design & its Evolution:

There are three visible stages in the evolution of the program:

1. Intended design stage: The key features of this stage are shown in the table above. The primary healthcare doctors could not be trained and therefore did not assess, treat clients with mental health disorders. This function was therefore done since inception by the Psychiatrist appointed by Sankalpa who was available on fixed days in a month (cf. daily presence of primary health care doctors). The community work was done by Ward level Health Workers of KMC. KMC supplied psychotropic medicines
2. Modified design stage: During this stage, the clinic continued to operate from the Ward Health Units of the two wards but the community work was taken over by Sankalpa staff. The supply of medicines by KMC had to be discontinued due to the expiry of the memorandum of understanding that and clients were not provided by any medicine from the pharmacy mandated KMC to provide medicines.
3. Current design stage: The only change from the above stage was that Sankalpa starting sourcing a few medicines on its own and provided them to the clients at no cost. KMC supply continued to be disrupted

The reasons for the difference in design during program evolution were:

1. Primary health care doctors were wary of treating a person with a psychosocial disability and this hurdle could not be overcome. Further, they

had to attend to an already high caseload of infectious disease in the clinic which made it difficult for them to take time out for training and seeing additional clients.

2. There was an outbreak of vector-borne disease in the project area and all KMC health resources were directed to combat the outbreak disrupting community and clinic level work as per intended design

Memorandum of Understanding (MoU) between KMC and Sankalpa lapsed and its renewal faced many administrative hurdles. The supply of psychotropic medicines was therefore disrupted. Genuine efforts to renew the MoU from both sides are underway.

### 1.5 Project Goal Statement

To improve the quality of life of persons with mental health problems living in cities, especially the most vulnerable

### 1.6 Project Objectives

- To set up a mental health service in two wards within the urban ward health system in collaboration with the Kolkata Municipal Corporation
- To provide person-centric treatment for persons with mental health problems from the mental health service
- To improve awareness on mental health in the community
- To provide community-level support to the person with mental health problems and their family members
- Person with mental health problems and with higher levels of disability receive support from government schemes, especially homeless person

### 1.7 Expected Project Outcome

- Mental health services become an integral part of the Ward Health Services
- Improvement in the quality of life of persons with mental health problems and their caregivers through access to treatment and support from the program

- Community knows early signs of mental health problems and is able to access treatment and support for it
- Community provides support to people with mental health problems and does not stigmatize them

# 2. UMHP Framework

The UMHP framework brings together the changes happening at the project level and at the client level in one frame. The UMHP consists two key components of service delivery – treatment services for a person with psychosocial disability inside Ward Health Unit (**Track 1**) and works in the community of the ward (**Track 2**). At the project-level, each of the two tracks has three phases:

1. Preparation phase

2. Implementation phase (Core program processes)

3. Evaluation phase

The preparation phase includes those processes that set the ground for launching the core processes of the project (Implementation phase) followed by evaluation of outcomes of the project to inform future program design and replication in other locations.

At the client level, the framework uses three treatment phases that each client is grouped under at a point in time, these are:

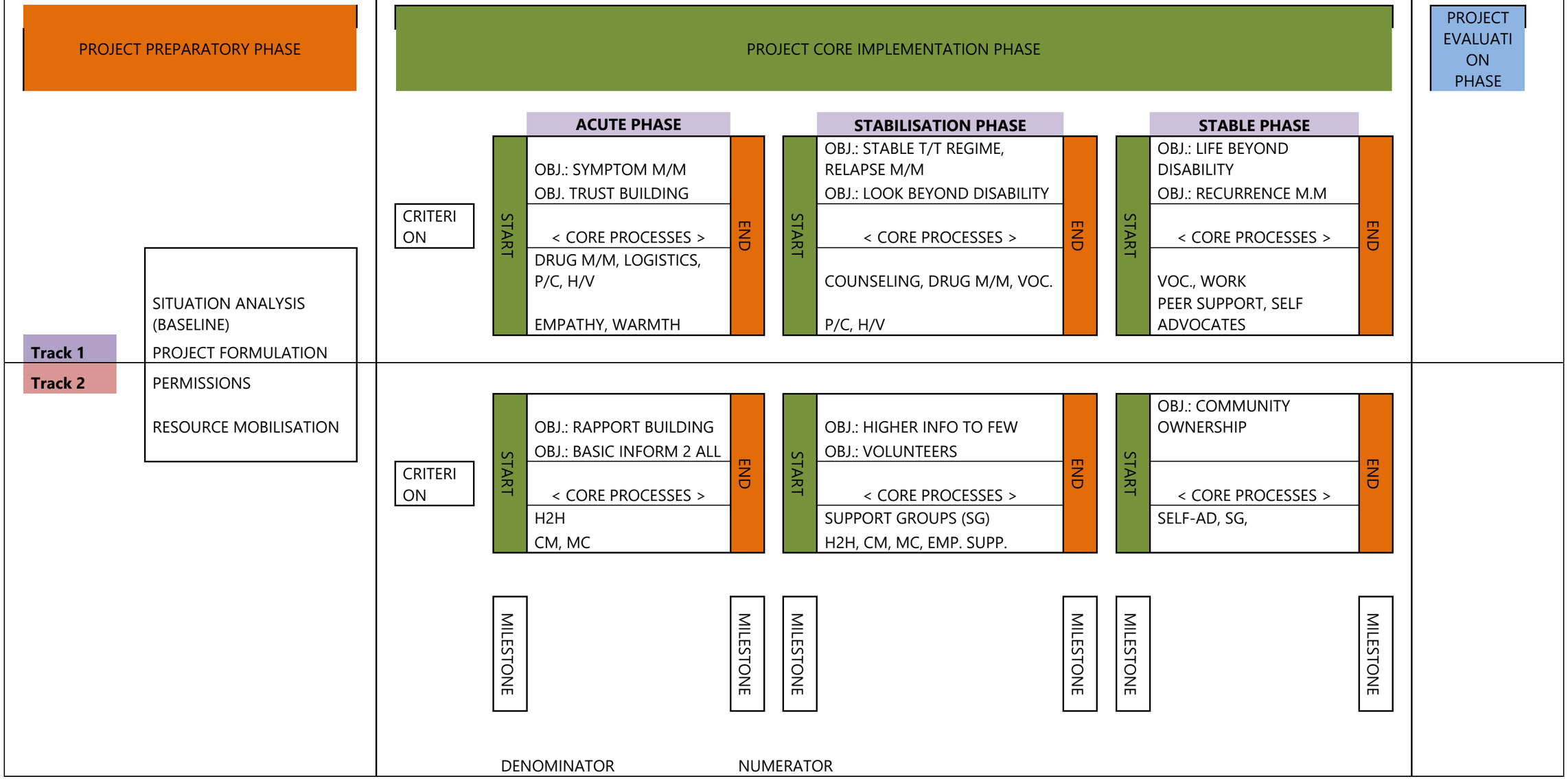
1. Acute phase of treatment

2. Maintenance or stabilizing phase of treatment and

3. The stable treatment phase

At the first contact with the client, it is pre-supposed that the client is in acute phase since the program is not informed of their past status. Thereafter, re-classification may be done, based on a criterion for each phase, which is explained in the write-up under each section. This approach allows a frame to understand the progression of the client across the treatment spectrum. Each treatment phase has a start and end both of which are marked by milestones. The number of clients entering the start point of a particular treatment phase is referred to as denominator for outcome evaluation of that phase, those successfully completing the phase makes the numerator.

# 1Framework for description of Standard Operating Processes of UMHP (Annexure 15)



**Legend for the Framework:**

| | | |
|---|---|---|
| Track 1 | = | Treatment & Support, |
| Track 2 | = | Community level Intervention |
| P/c | = | PHONE CALL |
| MC | = | MEDICAL CAMP |
| SUPP. | = | SUPPORT |
| SG | = | SUPPORT GROUP |
| H/V | = | HOME VISIT |
| CM | = | CORNER MEETINGS |
| EMP. | = | EMPATHY |
| SELF-AD | = | SELF ADVOCACY |
| H2H | = | HOUSE TO HOUSE VISIT |

# 3. Project Components

The UMHP provides treatment and care continuum to clients but the action is located in two locations:

1. The clinic and

2. Community

Based on this location, the project is said to have two components or two tracks:

1. A Mental Health therapeutic service (called the clinic) in the local Ward Health Unit (Track 1);

2. Community work (Track 2)

In addition, the project provides Rehabilitation services which seamlessly flow from the two locations.

### 3.1 Services provided by the Project

Specifically, the services provided are in line with the objectives of the program. The main emphasis of the program is on early identification, prompt treatment, and rehabilitation of persons with psychosocial problems. At each of the two locations, the list of services is shown below: (these are separated for ease of description, in reality, they all are part of a continuum):

1. At the Clinic (Track 1):
    a. Psychiatrist consult
    b. Counselor consult
        i. Individual therapy
        ii. Group therapy
        iii. Working with support system activities
2. Community work (Track 2):
    a. Awareness Activities:
        i. General Awareness:
            1. Door to Door Visit
            2. Pocket Meetings
            3. Street Camps
            4. Auto campaigning
        ii. Targeted Awareness Activities:

1. Club Members Awareness
2. School Awareness

b. Support System:
    i. Community Support Group
    ii. Self-Advocates
    iii. Vocational Training
    iv. Supportive Employment
c. Treatment continuum:
    i. Revisit
    ii. Home Visit

The main instrument of the service is an Individual Care Plan (ICP) for each client which includes assessment, goal-based therapeutic plan, interventions and measurement of outcome in a longitudinal time series. In addition, for all group or population-based activities, plans are developed which are similar in their principle to the ICP **(Annexure 31)**.

The services are provided by a mix of trained professionals and layperson from the community who provide a mix of the clinic, home, and community-based service. While individual or person to person contact is an important design of intervention, it is the group intervention & self-advocate strategies that the project purports to build up in the long-term as a sustainable bridge resource in the community

The project intends to uncover the hidden burden of psychosocial problems through the diagnosis of more cases and bringing them to rational treatment and then rehabilitate the person within the community. The solutions are individually tailored and stringently measured for their outcome. Barriers to access are constantly addressed through different strategies in the project. The project is targeted to communities that already face barriers to care for whatever reasons.

### 3.2 Limitations in Services provided in the project

A limitation of the service design is that while different conditions are identified, they may not be addressed given resource constraint and existing challenge at hand of treating a caseload of already identified cases. Some of the examples of conditions that are often brought to the clinic but not provided any intervention from the project besides referral to an appropriate service include:

a. Substance use problems;
b. Developmental disability

However, it should be noted that in the original design a limited set of mental health conditions were to be treated by the primary care doctor, but since in reality, a psychiatrist provided consultation, complex mental health conditions were also identified and treated.

Conditions like Epilepsy continued to sit on the margins with no consensus on their inclusion or exclusion, currently, they are treated in the clinic. Similarly, since the clinic is known as a mental health clinic, other conditions that community considers to be related to brain are also brought in such as Parkinsonism, Cerebral Vascular Accidents that are currently assessed and referred but ideally do not belong to this service unless a training program is provided to the primary health care doctor.

It should also be noted that in the catchment approach, while the project intends to address most mental health problems, people from nearby communities also attend the clinics. This and other reasons lead to a build-up of a substantial caseload in the clinic. Given that there is only one Ward Health Centre per ward the population of which is increasing, the number of clients that can be treated becomes limited.

Since the clinic is focused on treatment, a formal process of evaluation of the quality of services and client outcome is currently not adopted, although, the service does undergo a frequent audit.

### 3.3 Stakeholders of project

Important stakeholders of the project are:

1. Officials of Urban Health Mission
2. Kolkata Municipal Corporation, Department of Health
3. Doctors of Primary Health Care Centers (Ward Health Unit) & other staff
4. Community-level health staff of Municipal Corporation
5. Officials of the Social Welfare Department
6. Clients & their family members
7. Community members
8. Opinion makers and gatekeepers of the community (Councilors, Religious leaders, Club members, local schools)
9. Local Entrepreneurs
10. Local Police

11. Media
12. Other NGOs, CSOs
13. Funders

### 3.4 Information parameters of project processes or activities

Each project activity is targeted towards a client or a group to bring about some change. Further, in the catchment approach, the intention is to achieve expectable levels of saturation with the change. Hence, several activities are tracked in the project. The project tracks both input activities and outcomes at the client and population level. The main information parameters are the following:

- Identification of cases of psychosocial disability who had never been identified or treated before as a proportion of total cases identified
- The ability to achieve intended duration of intervention with clients
- Outcome of clients at end of intended duration
- Changes in the community that forms a precondition towards early identification (more awareness, leads to heightened sensitization towards early signs and symptoms and hence early identification and access to care)
- Reduced barriers to care
- Trained service providers and community workers who continue to enthuse the community on mental health issues such that program does not fade away over time

### 3.5 Resource Required

The resources required in the project are:

1. Medicines
2. Information material (Pamphlets, banners, handouts)
3. Travel allowance
4. Human Resource – this is dependent on the design of the project. The scalable design is in which the service providers are from the municipal corporation health department then salaries are not a project cost. However, training and training material would be an additional project cost. In case

the project staff has to be recruited, their salaries would be an additional project cost.

5. The project has the following staff:

    a. Exclusive for each Ward:
        1. Counselor (1)
        2. Volunteers (2)
    b. Shared for two Wards:
        1. Psychiatrist (1)
        2. Project Coordinator (1)
        3. Social Worker (1)
        4. Rehabilitation Officer (1)

    On the day of psychiatrist visit, the rehabilitation officer doubles up as the pharmacist. Earlier, when the MoU with KMC for medicines was in force, the pharmacist of the Ward Health Unit (WHU) provided medicine. However, lapse of the MoU has created the above situation. Once the MoU is renewed, the WHO pharmacist would be performing the earlier role. The social worker and volunteer are also entrusted with home visits and other field activities in their native wards.

### 3.6 Challenges of the project

Main challenges of the project are:

1. Caseload management
2. Acceptance of Counseling as treatment
3. Resource Constraint

Primary Health Care health staff especially the medical officers are not comfortable treating a person with a psychosocial disability. An in-depth analysis of the reason for this is however not available. This is a major limitation. Since the clinic is combined with community work, people from the community come calling and want to see the doctor even though they might not fit in the definition of

caseness[3], in face of high caseloads on the clinic day, it is a challenge to screen such cases out.

The spectrum of disorders or problems within psychological problems is vast. The clinic is not yet at the stage where it could target or prioritize one disorder or problem like depression or victims of gender-based violence. The community services are a follow-up to clients registered in the clinic in addition to awareness activities hence there is not enough bandwidth to pursue one single disorder and saturate the entire community over a time period. Some of the antecedent conditions or causes responsible for stress are modifiable but beyond the capacity of the current project team. If more resources are present then community-based strategies to address some of these issues can be attempted.

Counseling as a service is neither well understood nor accepted in the community, the doctor consultation and prescription are the dominant transactions in our health system. The days of the doctor visits at the clinic are crowded. The uptake of counseling services per se is below optimum. This, therefore, limits recovery from some common conditions like mild depression, anxiety, etc. which benefit from counseling services.

### 3.7 Evaluation / Audit of project

To check process fidelity, achievement of objectives an annual internal audit of the project should be done. Results of the audit should be made available to stakeholders

Alongside, an annual needs assessment of clients should be undertaken to align services accordingly. The above should be done by a combined team of insiders and outsiders to the organization

[3]The degree to which the accepted standardized diagnostic criteria for a given condition are applicable to a given patient (http://www.yourdictionary.com/caseness#UDEMoEFs8Kx0i5Zh.99)

3.8 Overall Process Map

See **Annexure 2**

# 4. Track 1 / Project Phase 1: Mental Health Clinic / Preparatory Phase

**Process Holder:** Clinic-in-charge

| Needs Change | Good ☺ | Standard |
|---|---|---|

## 4.1 Scope / Overview of the process:

The Mental Health Clinic is the epicenter of all activities in UMHP. There should be at least one clinic providing mental health services in the catchment population. Currently, there is a clinic in both Ward 78 and Ward 82. The clinic should be run out of the Ward Health Unit of the respective wards (in collaboration with KMC). The co-location of mental health service with the general health service helps in the introduction of mental health services in the community. If the project in the community is implemented by an anchor agency then as mentioned later in component 2, during door to door visit, the staff of anchor agency introduces themselves as representing Corporation. The name of the anchor agency should not be taken, the con-location reaffirms this truth.

The MHC provides two categories of services to the clients:

(i) Clinical services by the Psychiatrist and Counselor and
(ii) Support services by Counselor, Social Worker, Rehabilitation Officer, and Volunteers.

This process describes how the clinic is run on a day-to-day basis and what are the things that require extra attention

## 4.2 Policy guiding this process

Mental health services would not be stigmatized if they are provided from the primary health care center. It allows those with common mental condition approach and seeks care for themselves without worrying of the stigma attached to a separate clinic which

everyone in the community knows is for those with a psychosocial problem. Since the body and mind are inter-linked, many clients presenting with apparent physical health problem could harbor a psychosocial problem, similarly, a person with the psychosocial problem could have a physical health problem. The only way to prevent fractionated approach is when the same care provider undertakes a comprehensive assessment of the person and unravels both the problems in the body and the mind

### 4.3 Purpose / Objective of process

The purpose of this process is to inform the Clinic in-charge in running of the clinic to ensure that its objectives are met. The Objective of the clinic is to provide a client-friendly environment where the needs of the client can be addressed. The clinic provides following services to its clients:

1. Assessment & treatment
2. Support services
3. Referral to other services
4. Link to community services

The treatment of the psychosocial problem of the client could be a long affair, therefore, the clinic has to maintain records of the client and ensure that material and human resources are made available to the client so that chain of care is not broken. Many clients come to the clinic for the first time and this is, therefore, an important experience for them, initial fear, apprehension has to be addressed and Trust established, therefore the first visit to the clinic is often the most important. This process describes activities that would help achieve this objective

### 4.4 Result expected from process

The new client coming into the clinic would understand the need of treatment and establish trust with the treating team. The Results Framework for the clinic should be constituted to cover following dimensions:

- Physical Clinic Space - infrastructure
- Supplies and Material Management – necessary supplies

- Client friendly – waiting time, contact time, privacy, discussion, etc.
- Service provider friendly – limit on registration, crowd management, breaks in between, etc.
- Management Information System – for transparency and continuity of services

A framework should not be developed and adopted from day one but developed over time as a result of team effort. This allows an understanding amongst team members of the need of different elements that have been included in the framework. The team itself should score the framework before it is outsourced to a neutral agency. The clinic in-charge should facilitate this

### 4.5 Criterion / Preconditions in process

In addition to legal protection via an MOU between interested parties, there should be interest and enthusiasm in the health staff to launch new services. This process should be mediated by senior officials of the health department but project coordinator could do their bit by enthusing all involved in the challenge ahead.

### 4.6 List & Description of Key Process

| **Key Process** | **Main Role** | **Supporting Role** |
|---|---|---|
| 1. Preparation for the clinic using a checklist | Clinic in-charge | Pharmacist |
| 2. Registering the client | Counselor | Social Worker / Community link worker |
| 3. Initial Clinical Assessment of the Client | Counselor<br>Psychiatrist | Social Worker,<br>Rehabilitation Officer,<br>Clinic in-charge |
| 4. Getting a review date | Doctor / Psychiatrist / Counselor | Clinic in-charge |

### 4.6.1 Preparation for the clinic using a checklist

As the clinic in-charge, it is your responsibility to see that all elements of the clinic work smoothly to achieve the intended outcome. The clinic could be operational either daily (original philosophy) or weekly or some other periodicity, the preparation would be the same but the time one gets to prepare would differ markedly. The main instrument would be the checklist.

**TOOLBOX:**

The Clinic Manager's checklist should be marked daily (**Annexure 19**). This checklist lists the following items:

- Items/elements needed to operate the clinic smoothly
- Past status of these elements, at the previous closure of the clinic
- Items required in preparation for the next clinic
- List of actions that were undertaken to ensure that those items that are required for the smooth operation of the next clinic are available

An essential part of this checklist is the pharmacy where drugs that are essential, desirable should be listed and their minimum level, reorder level and current stock clearly recorded. Pharmacist of the clinic will support the clinic manager. The final stocks of drugs should be printed and presented to the prescribing doctor so it is in his / her knowledge.

You have to set the rule for registration of new clients (Registration day) in the specialist mental health clinic. The process is primarily driven by the model of delivery of mental health service. If the service is delivered by primary health care doctors then the registration is similar to any other client and it is the doctor who finally makes the decision on caseness of the client. The doctor, therefore, has to record in a register or fill out another form to record this client as a case for mental health services. Further, if the client is prescribed medicines available from pharmacy then the Client Registration Number for which medicines were issued serves as the second point of recording the person as a case. The two systems have to, however, tally or bring the information together to locate the client **(See Annexure 23)**

Another point to be kept in mind is that in the current UMHP model, a Community Level Screening identifies, and refers, suspected cases to the clinic. Other clients may come on their own or are referred by someone else but with the prior knowledge that they have a mental health problem and they are seeking care from a mental health service. This gives a certain privilege to the clients since they are not competing with other illness for doctor time. At the same time, it adds to the stigma of a mental health clinic.

As the Clinic-in-charge, therefore, you have to decide depending on the caseload building up in the clinic. You could dedicate one day a week for all clients with a mental health problem who need detailed work up while handling the simpler, relatively, cases on a day-to-day basis. This is the topic of preparedness and adoption of protocols, etc. as discussed in the training of doctors.

Whatever be the scenario in your clinic, advertise the registration day and timing, e.g. Monday, 10 AM to 3 PM. Currently, in the UMHP, the clinic works once a week, from 10 AM to 3 PM; Monday in Ward 78 and Tuesday in Ward 82.

Advertise the rules of the clinic especially that registration of clients would be done only till a fixed time. You should close registration once the registration number reaches a level agreed upon, currently, this number is 50 clients. Triage would become an important issue in primary health care clinic since the caseload would be higher every day. Some cases would be missed out by doctors in a busy OPD hence the community care workers who are well-trained serve as a check and continue to meet up with clients they had referred and if the workup by the doctor has missed the client, the community care worker should accompany the client and show again to the doctor. This is the essence of community mental health service where team play and multiple checks and balances ensure that services are received by those who require it

**Organizing the waiting space**

The waiting period is marked by small chit-chat and a lot of observation by clients.

*Clients observe those who have been coming regularly or those who had stopped coming, perhaps these had recovered!*

You can decide on the extent to which you would like to involve the clients and their caregivers during this time since all staff is busy conducting the OPD! The clients coming into the clinic would have to wait for their turn. As clinic-in-charge, you should

carefully organize the clinic space to make this waiting time least painful. Decorate the walls with information material that is in the local language and addresses the client and carers. Medical jargon should be avoided. If the clinic is very busy, you could request students from different mental health courses to screen clients during waiting time in the primary health care model or take a detailed history in separate mental health clinic model.

### 4.6.2 Registering the client

On the doctor day, clients queue up 8 AM onwards to deposit their registration card and consult the doctor. Ensure that the clinic opens earlier to allow clients to trickle in. In UMHP model, a volunteer staying nearby comes to the clinic earlier than the usual on registration day.

Create a system wherein all clients need not sit in the OPD and wait for the doctor, schedule appointments and inform clients the time slot within which they should come for the consult, this would reduce crowd in the clinic and sitting in time for the client. In the current UMHP model, Clients staying in the vicinity submit their Registration card and ask the volunteer or any staff when their appointment is likely to come and return around the time but those who come from far away wait it out.

A client who comes in for the first time to the clinic needs to be registered to the service. The process of registering a new client should be clear to all involved. If the mental health services are provided by the primary health care doctor then no different registration process than for any other client is provided. Herein, there is a generation of a simple registration number and a slip is given to the client which he then takes to the doctor. However, if separate mental health clinic serviced by a specialist provides care, then you should set a separate registration process. Before being registered the new client is interviewed by the counselor to determine the suitability of the person to be serviced by the clinic.

**First Contact Person**

In a separate Mental Health clinic as seen in UMHP model, a new client coming for a consult is first seen by the Counselor, however, if the counselor is busy or unavailable then social worker or rehabilitation officer could see the new client. The first step is to make a decision if the person fulfills the criterion of a "***person with mental health problem requiring support & treatment***". This is a judgment made by the staff

based on their knowledge and experience. Over time, the criterion of symptoms and related diagnoses should be set up to make the judgment more objective.

The registration entitles a client to the following:

1. a client registration number,
2. a case record file
3. a registration card
4. Treatment and other support services from the project both in the clinic, at home and other locations such as workplace, free of charge

The decision to register is, therefore, an important decision.

### 4.6.3 Initial Clinical Assessment of the client

**1. Initial Interview by Counselor:**

**In a specialist clinic: This step is bypassed in Primary Health Care design**

The Counselor in an interview with the person elicits the case-history, in brief. This is a quick interview and there is no documentation of this discussion. A decision is made whether the person has a common mental disorder, a severe mental disorder; both of which are Inclusion Criterion or any other condition – Developmental Disability, Substance Use Disorder, Physical health problem; all of which are an Exclusion criterion. In case of exclusion criterion, the person is guided to an appropriate service (Referral).

If Counselor is absent, you as Clinic In-charge should appoint social worker or some other staff for this role. It is therefore important that at least 2-3 people in your team know how to conduct the initial assessment on inclusion criterion

You should not set stringent protocols or standard case definition to define caseness which is the inclusion criterion. Leave it to the judgment of the professionals and their experience. Make a trained professional (e.g. psychiatrist) the final filter to reduce false positive cases. It is important to remember that the aim of mental health service is to reduce mental distress and not treat those who fit in clear clusters of diagnoses. Volunteers are not allowed to create new files.

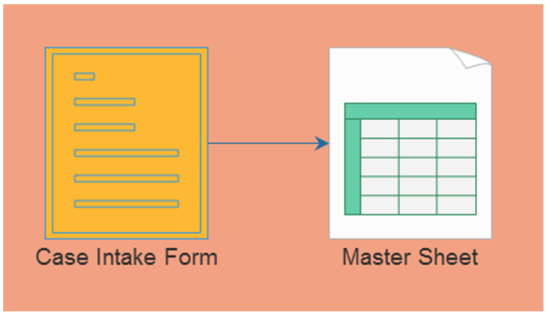
In the Primary Health Care design of provision of mental health services, it is important that counselor, social workers and other members of the team are well trained in screening the clients so that only the ones that truly need doctor's attention are transferred on them. This requires good team work, trust, and training

**Case Intake Form:**

As the Counselor, if in your opinion, after the initial informal talk with the client, the client has a psychosocial problem, then elicit detailed case history of the client. Record the history in the Case Intake Form (**Annexures 11**, **35**).

The Clinic in charge would then transfer information from Case Intake Form into an electronic database called Master Sheet (**Annexure 6**). This is important to generate reports that would guide future action. Master sheet becomes the repository of all background information on all clients

If you have created an electronic database and are well-versed with it, it might be better to do the transfer same evening or the next day




**General Health Questionnaire (GHQ):**

As the Counselor, if in your opinion, the client has a Common Mental Disorder, fill out the General Health Questionnaire (GHQ).

A score equal to or above 6 on the GHQ is an inclusion criterion.

In case you as the Counselor are unclear if the person meets inclusion criterion, send the client to the psychiatrist and ask for advice. Register the person in case the psychiatrist thinks the person fulfills the criterion.

Enter the confirmed result in the Daily Register.

**Counseling Sheet:**

As the Counselor, if you have assessed the client, then you must fill in the Counseling Sheet. This sheet records your transactions with the client. You can fill this sheet in the language of your choice – Bangla or English.

If you have planned an intervention with the client, make a note of the intervention along with its goals in the ICP. Also, provide the client with a follow-up date

**Psychometric Scales, at enrollment (Baseline): (Annexure 24)**

As the Counselor, you should administer the selected scales at the time of enrollment of the client. The scales selected are :

1. IDEAS - - - - - - - - - - - - What is the present level of Disability of the client?
2. GAF - - - - - - - - - - - - - -What is the present level of function of the client?
3. FBS - - - - - - - - - - - - - - What is burden on family taking care of client?

In the case the Counselor is absent, social worker or rehabilitation officer should fill in the scales.

Remember: You have marked the starting line for the client by administering the scales. These scales would be repeated every six months and data analyzed to understand progress or lack thereof on different dimensions of the client.

Clients meeting the exclusion criterion are appropriately referred to another facility and a small referral note is written out and handed to the person. The note mentions the address of the service that person could consult. If a laboratory test or any other investigation is requested by the doctor, then an advice is written to a selected service which provides testing at a subsidy to the clients.

**Unique File Number**

For all people meeting the inclusion criterion, a new file is opened with a Unique ID.

You must identify and create a simple yet unique Identification number for new clients. This is essential since their case records can be then easily maintained and retrieved for future transactions. The entire record being available makes treatment of a chronic ailment easier.

Features of Unique ID are:

- Each client is given a **unique file number** which lasts for the lifetime of his/her consultation at the clinic. If the client gets transferred from one facility to another then unique ID should carry the information**(Annexure 8)**
- Each client should have a physical file bearing the ID
- Retain the physical files in the clinic, do not hand over to the client
- Take the consent of the client that you would be retaining the file in the clinic while each prescription is handed out

Across Sankalpa, a common method for file number syntax has been identified. The file number has three parts:

(i) Project Name
(ii) Year of registration and
(iii) Running number e.g. UMHP/2016/078.

In UMHP, since there are two services delivery points, file numbers are given at project level and not ward level. Hence, a new file number at one MHC is given in consultation with the other MHC to prevent duplication. File numbers are issued throughout the week and not restricted to the day of the doctor-clinic.**(See Annexure 25, 32)**

**Assessment by Doctor / Psychiatrist**

If the design of intervention is Primary Health Care then the client is seen only by the doctor there is no other staff. In a specialist clinic, however, the psychiatrist sees a client after the counselor has seen him/her.

**For all new clients**, as the doctor you should undertake the following activities:

1. Listen to the problems of the client

   *(Namaste! I am Dr. xy, tell me your problems)*

2. assesses the condition of the client

   *Hmm, I think your problem is this…*

3. draws an individual care plan/treatment plan

   *(This is what we are going to do in relieving your problems…)*

4. initiate treatment
5. explain the condition to client and caregiver

   (*Usually, in such conditions, this is what happens…, if you have any questions, ask me…)*
6. administer psychometric scale (baseline)
7. Provide the review date

   *(Take prescription and hand it to the pharmacy, meet me again here after 7 days…)*

**Old clients** returning to the clinic for a review should be handled by you in the following manner:

1. Assess the progress of the client against goals of the Individual Care Plan/treatment plan
2. If required, revise the goals and treatment
3. Discuss with the client and caregiver course, prognosis of the condition
4. administer psychometric scale (periodic)
5. Attend to any other issues
6. Provide the review date


In addition to case history and assessment, you should record **weight** and **blood pressure** of all clients. However, if the numbers are overwhelming, you should request a colleague to take BP of the clients and note it in the file when they send the client to you.

**Psychometric Scales:**

The Psychiatrist administers the Clinical Global Impression (CGI scale) at two different time points:

1. CGI – 1: One month after the registration (*Is the client better end of acute*


*treatment phase?)*

2. CGI-2: Four months after the registration *(Is the client better in stabilizing or maintenance treatment phase?)*


**Record Keeping (Annexure 9)**

As the doctor, you should note your main observations in the Observation sheet in the client file. You should enter the details in the Individual Care Plan. In addition, you should write out a prescription.

The prescription should contain four main elements:

(i) main complaints
(ii) treatment
(iii) investigations advised and
(iv) a follow-up date

**Prescription**

The prescription is issued in duplicate – one copy is handed to the client to be presented to the pharmacy and the other copy is retained in the client file.

The retained copy is placed in a pocket on the inside of the front cover of the file to easily distinguish it from other prescriptions.

After the counselor has made note of the prescription it is punched along with other older prescriptions.

### 4.6.4 Getting a review date

As the doctor or the counselor, you should inform the client when he/ she should come in next. This information should be clearly placed on the prescription.

After consulting the psychiatrist, the client comes to the counselor with the client copy of the prescription.

The client could get two different dates to follow-up - one from the counselor for the counseling process and another from the doctor for review with the doctor. This ambiguity of two dates is clarified by the Counselor.

As the Counselor, you should refer to the doctor's prescription and make a note of the doctor-follow-up date. Then decide on the date you want the client to come for a counseling session. Whichever of the two dates is earlier, give it as the next date for the client to follow-up **(Annexure 33)**

A Software could prevent such multiple entries!!

**Actions:**

Record the follow-up date in following three locations:

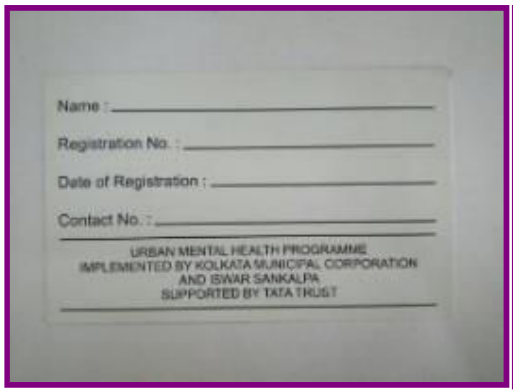
1. on the client file (retained in the clinic)
2. on the back side of the Registration Card (handed over to the client)
3. in a register (for record purpose)

I need to know how many clients are coming for review, next Monday. Oh, 30 already!!

As the project coordinator, you should record in soft copy the following information:

1. Date of Follow-up visit
2. data from CGI and other scales

**Registration Card (RC)**



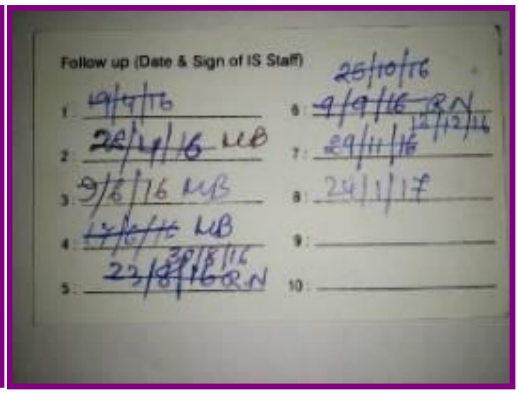




**Exhibit: Front Side of RC** **Exhibit: Back Side of RC**

After the client presents the prescription to the Counselor, a registration card is handed over to the new client. Old clients bring their registration card with them to the clinic.

Registration Card is a small card which has basic identification details of the client and file number on the front side and schedule of follow-up dates on the backside.

This RC is to be produced during each of the subsequent visits to pull out the client case file from storage

As Counselor, you should ensure that the date of the first follow-up is recorded. If the client adheres to it, the date is crossed and signature of the staff placed against it . If a client comes on a date other than the scheduled date, the actual date of contact is recorded after striking off the scheduled appointment date. **(Annexure 12)**

### 4.6.5 Receiving Medicines

Finally, the client presents the client copy of the prescription to the pharmacist and receives medicines (if supplied) all or in part. Balance medicines are to be purchased from outside

The pharmacist explains how the medicines have to be taken

Client then leaves the facility

**TOOLBOX:**

1. The program should have drugs as per a "list of drugs". Drugs from the list should be available in the pharmacy for the clients. Even if, for any reason, supply of drugs get disrupted and medicines are not available in the pharmacy, the prescription should not substitute the drug. If, however, for any reason, the doctor has to prescribe outside the list of drugs, then clear reasons for the same should be provided in an internal note. Some of these medicines could be bought via local purchase from the funds with the PHC. However, the risk of non-compliance with the list is that the local purchase budget could easily be exhausted in a short time.

The list should be periodically reviewed to reflect the advancement of science and nature of clients seen in the clinic.

As the clinic in-charge, you should discuss the list of drugs with the psychiatrist and make a list of medicines you can stock in your clinic. End of each doctor clinic day, the consumption, and balance stock should be presented to the doctor for his / her attention.

**2. Management of the high caseload:**

Over time, the number of files increases in the clinic and they occupy a large proportion of the clinic space. This is on account of two factors:

(i) Till the catchment area is not saturated the identified for new cases continue and New clients continue to come to the clinic, which is the sole service point;

(ii) The current UMHP does not have a policy for the closure of file, therefore, files continue to occupy space.

Strategies to be adopted to manage caseload:

1. Closure of file or exit criterion for clients should be drafted.

| **Disease / Condition** | **Recommended duration of treatment** | **Goals of treatment** | **Actual duration of treatment** | **Variance** | **Decision & Reason to continue** |
|---|---|---|---|---|---|
| **Depression[4]** | | | | | |
| **Acute Phase** | About 3 months | Remission | | | |
| **Continuation Phase** | 4-6 months | Relapse prevention | | | |
| **Maintenance Phase** | 3 months or longer, depending on clients' needs | Recurrence Prevention | | | |

**Similar approach is shown for Schizophrenia in Annexure 14**

2. It is important that protocols are adopted that specify the recommended duration of treatment for different illness. Clients exceeding this duration should be evaluated and justification provided. Clients who need to be lifelong on treatment follow-up should be identified and appointment suitably allocated so that they form a fixed proportion of clients in the community.

3. Follow-up categories:

[4] Refer Annexure 14

The project should create follow-up categories of different time periods (monthly, every two months, once in three months, every six months and so on). This would help decongest the clinic.

| **Category of Follow-Up** | **Frequency of the client follow-up** | **As a Proportion of total clients** |
|---|---|---|
| **Cat 1** | Every month | |
| **Cat 2** | Once in two months | |
| **Cat 3** | Every quarter | |
| **Cat 4** | After every six months # | |
| **#: can be reviewed at another set up like DIC by DIC in charge on a checklist** | | |

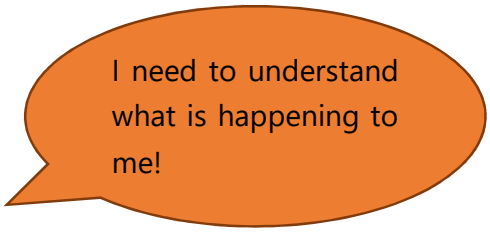
4. Setting up a step-down facility: The single service point cannot cater to this large number of clients. You should, therefore, create a step-down facility and refer clients in follow-up categories 3 and 4 to this facility where they are reviewed by a non-doctor using a standard checklist.

### 3. Note on Physical Files

However clumsy and space occupying the files might appear, they are the only record of the client's illness. There is no record with clients' themselves. Over time, clients often forget their own case history and therefore a meaningful construction of past events cannot be done. Further, Clients cannot manage files at home; hence keep the files in the clinic

### 4. Client participation in treatment planning

In the service delivery program, a clear framework for client participation should be developed. Activities that allow participation should follow from the framework. Given




the reality of high caseload in the clinic, socioeconomic and education profile of clients/caregivers, the current UMHP should provide a reasonable pilot to test aspects of client participation that can be incorporated into regular services with concrete results.

The current process in UMHP allows for dialogue between clinical team and client/caregivers during treatment planning, but there should be an assessment if the participation is optimum. Lack of insight of the client into treatment compromises treatment outcome and quality of life of clients/caregivers. Therefore specific processes to involve client/caregiver more in treatment planning should be incorporated. The processes that could be added are: showing clients/caregivers visual material to better understand their condition; formulation of short-term goals that a client should complete before next consultation; positive feedback and reinforcement, discussion on issues of marriage, job, etc.

### 4.7 Key Conclusion / Decision

| Compare profile of clients registered in clinic with that of baseline (Annexure36) |
|---|

At the end of this process, a person coming to the clinic with problems is accepted to the program as a client. This becomes the starting point of improving his / her functionality and quality of life.

The program team concludes that its identification process in the community has correctly identified a client and that it is now possible to improve the condition of the client through both interventions. The clinical team has also drawn the starting line by measuring the status of the client on selected scales and would repeatedly

measure the status on same scales in addition to clinical impression to gauge progress.

### 4.8 Information Capture & Tracking the process

| List 1 | List 2 |
|---|---|
| Identified Potential Clients in community | Clients registered in clinic |

Details of the client is captured. Tally the list of registered clients with that of the Identified clients. The comparison will inform the conversion of identified to registered clients in the community.

Baseline scores on different scales is captured

Consent for treatment is implicit

Medicines are given to the client hence their stocks are affected and they have to be tracked

**<SEE ANNEXURE 34>**

### 4.9 Internal Check & Balance of process

If a primary health care set up has to provide mental health services, the clinic space should have a minimum but important information material on mental health. Rather there should be volunteers or students who should hold small information sessions while people are waiting in the queue. These sessions could be on core mental health conditions or most commonly occurring co-morbidities or conditions that are commonly found in a community like anemia. Short duration, rapid sessions would ease the atmosphere in the clinic and inform those present

If a specialist clinic is set up, the topics of discussion should again be similar and not restricted to only core mental health clinical conditions.

To reduce stigma even amongst clients attending the clinic, focused information


sessions should be held. This is important since clients usually have low self-esteem and confidence and subtle but strongly conveyed messages during waiting time in the clinic could help them. A package on improving self-esteem and confidence of clients should be run on all clinic days in a month and another theme selected for remaining months

As Clinic in-charge, you should ensure that caseload does not overwhelm the service providers and thereby clinic becomes very focused on the consultation. Remember this is perhaps the only time when the client is available for discussion and for messaging hence smart use of the time should be done. Caseload could stress the team, so ensure you move around and keep everyone smiling and light-hearted

### 4.10 Evaluation / Audit of process

All new clients registered in the program should be strictly monitored. You should ask the question – will our intervention bring about a significant change in the functioning of this person? If your answer is yes, then you should be ok with the enrollment else you should avoid registration to prevent overcrowding and compromising quality of care in the clinic

### 4.11 Gaps and Suggestions

In Case Intake form there are several relevant fields but they need to be analyzed and then used to guide action. All fields should be part of some explanatory model else they end up being a checklist e.g. – Is there a past history of treatment for mental illness? Yes / No. How is this information important; what actions does it initiate; what series of measures does it require the team to initiate or follow if the answer to the above query is a Yes. It is this perspective that should be adopted in the incorporation

of different fields in Case intake form. Similarly, the information of who referred the client to the clinic is important to understand the performance of referral channels to the clinic. Based on this information, some channels need to be strengthened while others might need to be discontinued. A protocol should be made to clarify why a particular field is included and what is the purpose of the same.

An important indicator is:

*number of registered clients/number of identified clients in the community*

The present UMHP has set itself a target to treat 50-75% of all persons identified with a psychosocial disability. This is a very loose classification and allows for a very large number to become eligible for identification and therefore enrollment.

**(See Annexure 37)**

### 4.12 Training Requirement

All staff as a team should be trained on eligibility criterion for registration. There should be clear interpretation and understanding of what are we looking for and what we think has the highest probability of improvement with our services.

# 5. Track 1 / Project Phase 2 / Treatment Phase 1: Mental Health Clinic / Implementation Phase / Acute phase

**Process Holder:** Counselor

| | Needs Change | Good ☺ | Standard |
|---|---|---|---|

## 5.1 Scope / Overview of the process

This process describes the activities that enable a client to achieve an important milestone of maintaining the minimum essential period of initial contact with the service (often referred as regular) while being loyal to the treatment (often referred as treatment compliant). Irrespective of the diagnosis or formulation of a problem, the client and the service have to spend some time together to familiarize each other with the treatment of the problem at hand. Further, it also takes time for a client to stabilize or respond to a treatment.

**TOOLBOX:**

This process reflects on both the client and the service.

## 5.2 Policy guiding this process

There is no defined policy for this process yet. It goes in line with the adoption of the technical protocol. However, response to treatment should be broadly classified into phases e.g. Major depression treatment response is divided into three phases (Acute, continuation and maintenance phases). A milestone of the process reflects the achievement of the end of the acute phase when remission is achieved.

Once a policy is formulated, clients / caregivers should be explained at registration the need to reach this milestone

Information material for the client and caregivers to understand the significance of reaching this milestone should be developed.

### 5.3 Purpose / Objective of process

The purpose of this process is to describe activities that enable client and service reach the important milestone which signifies stabilization in the treatment process. For Common Mental Disorders which the service sees a lot, this is an extremely important process. For Severe Mental Disorders, this is again very important since it establishes the therapeutic alliance between the client and the service provider

### 5.4 Result expected from process

The key results of the service would be seen in this process. While the service has been able to recruit clients as evidenced from the registration numbers, its ability to bring about a change in life of the client is shown in the result of this process. Key questions like – what proportion of registered clients diagnosed with major depression achieved remission at the end of 8 weeks? In the technical protocol, average treatment duration for remission should be mentioned. For psychosis, this would translate as the proportion of clients who achieved remission from acute symptoms. The main result is to see if the client achieved reversal of the symptoms after spending a defined duration in treatment and support with the services. This is the only way that the program can portray the difference it is making to the lives of the person with psychosocial disability. These benchmarks should be set as standards against which actual performance is measured and variations presented.

### 5.5 Criterion / Preconditions in process

A technical protocol mentioning the time taken to achieve milestone for different conditions/diagnosis is required to make sense of this process

### 5.6 List & Description of Key Process

| **Key Activity** | **Main Role** | **Supporting Role** |
|---|---|---|
| 1. Treatment planning | Counselor / Psychiatrist | Clinic–in-charge |
| 2. Phone Call | Social Worker / Volunteer | Counselor |
| 3. Home Visit | Social Worker / Volunteer | Rehabilitation Officer / Counselor |

### 5.6.1 Treatment Planning

The treatment for the acute phase of any clinical state or psychosocial problem is different from the other states of the illness for two reasons:

(i) Client and the service provider have to establish trust between them. The service provider has to have a clear conceptualization of the current problem and the client has to understand the treatment process being initiated;

(ii) Clear signs of recovery from current symptoms as against more subtle manifestation in other phases of the illness.

The program interventions will be triggered by clinical assessments. Therefore the clinical assessment should generate categorical conclusions for the program to trigger intervention according to protocol. If a client requiring higher support is labeled as a clear category, then program team could search for the category label and initiate intervention appropriately. Labelling of categories is discussed below.

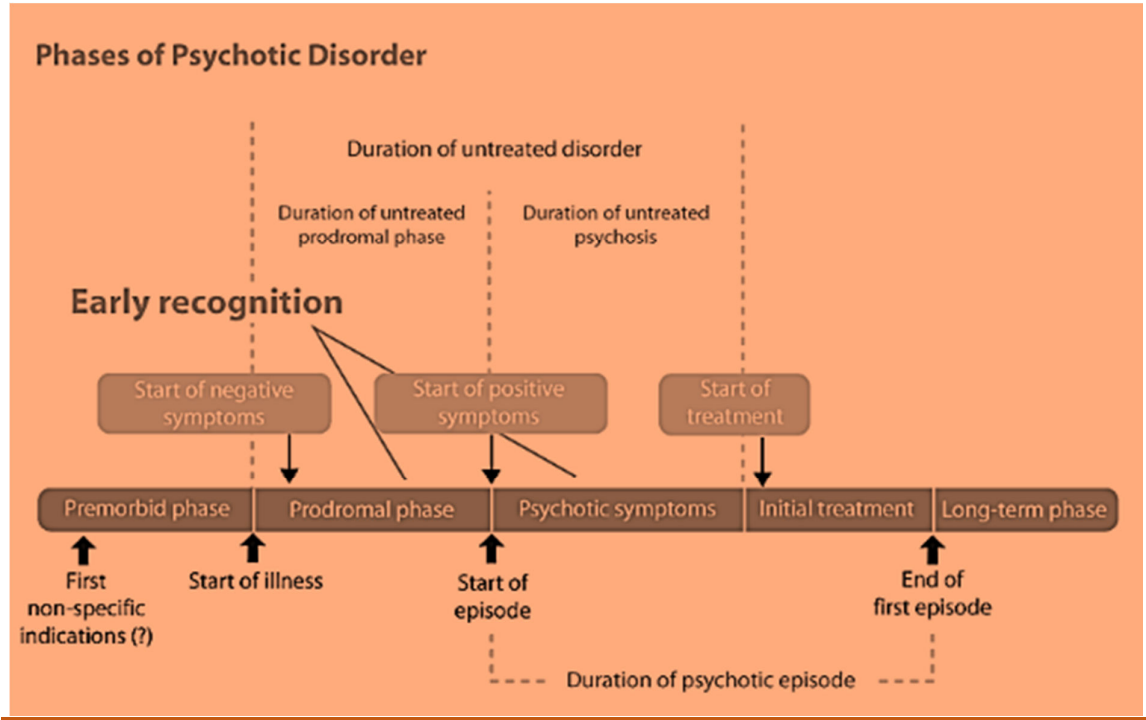
**TOOLBOX:**

**1. Phase the treatment:**

For each of the diagnosed condition there should be a protocol to convert its treatment into three phases:

- Phase 1 = resolution of acute problems (remission)
- Phase 2 = stabilization of illness / symptoms and
- Phase 3 = maintenance i.e. prevention of relapse

The illustration shown below makes the point, the milestone is shown as End of the first episode (if it is the first episode, it could also mean the end of acute manifestations).




**2. Goal: Identify the phase in which the client has presented**

The goal of the first phase of treatment is to control acute symptoms as per clinical protocol. As the psychiatrist or counselor, you would first identify if the client is in an acute condition. It is important to identify the phase in which the client has presented in.

The doctor should identify the phase of treatment in which the client is after assessment. If it is difficult to do so, then also a phase should be identified with caution with a margin of error. It is better than no phase at all.

Depending on the state of the client, there could be a need for admission for short stay.

As the clinic-in-charge, you should have referral forms in the clinic which clearly inform where the client should be admitted if there were a need and the process involved in doing so. If there was a need for an ambulance the same should be provided or arranged for as per protocol

### 3. Risk Stratification

In addition to categorizing clients into one of three above-mentioned categories, the clinical team should assess the risk posed by the client to itself and to others. This is essential to ensure the safety of all involved in care.

As clinic-in-charge, you should estimate if the client poses any threat to the security of those involved in care and take required measures to ensure safety

The role of the medicines would be crucial in this phase of treatment. The pharmacy should, therefore, be ready with essential supplies for clients in this category.

Therapeutic alliance with the client and caregiver: in this stage of treatment, the priority is in controlling distressing symptoms however, this has to be conveyed to the client/caregiver, more the latter than the former. It should be clear to the caregiver that the objective of the treatment is to interrupt the current condition and post successful interruption, treatment to stabilize the client would be initiated or planned. As the counselor, you should have a kit ready for most commonly seen conditions to inform the client through visual media and talk on what is being attempted in treatment

**Risk Stratification tool**: very few risk stratification tool exist that could be used in the current context. A reference is provided to the national council's risk stratification tool[5], but it has to be modified to be the right fit for the program setting.

**END OF TOOLBOX**

### 5.6.2 Phone Call

An important support service is the Phone Call Reminder. For clients in the acute phase of treatment, support is required to reach the milestone. The UMHP provides two essential support services in addition to treatment – phone calls and home visits.

[5] https://www.thenationalcouncil.org/care-transitions-network-people-serious-mental-illness/ (download as an MS Excel file)

The client and caregiver may find it difficult to stay with the treatment and report back to the clinic at regular intervals as required in the first phase of treatment. This could be due to the obvious clinical manifestations which might be difficult to handle.

As the clinic-in-charge, as soon as you get the intimation that a client is in phase 1 of treatment, a series of support services should be made available. You should ensure that the client details form has recorded a mobile number that is active. While at the clinic, you should ask the social worker/volunteer to dial the number and check it. This would also give the client the clinic number.

**PRIORITY CALLING**

How many clients in Phase 1 of treatment received a phone call within Week 1?

After ensuring the number works, you should according to a protocol, call the client at least once a week. This would allow both of you to understand the seriousness of this phase of treatment. You should watch out for any signs that inform you that the condition of the client has not improved as expected or might be deteriorating. You should advise the client to come to the clinic or send someone their home to check on the client if the client is in the catchment area.

The standard phone call inquiry has four parts to it:

1. Introduction & purpose of the call
2. Enquiry into current condition of the client and treatment compliance
3. Enquiry and information into follow-up action
4. Recording information in a database **(Annexure 7b)**

You as Social Worker or Volunteer should make the call. You should preferably speak to the caregiver. In case, caregiver is not present, enquire who the person was at the other end and speak to him/her, don't let the opportunity go away. Enquire into points 2 and 3 (see below).

Enquiry into point 2 means asking the present condition of the client, the decision you have to make is whether the client is better / worse or no change from the condition presented to the clinic.

You must know that in one weeks' time, the clients' condition is not likely to improve drastically but this is a call to let the caregiver know that the program is concerned with the outcome. However, ask the caregiver if the phone call should continue else do not call the caregiver if it is inconvenient.

*I made the call, I wanted to know if you were taking medicines as prescribed!*

Depending on the clinical condition, after the call, you should have made your decision. Further action depends on what your decision/assessment is.

The main item on the checklist that should be checked for is whether the client was taking the prescribed medicines regularly?

You should also remind the client of the next scheduled appointment for counseling

**TOOLBOX:**

Develop a form for the entire process of telephone follow-up, i.e.:

1. List of clients who are in Phase 1 of treatment
2. Intimation if any of these clients do not have mobile numbers mentioned in the case intake form, this intimation should be captured ideally in the clinic at the point of registration
3. Schedule of calls to be made by social worker/volunteer to the clients

Phone call form that allows entry of the time and date of the transaction and the four points mentioned above.

Clients living outside the catchment area of the project can only receive phone follow-up on a regular basis.

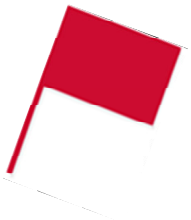
### 5.6.3 Home Visit

Clients who are in the catchment area of the project, benefit from the ability of the service providers to visit their homes. This is an invaluable support. An outsider could diagnose a problem and even provide a solution or support to the family in taking care of the person with psychosocial problems.

The current process of the home visit is different, it is targeted towards those who fail to attend to their doctor review appointment for three months. As part of support service for clients attempting to complete milestone, home visits have to be conceptualized differently. The current process of the home visit is detailed in the processes for Track 2 or component 2 which is discussed later. The suggested home visit process is discussed here

The triggers for a home visit are:

1. When a completed phone call suggests the client has unexpectedly deteriorated and the problem could not be solved over phone
2. When the phone call could not be done for a client who is at high risk
3. When the client misses scheduled appointment while in phase 1



4. Death or major mishap in the family which the project team comes to know of. This would require a recce to understand how the client would be taken care of going forward.

A home visit is undertaken by a volunteer or social worker. If you are either of them, then you should be clear about the objective of the home visit – one of the above reasons. You should be ready with what to do in the above situations.

If the trigger no. 1 is present, then you should inquire into reasons for same with a specific inquiry into compliance with medicines. You should then either suggest a solution yourself or discuss the case with the counselor/psychiatrist and suggest appropriate steps.

If the trigger no. 2 is present, then you should be ready to intervene in a crisis. You should have been trained in crisis management otherwise it is better to refer the client to a facility where crisis can be managed

**TOOLBOX:**

**1. Crisis:**

Crisis if reported is a red flag**(Annexure 43)**

You should fill in an **Incident report** for the crisis **(Annexure 42)**

If trigger no. 3 or 4 is present, then refer the process mentioned under Home visit section in Component II (Community level work)

The home visit is the last intervention available with the service team, if this does not resolve the condition, then intervention by someone known to the family or prominent community member is requested.

**2. Home Visit**

All details of the home visit should be filled out in the home visit form **(Annexure 7a)**

Since the home visit is last level intervention, clients who receive a home visit for any of the triggers should be identified separately in the MIS by a special symbol. Their progress, post the home visit, should be reported i.e. did they express expected behavior post home visit or not?

**3. Revisit:**

One of the objectives of UMHP is to reduce the duration of untreated illness or problem. Once the person is identified through the door to door house visit and details noted in the Identification sheet, he/she is expected to come to the clinic for initial assessment. If the person does not make contact with the clinic for three months, then a home visit is made by the same team. This home visit is called a "REVISIT".

Revisit is done by volunteers and any of the other staff depending on their availability. The transaction that happens during revisit is not recorded in any form and notes are made on a plain piece of paper of the reasons for not coming to the clinic. The objective of a revisit is to impress on the client and family the need to take prompt & appropriate treatment from any place of their convenience, not necessarily the IS clinic. During this

visit, barriers to access to care are identified and problems are solved. Only one revisit is done, after which the process is terminated.

**END OF TOOLBOX**

### 5.7 Key Conclusion / Decision

At the end of this process, clients who have completed or are likely to complete milestone would be known. This is a major achievement for the service and the client.

The series of events from identification, registration and then categorization of treatment in phase 1 allows the program to make reasonable conclusions if the service is making a difference. The clinical team makes a judgment on the client and feed the program manager with this information. The program would know the subset of clients who have responded favorably to the intervention.

### 5.8 Information Capture & Tracking the process

Risk stratification of clients, if they are in phase 1 of treatment, should be known.

Clients should be categorized into one of three treatment categories

Status of clients after phone follow-up and home visit should be updated to understand the category in which the client is – improved, worse, no difference. In this manner, the clinical team can generate information that can be used by program managers to make sense of the effect of the program

### 5.9 Internal Check & Balance of process

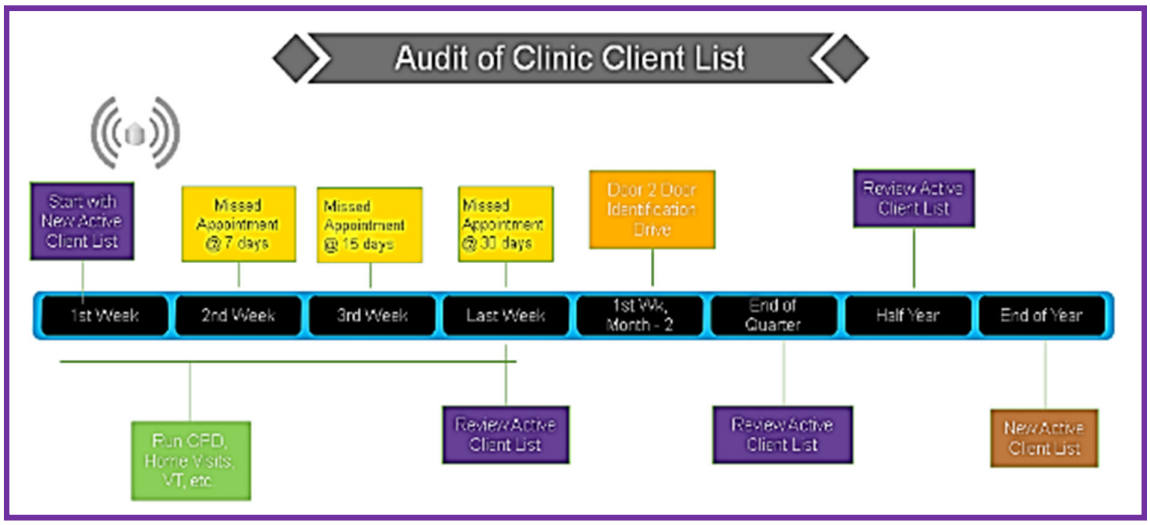
As clinic-in-charge or program manager, you need to ensure that clinical information is generating leads for programmatic intervention. The clinical team should, therefore, be trained in risk stratification, categorization of clients according to their treatment phases and take actions based on an accepted protocol. This will require repeated training and audit of service. Otherwise, focused support for those clients/caregivers who need it most cannot be provided.

You would be helped by investing in a database that generates some automated information for you to act on.

In case a database is not possible, at end of each clinic ask the team to categorize clients in a form. Then review the form entries and ensure that appropriate actions are taken by support teams (phone call, home visits, crisis intervention).

## 5.10 Evaluation / Audit of process

As program manager, auditing processes is critical but time-consuming. Hence, it is suggested that you set aside a separate window when you audit selected cases for actions as per protocol.




**The above exhibit suggests a possible solution to carefully audit the different processes of this project.**

## 5.11 Gaps and Suggestions

Currently, the clinical assessment is not generating leads for programmatic interpretation and action based on a protocol. It is important to develop and adopt categorization as suggested above. It would also help in understanding results of the program. Therefore, the team should be trained on adoption of protocols and classification of information and then an audit of support services should be done to ensure that resources are focused on those who need it most.

## 5.12 Training Requirements

The clinic-in-charge or the program manager should hold regular, repeated training on the desired information generation in the clinic. Translation of clinical assessment into programmatic information is a learned process and the teams would require some training before they are able to do justice to the process. At least once each month, the training should be held to ensure there is high fidelity in the translation of clinical information to programmatic information.

**Refer Annexure 44** **Also, see Annexure 40**

# 6. Track 1 / Project Phase 2 / Treatment Phase 2: Mental Health Clinic / Implementation Phase / Stabilization phase

**Process Holder**: Counselor

| Needs Change | Good ☺ | Standard |
|---|---|---|

## 6.1 Scope / Overview of the process: (See Annexure 46)

Once the client is in remission (endpoint of acute treatment phase), the client enters into a bridge phase of treatment called Stabilization phase. This is called bridge as it connects the destination (stable phase) with the origin (acute phase). This phase is transitory in nature. The doctor and the client meet more often during this phase to stitch together a treatment regimen that works best for the client. This phase allows the doctor to know the client better and vice versa, it also helps the client to know the illness & its treatment better. One of the important endpoints is that the client has an explanatory framework for his / her problem. The clients' needs to understand what he/ she is suffering from, this phase of treatment allows that understanding to emerge. A person with a psychosocial problem might have to try different treatment combinations before settling onto one, all the trial happens during this phase. Therefore in the life cycle of a client, he/ she records maximum clinic-contacts during this phase of treatment. The processes involved in implementing this phase are discussed below, the most important of which is the counseling and drug management.

## 6.2 Policy guiding this process

The Client has to reach a stable phase in treatment and therefore all efforts are directed towards that end. The policy driving this phase is to understand the needs and circumstances of the client and provide the best solution towards recovery. This client centric focus of the mental health service is best seen and tested during this phase.

### 6.3 Purpose / Objective of process

The purpose of this process is to inform the client that for him/her the next step after remission is to identify a stable treatment – one that works the best for the client. Role of the client, interaction with the team and trial of different treatment regime are the main purpose of this process. Another serving purpose is to improve adherence to treatment of clients. This requires several sub-processes and activities influencing several variables at different levels (see **Annexure 28**). Given the socioeconomic profile of clients coming to the clinic, this purpose is challenging for the service. This is a combined purpose of track 1 and track 2 of the UMHP

### 6.4 Result expected from process

UMHP expects that about 45-55% of clients who achieved remission and entered stabilization phase should be able to complete this phase. Further, changes required in track 1 and 2 could be implemented to achieve and then maintain this indicator. The service domains have been elaborated in **annexure 29a**

Drop Outs after Phase 1 is a big loss!!

### 6.5 Criterion / Preconditions in process

The client should have achieved remission to then be considered as eligible for this phase. However, all clients who achieve remission would not come or sign on the line so as to say for the stabilization phase. The program should, therefore, allow for a loss of a few clients who do not come post remission and drop out before stabilization phase starts.

### 6.6 Key stakeholders in the process

Key stakeholders in this process are – doctor, counselor, social worker, volunteer, client, caregiver and influential person in community

## 6.7 List & Description of Key activities & processes

| Key Activity | Main Role | Supporting Role |
|---|---|---|
| 1. Treatment adherence planning | Counselor / Psychiatrist | Clinic–in-charge |
| 2. Phone Call | Social Worker / Volunteer | Counselor |
| 3. Home Visit | Social Worker / Volunteer | Rehabilitation Officer / Counselor |
| 4. Pre-Vocational training | Vocational Coordinator | Counselor |
| 5. Support group membership | Counselor | Vocational Coordinator |

### 6.7.1 Treatment Planning

The goal of treatment is to ensure the client receives a treatment plan which could be constant for a reasonable period of time and allows functionality. To arrive at stable treatment, adherence of the client to the treatment during period treatment is being tested out is important. For this, building trust, understanding needs and circumstances of the client-caregiver dyad and professional competence to provide effective treatment solutions are important. Track 2 activities such as community-level support are also equally important. A home visit is a track 2 activity.

**Dialogue between Doctor and Client**

| | |
|---|---|
| Doctor: | *In 4-6 months, together we would have worked out the treatment that works best for you!* |
| Client: | *Doctor, it's been 8 months, what to do?* |
| Doctor: | *We should consider this a failure of the trial, let's start all over again* |

**Suitable duration of treatment trial:**

The program should decide as per different diagnostic condition the period it would consider the suitable duration of trial for stabilization to be achieved.

Stay the Course! साथरखें

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Psychosocial problems are marked by the long duration of treatment, the social stigma attached to illness, side effects that might not be too pleasant and poor understanding of illness by the client. Many times, the client and service provider do not share the same understanding. Therefore, three processes are seen in UMHP that are effective and important in ensuring treatment adherence:

1. Same doctor & counselor throughout
2. Simple prescriptions
3. No cost charged to client or minimal cost
4. Affection, support, and warmth of the staff
5. Reminders for scheduled appointment & contact for missed appointment
6. Frequent reviews
7. Methods to reduce waiting time in OPD

As clinic-in-charge, you should ensure that at least above 7 elements are always expressed by your service. These are all self-explanatory

Clearly, mark on the client file that client is now in Phase 2 of treatment.

**Client education**

Informing the client is an important factor influencing adherence. This task is of the volunteers, social worker and members of the Support group or Peer groups.

As clinic-in-charge, you should organize the client information function so that different people have a duty to sit with clients during the waiting time and inform them on factors influencing adherence, team members should be selected from above groups.

You should discuss three levels of factors:

1. Requirements – confidence, self-esteem, fear, self-stigmatization, fear of dependence of clients and help improve them. These requirements are essential for any further action to show the result. These efforts should improve the motivation of the client to take treatment and see improvement in oneself
2. Technical information on their diagnosis/problem, possible side effects, adverse effects, the course of illness, crisis signals, etc. These efforts should enable the client to understand nature of illness and need for treatment. They should also feel that real recovery is possible from the illness and their own perceived benefit from the treatment should improve. You should have information material for different disease conditions for different treatment goals and hand out suitable ones to the clients and not generic information material.
3. Cost-related information – clients should be informed that treatment is inexpensive but could be long term, hence costs should not be an issue. Cost considerations are sometimes the top priority of clients and such costs include indirect costs such as transportation, loss of livelihood, etc. You, as clinic-in-charge, therefore, should look at schemes that subsidize costs (free bus card) and make them accessible to the client

**Positive stories of treatment outcomes**:

As clinic-in-charge, you should provide positive true stories of clients who have either recovered or are in a stable phase of their illness with mention of actions they did to reach that stage. Such stories should be posted in the clinic and pamphlet handouts given or one or the other volunteer could narrate this story, show a video to those waiting in OPD. Client engagement and interaction are an essential feature to achieve the objective of this phase of treatment

**Counseling & Role of Counselor**:

The most important intervention during this phase of treatment is counseling. This is for two reasons:

1. Counselor spends time with the client to understand life circumstances and offer the client help to create an explanatory framework of the illness the

client is suffering (*What is happening to me, why it is happening to me? Is this a punishment for some sin? Am I God's angel?)*

| ***What is happening to me?*** |
|---|

2. An explanatory framework is very important for the client to understand about the illness, it will take time for this to develop and it goes on to the Stable treatment phase, but starts in this phase with mediation of the counselor

During this process, you as Counselor would be able to understand cultural belief, self-stigmatization, guilt and other variables that are influencing the way the client is understanding its present condition. You have to then find solutions to them

You would also be the main facilitator of the Individual Care Plan of the client whereby his / her goals, dreams and actions required to achieve those dreams would be noted. This is the basic document on which the progress of the client is tracked and you or the doctor could help the client see the progress made. See **Annexure 20** for a format of Individual Care Plan.

| **Report Card**: Share progress made by the client through a report card |
|---|

**First Step:**

As the first step, you as Counselor should congratulate the client and caregiver in achieving remission.


You should then inform them that there are stages to treatment, now they were entering the second stage of treatment


You should inform them of the aim of this phase

You should inform them of the importance of treatment adherence and therapeutic bond with clinicians and need to communicate what the client is experiencing to allow the clinicians stitch a suitable program for the client in partnership with the client.

You should plan to meet the client as often as prescribed by treatment protocol and not progress of client on dimensions mentioned above

You should take this information to the doctor, social worker and share information on the progress of the client.

**Counseling Skills:**


As a counselor, you have a difficult role to play. You might be required to use different techniques for the different diagnosis you see, different kind of clients you meet, it is, therefore, advisable to upgrade your skills and learn techniques that are most suitable to your client profile. Further, you should also access the larger pool of peer psychologists in the organization to discuss cases and bring them in for combined work

### 6.7.2 Phone call

The phone call support is an important support and you as a Social worker should keep a record of all clients in this phase of treatment and give them a fortnightly call (cf. weekly call in the acute phase of treatment).

From the MIS, you should generate a list of clients who are in Phase II of treatment and record their calls, including who all were able to receive a call. Use modified telephone call register to record phone calls (**Annexure 29b**)

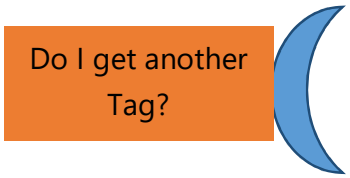
You should identify causes or reasons you think are responsible for treatment nonadherence. You should also have some solutions to overcome this non-adherence, for example, a client could say – *I did not take the drug for past 15 days, how do I restart?*

You should refer to a manual which contains most common reasons for non-adherence to treatment in your service area and solutions for them.

**A Manual is required to guide this action!**

For every fortnight period, you call the client, make a conclusion of the category the client belongs to:

1. Adherent
2. Non-adherent
3. Not sure



Phone call every 15 days & categorize for recall period of past 15 days

Then take appropriate actions.

- For an adherent client, give positive reinforcement
- For non-adherent client – schedule OPD appointment for counseling, home visit or consider offering membership of a support group. If all fails, then get someone known to the client and ask him/her to inform the client. If all fails, note the same in the file but don't force client.
- If you are not sure whether the client is adherent or nonadherent, ask the client to come to OPD or schedule a home visit where the direct examination is possible to check on adherence.

Note status in MIS

Clients with first non-adherence and those with repeat non-adherent state should be brought to notice of clinic-in-charge who should then discuss case with clinical team for solutions required to this situation

### 6.7.3 Home Visit

A home visit is arranged as a physical verification of a lead given by phone call. This can only be provided to clients in the catchment area.

Home visit details are discussed earlier in section on acute treatment phase

### 6.7.4 Pre-Vocational training and Support Group:

Membership to the above is discussed in detail in the following process. Clients who face poor peer support, alienation in families and lack of productive work, pre-Vocational training and/or membership in support groups could be started during this treatment phase itself. The Counselor should take a call on the requirement of these activities and suggest same to the client.

## 6.8 Key Conclusion / Decision

Less than a half of clients who achieved remission would make it till the end of stabilization phase of treatment. During the course of this phase, it would be clear that domains that are under control of UMHP can influence a significant number of clients to continue with their treatment and engagement with their psychosocial issue, but another proportion would fall out of the network. Dropping out of the treatment is not a worry since it is a common feature of clients receiving treatment for chronic ailments. The UMHP continues to support clients in the clinic and the community and if they decide to come back they would again receive services. There would be sufficient understanding of what helps a client reach end of this phase. Those learnings should be widely disseminated in the client population and community.

The process of new identification should be done after completing a census of all cases in the clinic. The clinic has a limited capacity to see clients and those who are not following up despite efforts to contact them or those who have recovered should be off-loaded from the active service list. New clients are identified by the door to door house visit in addition to a referral from different stakeholders, ex-clients, and self-referral.

### 6.9 Information Capture & Tracking the process

The most important information is to understand why clients continued to take care and remained treatment adherent while others dropped out. The dropped out clients are therefore equally important than retained and adherent clients.

Different tags are attached to the client to understand how he/she is moving along the topsy-turvy course of recovery.

Results of outcome should be shared with the client, all information, therefore, should be brought together in form of a report card (**Annexure 20 and 30** together).

- Eligible Denominator = clients who achieved remission end of phase 1 of treatment
- Actual Denominator = of the above clients, who present themselves for stabilization phase
- Numerator = clients who achieved stable treatment end of phase 2 after a suitable duration of trial

As a process indicator, the treatment adherence status should be recorded every 15 days. Over time, once the adherence behavior of clients is known, categorize the clients into three categories of the different follow-up period - 15, 30, and 45 days. Clients who drop out or turn non-adherent should be carefully interviewed (if possible) to understand reasons for drop out.

### 6.10 Internal Check & Balance of process

Clinic-in-charge should follow treatment adherence status of different clients. From the MIS, a fortnightly report on treatment adherence status should be received.

### 6.11 Evaluation / Audit of process

Every quarter review should be done as per the audit plan presented above

### 6.12 Gaps and Suggestions

1. Template for Individual Care Plan should be prepared and adopted by the project. Client report card should be incorporated into this plan.
2. Technical protocol to decide suitable duration of treatment trial for different conditions to decide when client should be considered successful or failure to achieve stabilization

### 6.13 Training Requirements

The technical protocol has to be adopted for different conditions in this phase and all staff should be trained on it. Measures to overcome treatment non-adherence should be listed and team should be trained to reduce non-adherence

# 7. Track 1 / Project Phase 2 / Treatment Phase 3: Mental Health Clinic / Implementation Phase / Stable phase

**Process Holder:** Rehabilitation Officer

| Needs Change | Good ☺ | Standard |
|---|---|---|

## 7.1 Scope / Overview of the process:

In the treatment of the psychosocial condition, this is the last process which however marks not the end but the beginning of yet another phase of the journey of the client with a psychosocial problem. The client receives this phase when the client is in the third phase of psychosocial problem – the stable phase where experience with illness and its meaning within the life of the client is relatively clearer; when symptom control is not the overwhelming need; a purpose in life, meaningful productive activities, sustainable relationships and personhood are the drivers of client's life.

The client has understood the illness and is now re-structuring life around it. At this time, the clinic, community and rehabilitation tracks/components of UMHP come together. The rehabilitation track is therefore introduced. Together all three components work to engage with the topsy-turvy recovery process of clients. While in the earlier two processes the main focus was to control acute symptoms of the client and tide over the crisis, the phase I of regular treatment focused on identifying a treatment regimen that would stabilize the client, this phase is much more important, a reclaiming of life and its meaning given the presence of the psychosocial problem.

During this process, the clients start (or facilitated to start) performing their roles and responsibilities and care team has to supervise the interaction between routine activities and treatment. A component of the program that makes activities (read Opportunities) available to the client is brought into play. Rehabilitation Officer becomes the nodal person in this phase. The client also faces challenges of

disclosure of the state of psychosocial condition, interaction, and negotiation with family members and outside world in the attempt to put the life back on track; including bringing to fore coping skills to face up to life's challenges including prejudice and discrimination.

The rehabilitation work is located in the clinic space and Drop-in-Centre. Support groups, self-advocacy, and facilitation of benefits for clients under government schemes are other activities during this process.

The program takes the aroma and flavor of a Community Based Rehabilitation program. It emphasizes the need to bring together medical, social welfare and the other support programs of the government together in a true primary health care strategy approach.

In a primary health care set up, such a process is difficult to execute since staff and material are not available to carry out activities of the process.

Key pillars of a CBR program are interventions that promote health, education, livelihood, and social life. In addition, there is a cross-cutting emphasis on empowerment, such as supporting people with disabilities to make their own decisions. CBR is put into practice through the joint endeavors of people with disabilities, their caregivers, community members and relevant governmental and non-governmental services, including health services.

Integration of mental health into primary care would call for the provision of support services that would help all clients with a psychosocial problem even if their main diagnosis is a physical illness.

### 7.2 Policy guiding this process

This process is guided by a keen sense of engagement with the person, a desire to see the client's condition recover. Comprehensive treatment is made accessible to the client in an atmosphere that provides support, affection, empathy yet self-affirmation and builds up the person, improving self-esteem, self-confidence, etc.

All required activities are provided from the same or nearby location, therefore breaks in service utilization is less likely. A person with psychosocial issues requires a different kind of services as part of their recovery process. The same team of

people can provide these different services. The continuity is important for the client, caregiver and the clinical team since a good therapeutic relationship is built around the experience of the illness. It is also a testament to the teamwork required from mental health services which are client-centric and guided by able leadership.

Involvement of clients in service provision, preparing clients for their role as advocates and making peer groups are part of the recovery-oriented policy of Sankalpa. The 'how" matters as important as "what" and "why" in this process.

### 7.3 Purpose / Objective of process

This process is the essence of the support that Sankalpa provides to clients and one that distinguishes it from other mental health services. People with common and more severe mental disorders show different behaviors in different phases of their recovery process, the services stay in touch with the client and continue to support the client throughout their recovery. The purpose is to make recovery process as pleasant an experience as possible.

It is known that recovery is not an easy process, and clients and their families face a lot of upheaval in recovery, they could leave medicine four or five times over several years, they could feel at loss with changes happening in their lives, they could face stigma and discrimination from people important in their lives, face low self-esteem, self-confidence, self-efficacy, feel disempowered, lose meaning of life, purpose or goal, etc.. The objective of this process, therefore, is to support the client and improve coping skills of the client such as problem-solving, emphasize with client so that functioning, emotional recovery and other domains improve not only in short term but throughout life. The UMHP does not, therefore, have a high discharge rate, even clients with CMD do not discharge because support services remain relevant to most clients in the community.

Currently, no recovery framework is adopted by UMHP, but it does act on the five domains - emotional, social, vocational, cognitive, physical and spiritual domains of the recovery process. The process, therefore, informs the need for the service to stay in touch with the client and provide outreach services to the client and family as essential part of recovery that goes well beyond symptom control and management.

Another objective of this process is to emphasize on integrated treatment for a person with psychosocial disabilities. This is relevant to primary health care, but the

scope of activities often go beyond health, but one could begin with provision of mental health, general health, de-addiction services from one place.

### 7.4 Result expected from process

Currently, no recovery framework is adopted that defines the domains in which recovery is measured. However, many such frameworks are available. The key results one is looking at end of this process are shown in Annexure 16.

The client becomes functional ( a significant improvement from baseline) and actively engaged in the pursuit of roles and responsibilities of life. Disability is reduced (compared to baseline) and life adjusted to the reality of a manageable illness. The client has meaningful relations and is able to express his own identity to both near ones and outside world. The client's contacts for treatment are limited and more engagement is with rehabilitation services where the client has a clear plan for the future. In effect, the recovery protocol is realized at end of this process and the aim of services remain to maintain this state for long periods.

### 7.5 Criterion / Preconditions in process

A prerequisite for this process is that the client should be stable on a treatment regimen. The client may not be symptom-free but functional. Even if there is a crisis, friends or caregivers are able to identify it and seek care.

## 7.6 List & Description of Key activities & Process:

| Key Activity | Main Role | Supporting Role |
|---|---|---|
| 1. Treatment planning | Counselor / Psychiatrist / Facilitator Support Group | Social Worker |
| 2. Vocational Training | Social Worker / Volunteer | Counselor |
| 3. Support Groups & Peer Groups | Social Worker / Volunteer | Rehabilitation Officer / Counselor |
| 4. Self-Advocacy | Advocacy officer | Social Worker / Volunteer |
| 5. Cultural Activities | Social Worker / Volunteer | Rehabilitation Officer / Counselor |

### 7.6.1 Treatment Planning

As one can see from Annexure 16, treatment (refers to Drug treatment) has at least 7 expectations from this process.

While the main concern is to Identify and maintain the client on a treatment regimen that keeps the client stable, there are other important requirements that inform processes and activities in treatment planning.

The main results are listed below (From Annexure 16 / Treatment domain):

1. Symptoms experienced by clients are managed well
2. Client and Caregiver understands medicines and their effects on body
3. Crisis management plan in place and client and caregiver educated on it
4. Client and caregiver has a reasonable provider relationship
5. Clients feel that treatment is a resource that should be used for Recovery
6. Client manages physical health well (management of illness or exercise )

7. Client has no substance abuse problem or takes treatment for abuse

Symptoms experienced by clients are managed well:

Antipsychotic drugs are the primary treatment for psychosis and schizophrenia. There is well-established evidence for their efficacy in both treating acute psychotic episodes and preventing relapse over time in conjunction with psychological interventions6. However, treatment choices should be as per clinical protocol and needs of the client.

As the counselor or clinic in charge, you should plan with the psychiatrist the treatment regime on which the client remains stable. Remember, the client may not be symptom-free but functional.

Some criterion to consider client stable should be developed as per diagnosis, but key markers are:

- Symptoms are minimal and handled well, do not interfere with functionality of client
- Client has an understanding of symptoms and can handle itself
- Client knows the frequency at which he/she has to come for review
- Client understands side effect of drugs and frequency at which monitoring for drug effect is required

**Client and Caregiver understands medicines and their effects on the body:**

Psycho-education of client and caregiver on the illness and its treatment is a requirement of this phase. As a member of the clinical team, this task is spread out or divided amongst all of you. The main task holder is the case manager, the person who is responsible for the client.

As the case manager you should do the following activities:

[6]https://www.nice.org.uk/guidance/qs80/chapter/introduction

1. Ensure that client has access to oral or written information on his / her own psychosocial problem or condition
2. Ask at each interaction what the client think is happening to him/her?
3. Inform other colleagues to inform the client in their interaction with the client on the nature of the problem, appropriate treatment and expected behavior of the client and caregiver.
4. Inform the client and caregiver of the possible side effects of drugs and how to manage them. Since most clients are from poor educational background, handouts might be of limited use, you have to manage their follow-up appointments in a manner to ensure they have regular monitoring

**Crisis management plan in place and client and caregiver educated on it**

As you know that Stabilization is not a uniform linear process, it is marked by changing feelings of the client about themselves. They are also prone to relapse at this stage. Therefore, a Relapse management plan should be made and the client & caregiver should be educated on it. Even if after this education, the client relapses, remember the symptoms are likely to be less severe7.

Given the context that many clients would have a limited educational background, translation of provided resources would have to be done, and more oral instructions are given so that information is registered. If there is any other crisis, then the client should be prepared for it.

**TOOLBOX:**

1. The Case Intake Form records psychological triggers for each client. This section becomes the basis to understand why and how client relapses. However, more detailed planning and management are required.

[7]http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/a_family_guide_to_concurrent_disorders/relapse_prevention/Pages/relapse_prevention_menthealth.aspx

You are advised to refer to the following link for more information: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/a_family_guide_to_concurrent_disorders/relapse_prevention/Pages/relapse_prevention_menthealth.aspx

The main stress is on identifying triggers, acquiring coping skills, seeking support, preventing triggers and following a structured routine.

Many other resource materials have been provided with the document that would help in the training of program staff in helping the client prepare a Relapse Prevention Plan.

2. Client and caregiver has a reasonable provider relationship:

As in-charge of the clinic, one of your jobs is to ensure there is the overall satisfaction of the client and caregiver with the services. The current UMHP scores highly in this process. Clients and caregivers feel accepted at the clinic and are all praises for all staff. The support and warmth towards clients and caregivers is a standout feature of the clinic. This should be maintained. Three main actions are:

- You should treat the client with dignity
- You should discuss treatment options with clients and caregivers
- Clients and caregiver should know who they could contact in case of any problem

3. Organize regular staff training around this aspect since this is the make or break of services. Clients have had prior experience of other services, and often point out how UMHP stood out since staff listened to them as individuals, provide support to them at all times and speak with affection.

4. Clients feel that treatment is a resource that should be used for Recovery:

In this phase of treatment, the clients have understood that drugs would not be able to completely rid them of all symptoms, they also realize that there is a life possible beyond illness, hence they become aware of the role of treatment in their life. You should inform clients to continue with their life's roles and responsibilities and treat treatment as a resource that should be utilized to fulfill life's goals.

The client's goals and aspirations should be recorded once the client is in this phase. This could be done on a separate form which is self-reported by the client or filled

in by someone else. This should be part of the Individual Care Plan of the client and progress tracked on these goals.

5. Client manages physical health well (management of illness or exercise ):

There are two aspects of this task:

1. Since a person with the psychological problem could have other physical health problem, they should be advised to manage those conditions well. These include diabetes, hypertension, the two most common ailments (Annexure 17a)
2. The second issue is that you should inform clients to take good care of their health through improved nutrition, exercise, rest, regular routine and avoidance of any substance abuse

The client has no substance abuse problem or takes treatment for abuse:

Many clients have a coexisting substance abuse problem. You should advise them to seek treatment from a suitable service and take actions to stop the use of addictive substances.

**NOTE:**

Counseling has a very important role to play in this phase of treatment. The goal of counseling and support group are convergent therefore counseling is discussed in the section on Support groups although it belongs to domain of treatment

**END OF TOOLBOX**

### 7.6.2 Pre-Vocational Training

As seen in Annexure 17b, the range of work that UMHP facilitates is from Pre-vocational training to independent employment. Pre-Vocational Training is unique to this phase of treatment and is the most important process during this phase. The key results that are expected as a result of vocational training are:

- Acquires skills (educational or job) that gets the client a job
- Is involved in work
- Has some earnings from work
- Develops a sense of self-respect out of earning a livelihood and supporting self or family

Registering a client in Vocational Training program:

As the Counselor, you would be making the decision to invite a client to join the Vocational training program. The reasons for joining the program are two-fold:

1. Vocational training program will enable client to build job skills and education skills that would allow the client find a job or start some remunerative work
2. It provides an opportunity to the client to come out of the house and mingle with other peers. This also happens when a client is made a member of the Support Group, so is discussed in more details under Support group section

**The criterion to invite a client for Vocational training:**

The Counselor makes the decision to invite a client for vocational training. The decision is taken in consultation with the Vocational coordinator, psychiatrist, social worker or even volunteers. There is no clear criterion as of now who to invite for vocational training and female clients have been participating more than male clients. All clients want to work. Female clients who are homemakers would also benefit by spending some time in productive work.

All clients should be offered the option of Pre-Vocational training and up to 40-45% of clients should be involved in work of any kind, not at Sankalpa but anywhere.

**Organizing the training:**

The pre-vocational training is held once a week for a few hours, as in-charge of Vocational activities, it would be ideal to organize full day training and work mirroring a routine workday. The Drop-in-centers should be developed to serve this function.

As Vocational activity in-charge, you should schedule activities that involve clients for the full day. This will help build their self-esteem, stamina, and confidence.

You should focus to develop clients for Competitive Employment and training should be suitably aligned.

You should ensure that vocational products made should be sold so that clients know that their products would be sold and should be sincere in finishing of the product.

Assessment of the skills of the client, training for job vs. Finding a job and providing supportive training:

Currently, UMHP conducts pre-vocational training and then scouts for work opportunities of some clients; for a few other clients, direct work engagement is searched and then support provided in terms of counseling and conflict resolution. This has been detailed out in the chapter about Naya Daur program.

You as the in-charge of vocational activities should do a rapid assessment of the skills of the client – Baseline skills score

You should then design a training program for the client with clear goals and milestones and defined duration of training

Periodic assessments of the client should be done to see if progress is made

At the end of the training, the client should be assessed to see if the desired skills and other requirements are met.

**TOOLBOX**:

1. If you want to know how to organize activities throughout the day for clients then study the Clubhouse Model, refer this site - http://www.iccd.org/whatis.html

2. Advanced training in the vocational centers in the community:

Clients who like to learn further or learn skills that are not provided in-house but readily available in the community such as computer training, typing, etc. can be enrolled in such training. You should facilitate admission. In case you have project funds to pay a fee and the client qualifies the criterion for financial help; you should follow all procedures and pay a fee for the client subject to the condition that training is completed and requirements fulfilled.

3. Identifying jobs in the community & placing the client:

As Rehabilitation Officer or Social Worker, you should scout the area for job opportunities, home visits are helpful in identifying local employers.

If a suitable job is found, then encourage the employer to employ the client, there is no need to disclose the status of mental health to the employer.

The disclosure of illness to the employer is dependent on the consent of the client, understanding of the employer and an appropriate time. If this could threaten the job, the disclosure is avoided.

**4. Oversight in the job:**

Clients are involved in a range of jobs and as Vocational Trainer or Social Worker, you should follow up clients at their work sites and at homes, this is an important oversight. However, remember if the employer or the client do not want you to come to the place of work then do not insist, follow-up by some other method such as ask the client to speak over the phone and so on.

You should develop a checklist to see if the client is coping adequately with the workplace (See Annexure 18)

The employer should make a concession for functional areas that are compromised by the psychosocial problem and not for unrelated areas, this should be made clear.

5. Targeting clients for work:

As a result of your work, what proportion of clients could find independent work? You should target a range of 20-35% of all clients attending your employment program to find independent work.

### 7.6.3 Support Group / Individualized Peer Group

UMHP has brought together clients and their caregivers in a group to support each other; this is called a Support Group.

The rationale for Support Group is provided by research evidence that shows clients have often emphasized the need for support as they learn to cope with their illnesses. Usually, families, friends, and relatives do not communicate with the clients much, leading to loneliness, social isolation and consequent poor quality of life. One of the reasons for social isolation could be stigma due to mental illness and other members of society might bully or harass or simply not interact with clients. It is to overcome this feeling of loneliness that support groups come into play.

The objectives of the support group are:

(i) to learn from each other to better manage illness & related issues;

(ii) To form a support for each other that could continue beyond the project life.

More specifically, the changes one is expecting to see in clients from support group participation are:

- Sense of self and identity
- Acceptance of the illness
- Hope
- Coping with effects of past trauma (physical / sexual)
- Active Coping Skills
- Meaningful & Satisfying roles in community
- Does not feel that one is alone in how one feels

- Self-Efficiency and taking charge to change one's situation
- Some satisfying relationships
- Understands cost-benefit analysis of actions
- Is able to understand what is happening around him/her
- Has an explanatory framework for his / her illness

**Joining a Support Group:**

As the Counselor / Social Worker, offer clients and their caregivers to join a support group. Your decision to offer membership of a support group should be based on an assessment by the team led by the counselor. Sometimes, the psychiatrist also advises that a client is brought into a support group.

You should remember that a support group should not replace your routine medical treatment. The support group is also not group therapy. Essentially the purpose is sharing and learning from others.

As the convener of the support group you should form a support group for a person with either similar diagnosis or similar problem, so they can relate to each other. The vocational activity is an important pull for the meeting. The group communicates hope to its members, an important and essential ingredient for recovery.

**Benefits** of participating in support groups may include[8] (See also Annexure 21):

- Feeling less lonely, isolated or judged
- Gaining a sense of empowerment and control
- Improving your coping skills and sense of adjustment
- Talking openly and honestly about your feelings
- Reducing distress, depression, anxiety or fatigue

[8]http://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655

- Developing a clearer understanding of what to expect with your situation
- Getting practical advice or information about treatment options
- Comparing notes about resources, such as doctors and alternative options

**Facilitating the group:**

For members of the support group, discussing problems in front of strangers could be difficult, hence you, the counselor or the social worker should be present to facilitate the group, till the time the group is comfortable with each other. Remember, at this time you should not provide therapy but facilitate the group discussions. Ideally, the support group should be led by a group member who is a non-professional.

Currently, there is one group each in each of the wards. Barring a few exceptions, the members are mostly women.

Facilitate meetings of the support group at least once a month in the Mental Health Clinic.

Even if 15-16 members attend the meetings go ahead with the meeting. Often, fewer members come for the meeting.

Women participation is important since women in many project areas find it difficult to come out of their homes and remain isolated inside the house. Once they come out of the house, they interact with others who do not have any baggage of previous knowledge about them and therefore interact based on current information. This helps in relieving worries and findings strategies to solve problems faced.

As Counselor or Social Worker focus your energies on developing a leader for the group who should then in consultation with the group prepare an agenda for the group.

The key activity in Support group is educating more on illness and then sharing amongst members how they overcame a situation so others can take some lesson and inspiration. Emotional support and disclosures are an important part of Self-help group meetings.

You need to learn several activities that help bring the change in the client as listed in the Objectives section. All these activities should be recorded in Support Group manual. Support group facilitator should be trained in these activities. For each member, it is important to accomplish the change (listed above) else it would become an exercise that does not have any focus.

**TOOLBOX**:

Develop Support Group Workbook which has several activities that help clients achieve their objective. Also, include audio and video files since many clients are illiterate or poorly educated.

*Peer support, mentoring, and modeling can be important factors in helping people to frame what is happening to them, to remind them that they are not alone, and to develop coping strategies. Peers can be effective in helping them to manage prejudice and discrimination, develop friends and acquaintances, find meaningful work and problem-solve the daily struggles of life. Connecting with peers can also provide an opportunity to share with other people with psychiatric disabilities what they have learned from their own experiences*

(Source: http://www.psychosocial.com/IJPR_17/Phases_of_Recovery_Spaniol.html)

### 7.6.4 Self-Advocates

Improvement in conditions of a person with psychosocial problems and services for mental health is best done with the participation of clients themselves. The clients showcase all changes that are expected in a person with a psychosocial problem who receives appropriate treatment, care, support with warmth, affection and continuous support. When people with this experience narrate the changes they have experienced in their lives from their perspective it is an invaluable source of information for policymakers, planners and managers and healthcare staff to understand aspects that need improvement.

Because of widespread ignorance and misunderstanding about people with mental disorders, they are often feared and face severe stigmatization and discrimination. Government policies are often reflective of these fears. It is sometimes presumed that government's primary responsibility with respect to people with mental disorders is to protect the general population from them. Such a perspective is not conducive to promoting access to high-quality treatment or respecting human

rights (World Health Organization, 2005b). Furthermore, unlike people with other types of illnesses, people with mental disorders are often presumed to lack the capacity to make their own health care decisions.

As clinic-in-charge, you have this important mission of creating self-advocates. The main coordination could be left to either the Counselor or Social Worker, but this should be mainly your work area.

**Training clients to evolve as self-advocates:**

The advocacy officer is the main person responsible to structure the training schedule, contents/curriculum and find resource person for training. However, as clinic-in-charge / counselor, you would either assist the advocacy officer or be the main person yourself in organizing training function.

The total duration of training is 8 days which is spread out over a month or two depending on the suitability of the clients. For each day, topics are suggested which should be conveyed to clients using role plays, audio, video content.

**TOOLBOX**:

Refer to the Self-Advocate Manual for content, schedule, and expectations from the training

The main goal of a self-advocate is to fight the prejudice and discrimination against a person with psychosocial disabilities and improvement in mental health care. For this, the self-advocate should be well trained in these concepts and the methods to be used to fight such incidence. All this is covered in the Manual.

### 7.6.5 Cultural Activities:

One of the most important events in the recovery of a person with the psychosocial problem is when he/she regards the problem as part of life and is ready to look beyond it and get on with life. Fun, enjoyment and other important things of life are therefore important in this phase.

To promote fun and entertainment, as UMHP program in-charge you should organize cultural events at the annual interval.

Organizing the event:

Identify a location for the event. This should be a public space accessed by general public

Print invitation cards and hand out Invitation for participation to volunteers, important stakeholders in the community. Inform clients & their family members orally. Put up a print out in the clinic announcing the event.

Create an organizing committee for the program: From amongst the clients, caregivers, self-advocates, volunteers and staff and distribute responsibility for different functions. This would build self-esteem and confidence of those involved. You should troubleshoot any problem that comes.

Create a schedule of events on the day of the event and ensure that all know about it clearly

Invite students from schools in the catchment area. The Social worker and volunteer should be asked to go to each school and provide a fixed number of forms for student participation in the function. This would allow all schools to participate yet not overwhelm the event.

Get local business people to sponsor the awards, especially the employers associated with the program. The Rehabilitation Officer will do this job

On the day of the event, acknowledge the contribution of different stakeholders to the program and reward them for their contribution publicly

As program in-charge or clinic-in-charge, you should develop and follow a checklist for all requirements in the event and go accordingly.

As the Vocational coordinator, you should organize a sales counter for all items prepared by your team. All items should be clearly labeled and cash receipts provided for each sale. Later you should share in the team the amount from sales recorded during the event.

This program provides an opportunity for all to de-stress themselves and express their joy. This is important for a person with a psychosocial disability and their carers including service providers.

After the event is over, you should put some photographs in the clinic for others to see. Do the same in the Drop-in-Centre.

### 7.7 Key Conclusion / Decision

This process is applicable to a few clients who reach the third stage of illness. There is no closure as of now, but as has been recommended, clients who have become stable and are managing their lives should be followed up at a lesser frequency and can be asked to come to the DIC rather than a clinic. They should, however, continue to be motivated to take medicines and see the clinicians regularly.

The framework adopted to document this SOP allows to determine a denominator for this phase, the results can then be calculated on it. It is difficult to establish a target, but a range of 25-35% person with a severe psychosocial disability in this phase and progressing should be a good target for a program 5 years old.

### 7.8 Information Capture & Tracking the process

Information capture and tracking are based on key concepts, their definitions, and indicators used in this phase. Essentially, all clients should be categorized in the phase of illness they were and then progress on different domains recorded. A results framework need to be developed which specifies scales that would be used for this phase. Since this phase has several dimensions unlike earlier phases, several information parameters would be tagged to describe the progress. The above-mentioned 5 domains could be used, to begin with, i.e. progress on each can be separately evaluated and presented as 5 variable equation e.g. a number of clients who are doing well on treatment, work, support group participation parameters but not involved in self-advocacy and cultural activities. Parameters for each domain could be measured as is suggested in each section.

Since this phase has no clear termination, the progress of clients should be informed at 1 years, at 2 years and at 3 years and then at 5 years. For those clients beyond 5 years, annual status reporting should be good.

### 7.9 Internal Check & Balance of process

As clinic-in-charge, you should keep an eye on relapse rates amongst clients who qualify in this phase. You should also focus on their self-esteem, self-confidence, and ability to cope with stresses in life. As these clients are followed up less, they

could slip under the radar, therefore, adopt the audit process suggested in the above process.

### 7.10 Evaluation / Audit of process

Each of the client in this phase should be written down as a detailed case study to understand what factors have led to recovery. Further, longitudinal follow-up of the clients would allow understanding how recovery is maintained, this is very important internal audit for this process **(Annexure 37)**

### 7.11 Gaps and Suggestions

There is currently no clear phasing of treatment hence it is difficult to understand the journey of clients in the treatment process, adopting of the phasing system and then reporting on the denominator would provide clearer picture on results

### 7.12 Training Requirements

Each of the major diagnosis seen in the clinic should be divided into its treatment phases and markers of each phase should be worked out with the clinical teams and social teams. Separate case sheets should be developed for each illness and used for training. The scales should also be clearly adopted for each diagnosis and then team trained to use them.

**END OF TRACK 1**

## Track 2 / Component 2

### Introduction

The Community-level work is the second component of UMHP. The difference between UMHP being an outreach of a mental health clinic versus a community-based mental health program is defined by track 2 or Component 2.

Track 2 is the gamut of processes and activities that are conducted with the general population in the community. The overall aim of UMHP has dependencies on community-level changes. The objectives of track 2 are following:

Improved level of awareness and knowledge on mental health, this is mental health literacy. It means that the community is able to understand that psychosocial problems are states which require treatment and are amenable to improvement. They should be able to attribute a person's changed thoughts, behaviors, and emotions to a state of the person that is not a part of the person's personality or character but an imbalance that is amenable to treatment, care, and support provided by mental health clinic (Track 1) or similar services.

Another dependency is that with above awareness, the attitude and behavior of the community members towards a person with psychosocial problems would change for the positive reducing stigma, discrimination, prejudice, etc. This means providing employment opportunities, taking care of the family, helping in crisis management, teasing or ridiculing homeless person with psychosocial behavior, avoiding marrying away as a measure of cure, etc.

Track 2 work follows track 1 for the reason that the mental health clinical service should be ready and available if a person with the psychosocial problem is identified. A referral to the clinic is generated. Further, preparation and setting up of track 1 is independent of track 2 because the location of mental health clinic is pre-decided by the location of the Ward Health Unit. All assumptions about the access of WHU from all corners of the community are therefore applicable to the mental health service as well.

So the track 2 is a much more difficult and unpredictable work than track 1. The design of UMHP allowed for the same workforce to be involved in both tracks, barring the doctor. In the grand design of things, the intention of UMHP is also to introduce community-level interventions that promote mental health, however, priority is for those with a psychosocial problem. At the time of documenting the

SOPs, some track 2 activities in the promotion space had just started (Life Skills training for school students).

In UMHP design, a Drop-in-centre is a part of track 2 rather than track 1 since it has several activities in health promotion dimension. The person with the psychosocial problem, his / her family and other members of the society see same faces when they go to the clinic or in the community. This is helpful and an important feature of the UMHP.

The processes in the preparatory phase and the core implementation phase of track 2 are described below, while evaluation of track 2 is considered along with that of track 1 in the evaluation section.

**<SEE ANNEXURES 38, 39 and 45>**

# 8. Track 2 / Project Phase 1: Community-level work / Preparatory Phase

**Process Holder:** Social Worker

| Needs Change | Good ☺ | Standard |
|---|---|---|

## 8.1 Scope / Overview of the process:

In the preparatory phase for track 2, two important processes are involved – first is the informal sanction or rather cooperation from the gatekeepers and important stakeholders of the community and second is an advertisement of the new mental health intervention to the community. Two critical activities in these processes are - familiarity with the local team members in-charge of track 2 and familiarity with the client group (community and its residents) including their attributes - different social groups, hamlets or smaller habitation units, major sources of employment, resources (schools, clubs, local doctors, important stakeholders, etc.). The processes would describe how to approach the clients, key message to be delivered and gauge their reactions.

## 8.2 Policy guiding this process

Sankalpa's belief that community is an essential resource and partner in the recovery of a person with psychosocial problems is expressed in engaging with the community in track 2 of UMHP. Sustainable changes in the community (knowledge, attitudes, behaviors) is the aim of track 2 and most services that Sankalpa has started. This philosophy of community engagement drives track 2 of UMHP.

## 8.3 Purpose / Objective of process

The objective of the process is to measure the situation in the community prior to the intervention called Baseline. Although project staff is familiarising itself with the

community, it is important to document the same. This would later serve as a base to compare the situation after a few years of intervention (Endline). A sound documentation and analysis is a requirement of this process.

### 8.4 Result expected from process

We expect two things to happen – first we expect to understand the knowledge, attitude, and behaviors of the community (its different groups) on mental health. How does community understand the causation, the progress of psychosocial problems, is it in line with modern thinking, why have they developed this line of thinking, etc. are key questions that are asked at this stage. This would help in designing Information material on mental health. Secondly, we aim to understand who important stakeholders in the community are and how they govern or influence the behaviors of community re mental health. We also expect to get insights at a superficial level on major social issues faced in community – domestic violence, substance use, occupations in the community, resources, etc. This baseline information is pivotal to the program.

### 8.5 Criterion / Preconditions in process

UMHP design allows it to be implemented in any community however, there should not be any major health concern in the community when the program is launched which diverts the attention of the community.

Some communities would have a prior experience with a mental health program and therefore have pre-conceived notions about it. This could be a deterrent or an enabling factor in UMHP implementation, but one that should be kept in mind before the program is launched.

## 8.6 List & Description of key activities & processes

| Key Activity | Main Role | Supporting Role |
|---|---|---|
| 1. Recruitment of the track 2 team | Program Coordinator | Social Worker |
| 2. Build a network (of community caregivers, local police, NGOs, CBOs, social welfare department of the Government and government hospitals) | Program Coordinator | Social Worker |
| 3. Baseline exercise | External agency | Program Coordinator |
| 4. Resource Mapping | Social Worker | Volunteers |

### 8.6.1 Recruitment of the track 2 team

In UMHP implemented by Sankalpa, community level work was to be done by the Urban Ward Health workers. In this case, while there was no fresh recruitment of staff, there was a need to engage with them. The meeting with staff is to debrief them on their roles and responsibilities and enthuse them on their work. The most important thing for the staff is reporting line, they would follow instructions given to them by their reporting officer. Hence in such engagements, the reporting officer shod be part of the debrief meetings and lead them.

**Share the big picture:**

It is important to share the complete design of the intervention with the track 2 team. While track 2 and 1 teams are most common, the doctor should know his / her team members and it is important that in this meeting they understand their role profile

Printed role profiles in the local language to be handed over by the Social worker or program coordinator to each staff.

**Who is my leader?**

It should be clear to the team who is leading them to avoid confusion in reporting. This is the biggest conflict that can arise and should be avoided right from the beginning. Since the staff would be working for different health programs, they need to understand whether they will have a different line of reporting for mental health or a different day to discuss the progress – whatever be the chosen mechanism, it should be clear

In case, the UMHP is implemented by a separate team then, in that case, the team recruitment is a priority. Select suitably qualified candidates and not necessarily members of the local community. Good staff members are capable of working in any location, therefore at the stage of building the team look for quality. Prefer women members in the team since most of the community work would involve interaction with families during day-time.

Team training on essential components of the program:

The team should be trained only for the task they are supposed to carry out. See **Annexure 47**

### 8.6.2 Meeting with the gatekeepers of the community

The program in-charge should meet the main gatekeepers of the community. The main gatekeepers[9] are – Ward Counselor, members of the local club, principal of the local school, major employers of the area, religious leaders, etc.

Irrespective of the team implementing UMHP (local ward health unit staff or separate staff), meeting with the gatekeepers should be scheduled. There are two reasons for this:

(i) Mental health programs aim to influence behaviors of local people towards those with psychosocial problems. This includes modulating the behavior of neighbors, other members of the community which can only be mediated by

[9] Gate keeper is a person who controls access to something or someone (Source: yourdictionary.com)

influential people who people listen to. Therefore, meeting with gate keepers inform them of this specific goal of UMHP.

As the program coordinator and Social Worker, you should meet the gatekeepers and introduce yourself and objectives of the program. It is important to create a high moral ground for the program. Remember, gate keeps are also representative of the same community that UMHP purports to intervene in. Only a high moral ground backed by scientific evidence would provide them the courage to overcome their own dogmas and believe in true purpose of UMHP

(ii) The second reason is to achieve more efficiency for the effort put in. approval by gatekeepers could provide easy access to schools, local clubs for different events that would enable message to be sent to many audiences.

### 8.6.3 Baseline Exercise

Baseline exercise is a formal statement of the situation as seen before intervention (UMHP) was started. It is required to understand changes in the community attributable to UMHP. Such evidence makes a case for UMHP in other wards.

As program coordinator, you should outsource the baseline to an external agency who is a specialist in undertaking such work. However, you should also use regular activities to gather evidence on the current situation. This internal collection of information would provide a control to information collected at baseline.

The scope of Baseline should be restricted to the items that should change in the community. These are mentioned above. Internal data collection should also be driven by same parameters.

Baseline report should be shared with important stakeholders for them to understand the current situation. Similar information from other locations should be collected from literature and a ranking of where this area stands should be given to the team and stakeholders

Baseline data should be inserted into the MIS to serve as one parameter for indicators

### 8.6.4 Resource Mapping

Resource mapping has been described in the outreach project. The outreach team has done good resource mapping. The UMHP team should do resource mapping on similar lines.

The project team should be oriented on the project and then sent to the community to visit each and every lane and draw a map of the area by hand. On this map, you should mark important resources such as religious places, trade clusters in the area and other organizations that could be of help in the awareness work, schools, colleges, hospitals, clinics, vegetable market, etc.

As UMHP Coordinator, you should get the team to do mapping for half a day and on their return discuss observations from the field visit. The maps and other information should be neatly organized in files.

If possible, maps should be digitalized. Resources identified should be made available in the MIS

### 8.7 Key Conclusion / Decision

This process prepares both the team and the community for the community level interventions that would follow the preparation. The community should be understood in gross terms and as a team, you should know the important stakeholders of the community which would help you in moving around the community.

### 8.8 Information Capture & Tracking the process

Preparation should identify several variables that would help understand the community, such as – different linguistic groups in the community, different habitations, main employment (main and marginal), status of women in terms of mobility and role performed, the newspapers and the news reported by them on main concerns in the community, etc. Two outputs should be kept for information capture – (i) Baseline information variables should be made available in program intervention design so that one is constantly reminded of change rather than wait for end line evaluation; (ii) if possible, mapping software should be used to place the information on a map to provide visual insight to the work which would prove very helpful in understanding access issues.

### 8.9 Internal Check & Balance of process

This process is led by the UMHP Coordinator and coordination with the team almost daily is a must. One or two team members should take responsibility for documenting the entire process including taking photographs. This is important and also provides quality control for the coordinator who cannot be present at all places

### 8.10 Evaluation / Audit of process

Quality check of the baseline is important on a sample basis and ideally, should be outsourced to a third agency if budgets are available.

### 8.11 Gaps and Suggestions

In the current process, there is no link between information from baseline and regular operations of track 2. This anomaly should be done away with. The MIS should provide baseline values of change parameters always and routine data collection should then inform the program against the background of the baseline values.

### 8.12 Training Requirements

Manual of Essential learnings in mental health should be developed and all staff should be trained on it. Further, standard methods of data collection for baseline should be adopted and staff should also be trained on them. This would allow the quality of routine data collection to be good and comparable to that of baseline.

A matrix should be developed to detail the function of a staff and competencies required to perform the function. Training is then organized to increase competencies.

**Resource for Learning:**

***Resource Material from WHO:***

1. A good resource is the World Health Organisation's toolkit for its course – "International Diploma in Mental Health Law and Human Rights". The training tool & materials have 7 modules that are handy for learning on mental health. Download link: (http://www.who.int/mental_health/policy/training/en/index2.html)

2. Planning and Budgeting to deliver mental health services. This manual is a good resource for the program manager

(Download link:
http://www.who.int/mental_health/resources/en/Planning_budgeting.pdf)

***Resource Material from NIMHANS***

1 Manual of Mental Health Care for Health Workers (NIMHANS, available at Director's Office)

2 Priority Mental Disorders Training Module ( NIMHANS, available at Director's Office)

3 Manual of Mental Health Care for Health Workers (3rd edition)/ 2004 by Drs. Murthy and Chandrashekar

All these publications can be bought from NIMHANS. The link provides more information on how to get them (
http://nimhans.ac.in/sites/default/files/Publication%20List_3rd%20draft.pdf)

# INSERT

**Fee**

The consultation by the psychiatrist and / or counselor was always free to the patient. This is an important decision since few patients have lost their savings paying fee for private psychiatrists and purchasing medicines. One client informed that treatment from a private psychiatrist cost him on an average INR 18,000/- to INR 24,000/- per annum (Doctor fee - INR 500/- per consultation per month and Medicines INR 1000-1500/- per month) This does not include the cost of other support services that the patient receives from the project therefore few receive any other additional support services. However, it is not only free service and some free medicines but quality of care that attracts patients to the clinic. However, the pressure of higher numbers could compromise quality and a certain ceiling of number needs to be kept for each clinic.

# 9. Track 2 / Project Phase 2: Community level work / Implementation

**Process Holder:** Social Worker

| Needs Change | Good ☺ | Standard |
|---|---|---|

## 9.1 Scope / Overview of process

This process describes how the core community level intervention is implemented to support track 1 activity. Track 2 has its own objectives which along with track 1 objectives help achieve the overall goal of UMHP.

The social worker and volunteer are the main agencies in this process. The interaction with the community is an important learning for the staff since at least the volunteers if not the social worker are usually one of them. Local beliefs, customs, and perceptions along with local politics influence community-level intervention. In a UMHP program which is relatively young, most processes are to change community knowledge and attitude on mental health. It does not yet go to influence the causal or contributory factors responsible for some of the problems. That would be taken up later or left to the other organizations who are specifically working on improving the proximate causes such as gender-based violence, resource distribution, unemployment, etc.

## 9.2 Policy guiding this process

The introduction of the team that they come from the ward health unit provides legitimacy to the community level interventions. The community might not, in the beginning, treat the volunteers with the same respect as it would the other professionally qualified staff. The policy that drives this process is the empowerment of the front line staff with knowledge on mental health that is both necessary for the job but also to convince the community. The volunteers who are one among the community have now gained knowledge and are an important resource for them to lean on. The other aspect of the policy is that knowledge in itself is empowering. New knowledge as received by the community delivered by a qualified team coming from

a legitimate service with blessing or support of key stakeholders should be an important change agent in the way mental health is perceived in the community.

### 9.3 Purpose / Objective of process

The core objective of this process is to deliver knowledge to the community and therefore bridge the knowledge deficit which is assumed to be responsible for late identification and inappropriate treatment of a person with psychosocial problems in the community.

The door to door visit is perhaps the most important part of the UMHP. It is the only instrument for understanding how the community lives and problems they face. This process brings the reality of the lives of people in the catchment area to clinical practice and both influence each other. It is in the reality of everyday living that treatment tries to find its context, bringing in the true meaning of community-based mental health.

### 9.4 Result expected from process

The result expected from this process is acceptance of the mental health program by the community. This acceptance is the most important element in a community-based program. The manner in which the staff interact and impart knowledge influences their acceptance in the community. Only on the bedrock of acceptance, other results such as improvement in knowledge of community on mental health, early identification of cases with psychosocial problems, bringing to treatment those who have been suffering from psychosocial problem since long but never received treatment, etc. can be seen.

### 9.5 Criterion / Preconditions in process

For community work, there should be some stability in the community. Any event that creates instability would affect community-level interventions.

9.6 List & Description of Key activities & processes:

| Key Activity | Main Role | Supporting Role |
|---|---|---|
| 1. Door to Door visit | Social Worker | Counselor, Volunteers |
| 2. Pocket Meeting | Social Worker | Volunteer, Counselor |
| 3. Awareness Meetings in Club, Schools, Auto Campaign | Social Worker | Volunteer, Counselor |
| 4. Medical Camps | UMHP Coordinator | Counselor, Social Worker |

### 9.6.1 Door to Door visit

The purpose of the door to door activity is:

1. To improve information and knowledge on signs of mental illness through face to face interpersonal communication. An information leaflet containing information is distributed in each household.
2. To inquire if there was anyone in the family or their acquaintance with symptoms suggestive of mental health problem (Identification).
3. to inform of the clinic and its services, especially clinic timings and that its free

In the community, a person with psychosocial problems is identified through the door to door identification visits by social workers or volunteer (or the corporation health workers) in the field areas (Ward 78, 82).

As Project Coordinator, you should coordinate this exercise.

There are three important parts to this exercise:

1. The instrument used to “Identify” and training of the team on this instrument

2. The introduction and presentation of the person to the family including the content of the introduction; material that is left behind with the family and

3. A strategy to cover the entire catchment area

As project coordinator, you should undertake following steps:

1. Make two-member teams for the door to door exercise. You should also be part of a team

2. The criterion for identification of a person with psychosocial problems should be outlined, team trained on them

3. You should do the planning for the door to door exercise. Divide the entire field area into smaller parts to be covered by the team.

4. Areas to be visited on a particular day should be marked on hand-drawn maps.

The instrument to be used for identification should be selected by the team in consultation with the professionals. It could be the General Health Questionnaire (GHQ), PHQ-9 or any other instrument which has been tested for a similar setting.

Currently, door to door identification does not use GHQ, it relies on the ability of the personnel (unstructured interview) to identify a person with a common mental disorder or severe mental disorder.

1. Organise training on the instrument to be used**(See Annexure 51)**

2. Organise a brief introduction & training for the team on psychosocial problems but do not spend much time in diagnosis, emphasize however on interview skills. The time available for the door to door interview is barely 7-10 minutes, hence in this time sufficient information has to be captured that allows the staff to conclude if the person has a problem or not

3. Training should be organized each day for first 15 days in two parts of 45 minutes each – first part in the morning before heading out to the field and then on return from the field.

**Entering the house, introduction:**

The Sankalpa team undertaking door to door visits is an all-female team and most of their interactions are also with women members of houses. The volunteers are local residents of the area and therefore know some households; this provides them access to local families.

The processes involved are as follows:

**1.** Initial introduction – Introduce yourself as part of the Ward Health Unit and **NOT from Sankalpa**

***Namaste! We have come from the Ward Health Unit!***

2. Introduce concept of psychological problems and available treatment for these; tension involving different tasks of daily life

***Mann ka problem hota hai na?***

3. Inform audience on symptoms and signs of both common and severe mental disorders.

4. Just as there is treatment for physical health problems, treatment is now available for psychological problems

5. Information leaflet – hand over information leaflet (see below)

**Information leaflet:**

The messaging with key messages in the community is done in rounds. While a young UMHP (up to 5 years old) might struggle to saturate the entire catchment with round 1 of key messages, as time passes by newer information become relevant to the community. This is then administered in form of round 2. In the current design, these rounds of key messaging are contained in the different version of information leaflets. For measurement of change, the concept of rounds should be kept in mind to understand what change has happened in the community after different rounds of information or key messaging (for details see Information tracking section).

You should leave information leaflet with signs and symptoms of mental illness with the family.

The main instrument is the information leaflet which is currently in its second version and bears information on signs and symptoms of mental illness. The leaflet is handed over to the family member and signature taken of those who attended the door to door meeting.

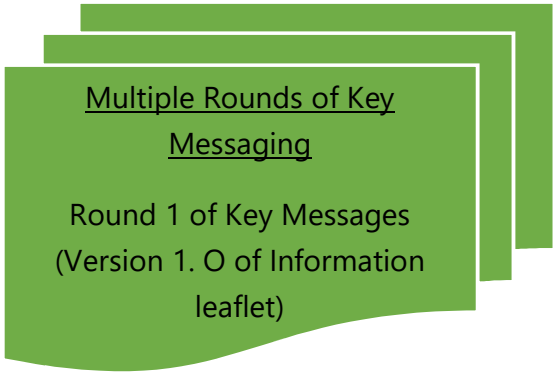
The information leaflet is an important document used by the volunteers during different awareness activities. There is a set of 6 leaflets, each on a singular topic/disease. The volunteers or other members of staff hand out relevant leaflets during door to door visit, depending on what they think could be the cause of suffering in the family if there is no suffering random leaflet is given out. There is no general mental health leaflet

The information leaflets are on following topics:

- Depression
- Anger
- Stress / Anxiety
- Psychosis
- Epilepsy

These leaflets are in Hindi, English, and Bangla. The leaflets have the mobile number of the contact person of Sankalpa and people are asked to come to Ward Health Unit if they find any need any help.

**Creating Version 3.0 of Information leaflet:**




The suggested process of creating version 3 of the leaflets is to study some of the reasons for "vulnerability" of the community and incorporate that information in leaflets. This could be on the lines of Brown and Harris Study, 1978 which studied the vulnerability factors amongst working women in London Burroughs. If a similar attempt is done, the program would get better insight into the problems faced

by women (main constituency) and many activities outside the clinic space could then be designed. The sight of this being a community mental health program as against a mental illness treatment gap reduction program has to be kept in mind. While the diagnostic signs and symptoms are appropriate, the above should be included.

**See Annexure 48**

**How often should the Door to Door (D2D) visit be done**?

- In the initial years of the program, conduct door to door visit frequently as the main activity (three days in a week).
- As the program matures and larger areas of the catchment are covered, change the frequency and strategy of the door to door visit. Consider door to door visits as rounds (like key messaging).

As program coordinator, identify a fixed period in each month dedicated to undertaking door to door identification instead of doing it thrice a week.

| Rounds of D2D survey | Generation of Key Messaging | Coverage |
|---|---|---|
| Round 1 | Generation 1 of KM | 100% of Catchment area |
| Round 2 | Generation 2 of KM | Only select houses in the catchment receive it. This selection is dependent on specific information needs of these households |
| Round 3 | Generation 3 of KM | 100% of Catchment area receive it |

**Data from door to door house visit:**

Transfer data of door to door visit captured in a register into soft copy - "Door to Door soft copy" (**Annexure 3**)

If a person is identified as a potential case, fill in the details in the IDENTIFICATION SHEET and advise the person or family member to visit the clinic on the day Psychiatrist

is available. The identification sheet data is translated into soft copy called "Potential Client List" (**Annexure 4**)

### 9.6.2 Pocket Meetings:

During door to door meeting, volunteers have never turned away, however, this activity has its limitation. The number of doors (households) is high and the average time spent at each house is around 5-7 minutes. The attention paid on messages and the depth of information shared is introductory. In order to overcome such limitations, the project conducts another activity – Pocket Meeting.

As a social worker, organize Pocket Meeting in a small part of lane or by-lane with few houses and few community members. On an average 10-15 people should be present in a pocket meeting. The setting should be informal and sufficient time should be available for discussion on key messages.

KAP Kit

The key messages should be part of the Knowledge, Attitude, and Practice (KAP) message kit.

These were originally 7 messages and another 8 have been developed by volunteers based on their observations in the community. You should continue to develop newer versions of this kit so messages can evolve along with the project.

The purpose of the pocket meeting is to increase information and knowledge of people through detailed discussion and dialogue. The volunteers are accompanied by a social worker, counselor, and rehabilitation officer depending on their availability. If the counselor and social worker are present, they take the main seat and discuss with the community (Ward 82).

**This is ABCD of Mental Health!!!**

Keep messaging around following themes:

1. Mental Illness is another illness like any physical illness

2. Identification signs of mental illness
3. Appropriate allopathic treatment for mental illness is available and should be sought
4. Prompt treatment is important and wasting time in superstitions should be avoided
5. One should not ill-treat person with mental illness
6. Emergencies in mental illness should be taken to government hospitals and not brought to the OPD
7. Marriage does not cure mental illness
8. Mental Health is a right and not a privilege

As Volunteers, your role is to meet the community members beforehand and inform them of purpose and time demand of meeting. Basic arrangements such as a mat on the floor, tea, biscuit and a banner should be made.

As Volunteer, you should distribute Information leaflets to all attendees. The dialogue between staff and audience is the main mode of discussion.

Either counselor or social worker, you should ask the audience how they would react in different scenarios involving a person with psychosocial problems.

| Do you have a digest of case scenarios to discuss with the audience? If not, prepare one |
|---|

If a response is incorrect, make a record of the same and then inform the audience of the correct response and rationale for it. This collection of incorrect responses is the data needed to understand KAP of the community.

Encourage the audience to share or speak their present or past experience/problems related to daily living or specifically with a person with psychosocial problems within their family or outside. This process of sharing experiences is very important, it allows externalization of thoughts and feelings for the audience but for staff it provides insight into how the audience is processing different issues related to their lives.

As Social Worker / Counselor, you should ensure that all women or members present in the meeting speak. There is a chance that one or two dominant speakers would influence others present, but try to break this up.

At times, the discussion would become free-wheeling with several parallel talks.

You might think that the community knows all the correct responses (knowledge) yet you have not seen a display of this knowledge in their behavior. This is ok since knowledge might not always get translated into action.

The meeting reinforces key messages even if the community seems to know them all. Even if the audience is mostly women look out for and encourage the participation of younger women especially adolescent girls. For them, this might be the first information on mental health.

A limitation is that pocket meetings leave out males from the discussion in the community. The males would be covered by awareness meetings in clubs or public information campaigns (discussed later).

Ensure that the meeting does not go beyond 35-45 minutes. If there are queries at the end of the meeting, try to resolve them.

Take Signature of all present.

**<SEE ANNEXURE 49>**

### 9.6.3 Awareness Meetings in Club, Schools, Auto Campaign

In addition to above community level awareness activities, Social worker / Volunteers should conduct awareness events in relevant local institutions such as local clubs and schools.

In the clubs, the audience is office bearers of the club and other members. They are important stakeholders and carry weight in society. Their involvement provides sanction to community work and helps in intervening in some situations.

Many times, clients or caregivers give more weight to the message if delivered or reinforced by club members. Involvement of this stakeholder group is very important for the program. The school students and teachers are informed of key messages in Mental Health. In both places, a power point presentation is used.

Auto campaigns are done by hiring an auto and messages from the KAP kit are announced as the auto travels across the catchment. The volunteer should do this work.

You should place the poster outside the auto so everyone understands what is the context in which the pitch is being made?

### 9.6.4 Medical Camps

Currently, medical camps are organized by the outreach team, however, it is advisable for UMHP to conduct camps in the area of the Ward Health Unit. This would help the community know of the service providers and vice versa.

As an anomaly, a few camps were jointly organized, rest is done independently. The processes involved in the camps are described in the outreach chapter. Same could be followed by UMHP when it scales up and decides to organize camps.

## 9.7 Key Conclusion / Decision

The key conclusion at the end of this process is that the team understand the community context and how the messages are received by the community. For the clients, recovery process has been initiated in the clinic which is carried forward through community-level interventions. Track 2 processes and activities try to modulate the environment in which the clients live

## 9.8 Information Capture & Tracking the process

In order to measure changes due to this process, it is important to do the following:

1. Identify contents of Key Messages (KM) that would be delivered in series i.e.
    a. 1st round = KM-1 (set of 5 messages)
    b. 2nd round = KM-2
    c. 3rd round = KM-3

    We assume that with 3 rounds, we would have delivered all the key messages

**KM-1 = 5 things on MH the community ought to know**

2. Now, different units of community or households will receive the generation of KM at different times, see below:

| | **Unit – 1** | **Unit -2** | **Unit – 3** |
|---|---|---|---|
| April 2016 | KM-1 | | |
| July 2016 | KM-2 | KM-1 | |
| October 2016 | KM-3 | KM-2 | KM-1 |

3. Identify changes expected after receipt of KM-1, KM-2, etc.
4. Decide time period after which results will be measured in sample of households belonging to Units 1,2 and 3
5. As suggested results should be measured in three-time intervals in sample households:
    a. Immediate: immediately after the messaging, zero time (t1)
    b. Short term: 1 month after messaging, +1 m (t2)
    c. Long-term: 6months post messaging, +6 m (t3)

| | Immediate | Short term | Long-term |
|---|---|---|---|
| | Zero month | +1 month | +6 month |
| | April 2016 | July 2016 | October 2016 |
| | t1 | t2 | t3 |
| KM-1 | R11 | R12 | R13 |
| KM-2 | R21 | R22 | R23 |
| KM-3 | R31 | R32 | R33 |

Code R11 = R stands for the word Result, 1 stands for KM-1 and the last 1 stands for t1.
Similarly, R12: Result for KM-1 at time period = t2 and so on
R21 stands for the result of KM-2 in time period t1.
The time schedule of events would look like the table below:

| | M-1 | M-2 | M-3 | M-4 | M-5 | M-6 | M-7 | M-8 | M-9 |
|---|---|---|---|---|---|---|---|---|---|
| **Unit 1** | KM-1 | | | KM-2 | | | | | |
| | R-11 | R-12 | | R-21 | R-22 | R-13 | | | R-23 |
| **Unit 2** | | | | KM-1 | | | KM-2 | | |
| | | | | R-11 | R-12 | | R-21 | R-22 | R-13 |

We will have to find a way to distinguish R-11 of Unit 1 from R-11 of Unit 2, a code can easily be identified for the units and can be added as prefix or suffix. It is the idea of measurement that is more important at this stage than a detailed manual of how to do it

6. Measurement should be done by the Program coordinator and not the team that delivered the KM.
7. See **Annexure 55**

| **Kinds of MIS** | | | |
|---|---|---|---|
| Client MIS | Community MIS | Program MIS | Logistics MIS |

**Result**: Communities should then be ranked on their levels of K, A, and P.

A community-level MIS should, therefore, be plugged into separately from the client based MIS and program based MIS. This community MIS should include resource mapping from the baseline and other descriptors of the community identified during mapping.

Few houses in the community should be identified for longitudinal measurement of KAP. They should be visited several times in immediate, short and long term post-delivery of rounds of a key message to understand changes.

### 9.9 Internal Check & Balance of process

Program coordinator should keep a check on the message delivered by the team to the community. This should be done by independent visits by the coordinator to some of the houses visited earlier by social worker and volunteers. The program coordinator should measure the response of the household on a questionnaire to understand immediate, short term and long term effect of messaging to the community.

The newer rounds of information called Key Messages should be developed and pilot tested and are principal contents of change. They should be approved by program coordinator.

### 9.10 Evaluation / Audit of process

Six monthly process audit of this process should be done. This is essential since the extent of spread of this process is large. If too much time gap in evaluation is allowed, then measurement of process fidelity might not be possible

## 9.11 Gaps and Suggestions

Track 2 process needs an analytical framework as has been suggested for track 1 above. This is important to link activities and processes to outcomes at the component level. A suggested framework is present in **Annexure 55**

It is suggested that door to door house visit should not be stopped or made less frequent or follow stricter criterion for case identification. All staff of Sankalpa should be made to undertake door to door as part of their annual orientation. For different projects, this would provide a good grounding and training of problems people face and what interventions would best suit them.

Currently, therapeutic interventions are provided in the clinic only, besides the doctor day other days are used for other therapeutic inputs. Only one-half of the day can be used due to timings of the Ward Health Unit. If there is a community space which can be used throughout the day then many therapeutic interventions can be moved there. This would allow more liberal case identification and based on the therapeutic inputs more cases can be identified. Since the clinic does not have an exclusion criterion, nearly all types of psychosocial problems come for doctor assessment and treatment planning.

## 9.12 Training Requirements

The team identifying potential clients in the community is not formally trained on identification but has picked up signs and symptoms based on their observation, discussion & informal training with colleagues in the clinics. There is no standardized process of training them and improving the output of this process - identification. This process is a most critical process in the program. There are two reasons for this: (i) The clinic provides psychiatrist consultation one day a week this, therefore, is the rate-limiting step; if more cases are identified then the clinic would be overwhelmed and lead to poor service performance; (ii) many neurological cases (Parkinsonism, Cerebral-Vascular Accidents) are also identified and brought to clinic, once they come to clinic, it is difficult to refuse them. They are a demand on time. Since many of these neurological cases could have co-existing disorders like depression, etc. the team has to be clear which case of depression would they consider. In such cases, if a neurological case is assessed to suffer from depression, referral notes should be issued to the treating doctor. Hence better

training on clear inclusion criterion would allow more specific screening leading to specific identification.

**End of track 2**

# Conclusion

The aim of identifying serious mental illness early enough to make treatment available and prevent homelessness informs the program design and components. The mental health clinic inside the ward health unit is an important achievement. In scale-up, absorption of mental health services into primary health care services would require more facilitation by Sankalpa and this experience of implementing UMHP would come in handy. Same is true for community-level interventions. While treatment, care, and support are immediate outcomes of the project, development of self-help groups and advocates would bring a change in mental health service provision not only in the ward but also in mental health in the city.

As more information is made available on mental health implementation, other thickly populated cities could draw from the example of Sankalpa and design their own programs. Sankalpa in such case would evolve as a training agency. UMHP is a constantly evolving program and these SOPs would also require revision after few years of further implementation of the program. Thus far, the journey of UMHP has been an eye-opener on how mental health delivery can be delivered in an urban location in a country like India.

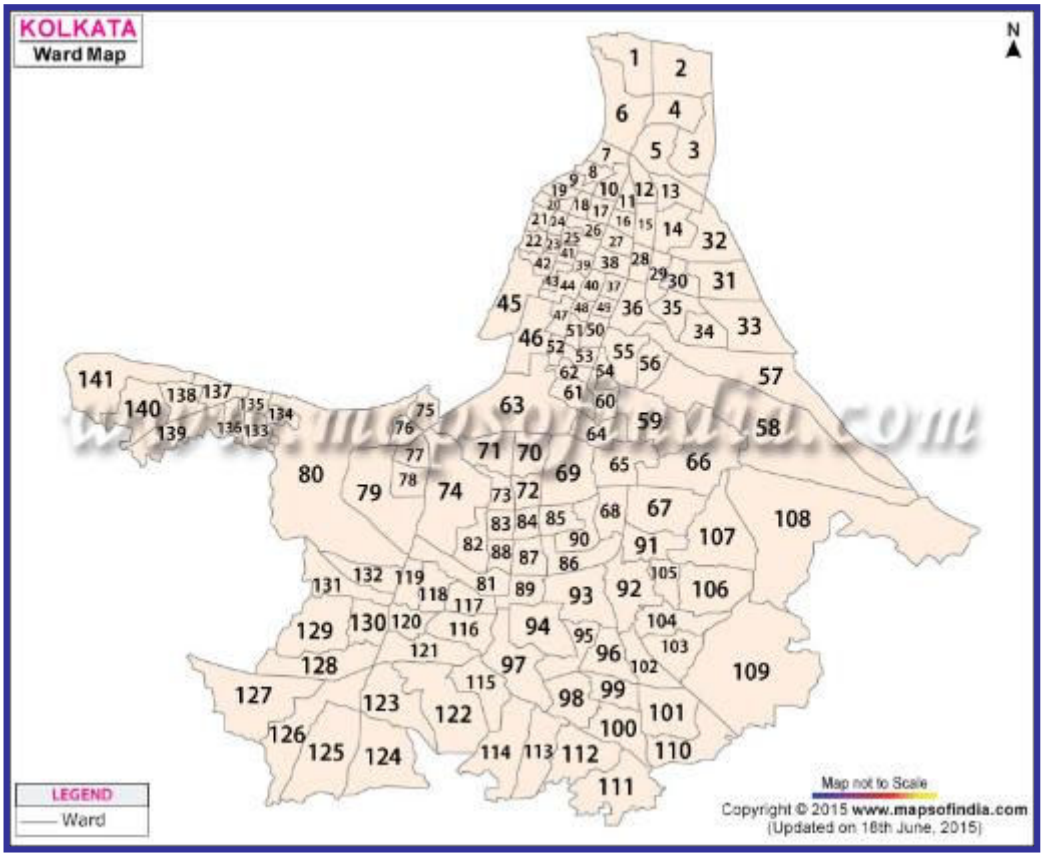
**----------END OF DOCUMENT----------**

# Annexures

Annexure 1: Ward 78, 82 (Census, 2011) & Ward Map, Kolkata

| | Ward 78 | Ward 82 |
|---|---|---|
| No. of Households | 10637 | 9,994 |
| Total Population | 54,090 | 38,838 |
| Males | 28,435 | 19,782 |
| Females | 26,655 | 19056 |
| Literate Population | 40,336 | 30,753 |
| Literate Population % | 75% | 79% |
| Literate Females | 17,874 | 14,331 |
| Literate Females % | 67% | 75% |
| Total Workers | 18,720 | 17,357 |
| Total Worker Females | 2,837 | 4882 |
| Total Worker Females (%) | 11% | 26% |
| Total Main Workers | 16,335 | 14,773 |
| Total main female workers | 2,023 | 3607 |
| Total main female workers | 71% | 74% |

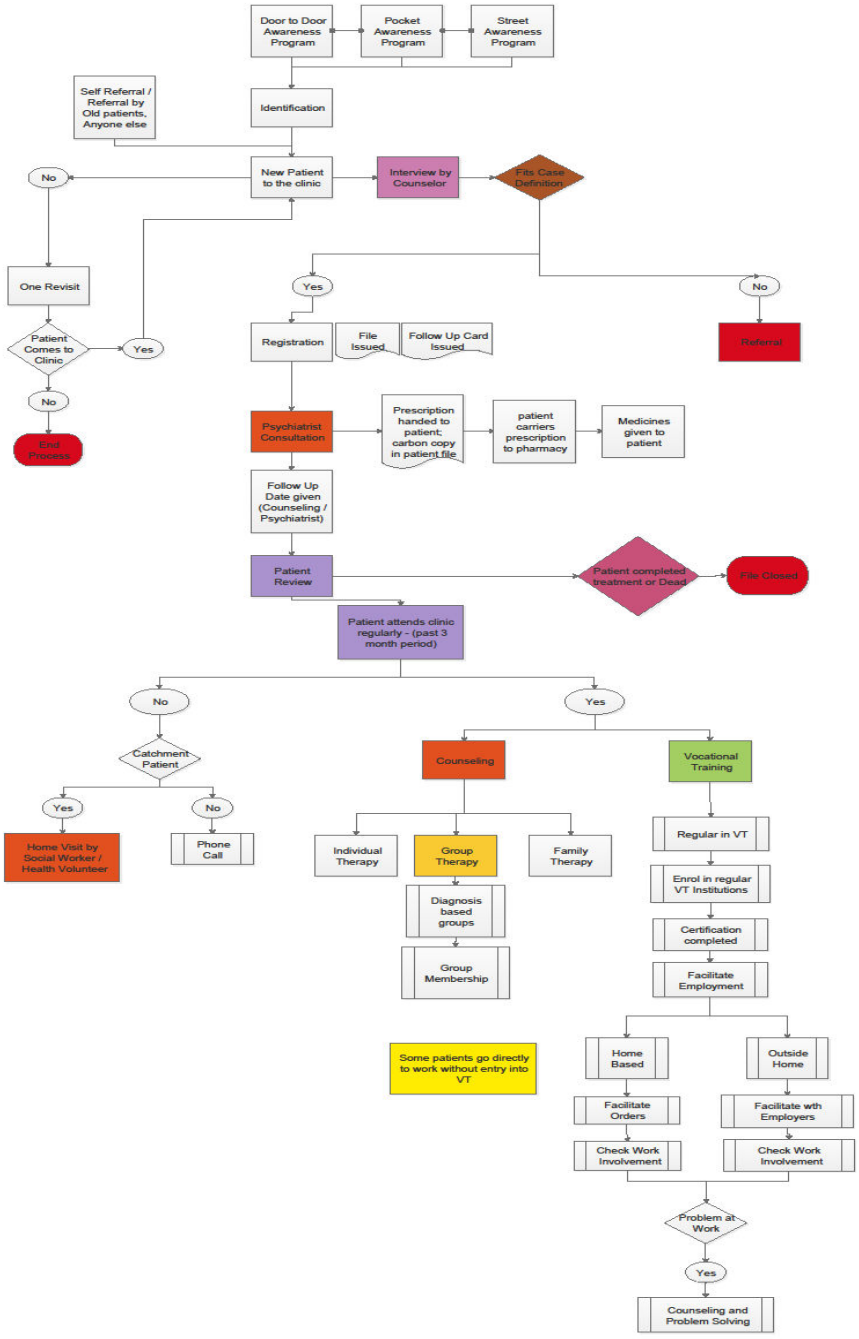
Source: Census 2011



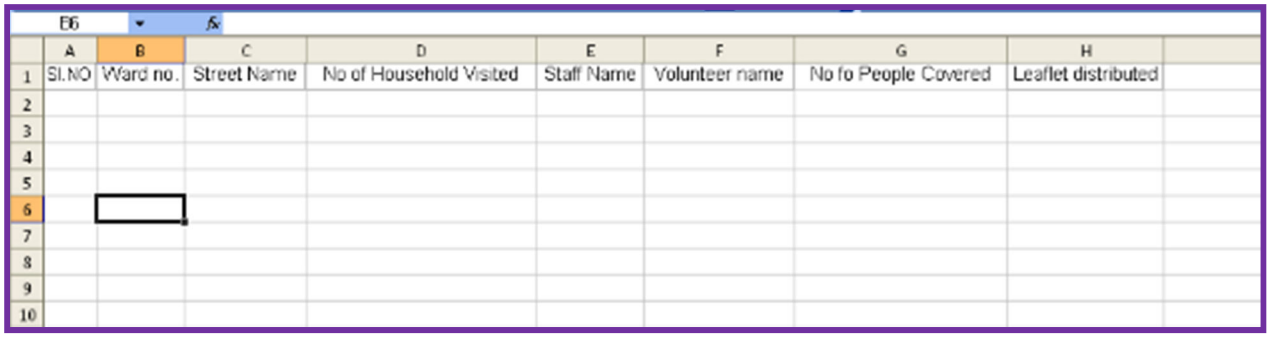

Location in Kolkata

Location in Kolkata

Annexure 2: Process Map of UMHP


Door to Door Awareness Program
Pocket Awareness Program
Street Awareness Program
Self Referral / Referral by Old patients, Anyone else
Identification
No
New Patient to the clinic
Interview by Counselor
Fits Case Definition
One Revisit
Yes
No
Patient Comes to Clinic
Yes
Registration
File Issued
Follow Up Card Issued
Referral
No
End Process
Psychiatrist Consultation
Prescription handed to patient; carbon copy in patient file
patient carriers prescription to pharmacy
Medicines given to patient
Follow Up Date given (Counseling / Psychiatrist)
Patient Review
Patient completed treatment or Dead
File Closed
Patient attends clinic regularly - (past 3 month period)
No
Yes
Catchment Patient
Counseling
Vocational Training
Yes
No
Home Visit by Social Worker / Health Volunteer
Phone Call
Individual Therapy
Group Therapy
Family Therapy
Regular in VT
Enrol in regular VT Institutions
Diagnosis based groups
Certification completed
Group Membership
Facilitate Employment
Some patients go directly to work without entry into VT
Home Based
Outside Home
Facilitate Orders
Facilitate wth Employers
Check Work Involvement
Check Work Involvement
Problem at Work
Yes
Counseling and Problem Solving

## Annexure 3: Door to Door SoftCopy



| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | Sl.NO | Ward no. | Street Name | No of Household Visited | Staff Name | Volunteer name | No fo People Covered | Leaflet distributed |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

**Figure 1: Door to Door Softcopy**

## Annexure 4: Potential Client List

| | | | |
|---|---|---|---|
| 1 | **Sl. No.** | 19 | **Family Size** |
| 2 | **Date of Identification** | 20 | **Hh Monthly Income** |
| 3 | **Name of HoH** | 21 | **Primary Caregiver** |
| 4 | **Name of the Client** | 22 | **Present Symptoms** |
| 5 | **Relation with the HoH** | 23 | **Duration of Illness** |
| 6 | **Ward no.** | 24 | **Past Treatment (Yes/No)** |
| 7 | **Street Name** | 25 | **Current Treatment (Yes/No)** |
| 8 | **Hh. No** | 26 | **Informant** |
| 9 | **Phone No** | 27 | **Referred By**<br>**1. Health worker**<br>**2. IS/Social Worker**<br>**3. Community Member**<br>**4. Self**<br>**5. Self-Advocates**<br>**6. Other clients**<br>**7. Police**<br>**8. CMHC Members**<br>**9. Events** |
| 10 | **Sex (M/F)** | 28 | **GHQ Screening Done (Yes/No)** |
| 11 | **Age** | 29 | **GHQ Score** |
| 12 | **Marital status** | 30 | **Screening is done by** |
| 13 | **Number of Children (If any)** | 31 | **Date of Registration** |
| 14 | **Religion** | 32 | **WHU No.** |
| 15 | **Caste** | 33 | **Registration Number (WHU)** |
| 16 | **Education** | 34 | **Revisit Date** |
| 17 | **Work status (Yes/No)** | 35 | **Reasons for not registering** |
| 18 | **Occupation** | | |

**Figure 2: Potential Client List**

Annexure 5: Task list of Volunteer

| SN | Tasks done by Volunteers |
|---|---|
| 1. | Door to Door Awareness & Identification drive |
| 2. | Pocket Meeting |
| 3. | Street Camp |
| 4. | Club Members Awareness |
| 5. | School Awareness |
| 6. | Community Support Group Meeting |
| 7. | Revisit |
| 8. | Home Visit |
| 9. | Helping in the OPD & Health Camp |
| 10. | Help in Vocational Training |

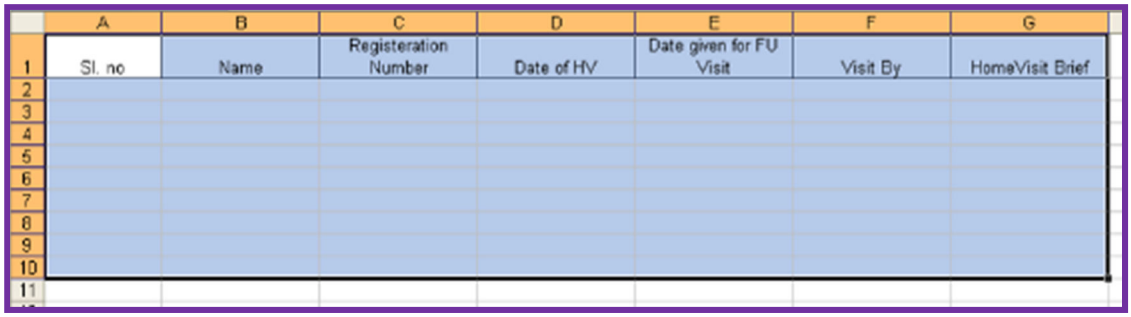
Annexure 6: Master Sheet

| S No | Field | Required in Scaled Up phase |
|---|---|---|
| 1. | S No | Yes |
| 2. | Name of Client | Yes |
| 3. | Name of head of household | Yes |
| 4. | Relation of head of household | Yes |
| 5. | File/registration number | Yes |
| 6. | Date of registration | Yes |
| 7. | Registration card was given | Yes |
| 8. | Address | Yes |
| 9. | Catchment | Yes |
| 10. | Clinic Ward No | Yes |
| 11. | Contact telephone number | Yes |
| 12. | Distance from home to WHU | Yes |
| 13. | Sex | Yes |
| 14. | Age (completed) | Yes |
| 15. | Marital status | Yes (refined as Current marital status) |
| 16. | Religion | No |
| 17. | Caste | No |
| 18. | Community | Rephrased as Catchment |
| 19. | Level of educational attainment (completed) | Yes |
| 20. | Work status | Yes, Refined as Current Work Status |

| | | |
|---|---|---|
| 21. | Employment Status | Yes |
| 22. | Living arrangements | Yes |
| 23. | Relation of Informant | Yes |
| 24. | Relation of Caregiver | Yes |
| 25. | Family Size | No |
| 26. | Household monthly income | No |
| 27. | Comorbid Medical Condition | Yes |
| 28. | Diagnosis (mental illness) | Yes |
| 29. | Grouping | No |
| 30. | Duration of mental illness | Yes |
| 31. | Mode of Onset | No |
| 32. | Course of Illness | Yes |
| 33. | Treatment history | Yes |
| 34. | Details | No |
| 35. | Family history of mental illness | Yes |
| 36. | Source of referral to WHU | Yes |
| 37. | Mental illness identification done by | Yes |
| 38. | Work Performance  before MI | Yes |
| 39. | Current Work Performance | Yes |
| 40. | Baseline IDEAS score | No |
| 41. | Baseline GAF score | Yes |
| 42. | Baseline FB score | Yes |
| 43. | Baseline CGI Score | Yes |

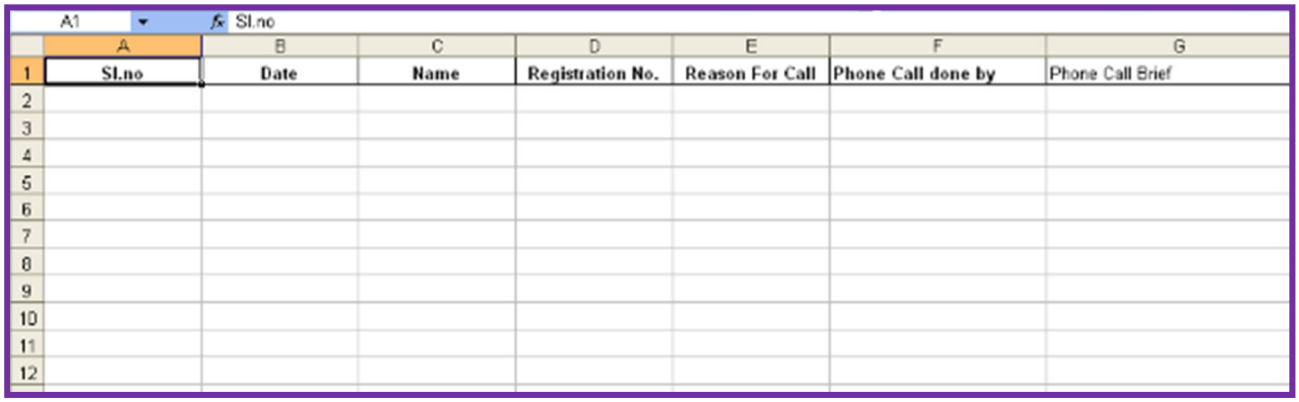
| | | |
|---|---|---|
| 44. | Medication and dosage | Yes |
| 45. | Planned OP follow-up date | Yes |
| 46. | Actual OP follow-up date | Yes |

## Annexure 7a: Home Visit Sheet



| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | Sl. no | Name | Registeration Number | Date of HV | Date given for FU Visit | Visit By | HomeVisit Brief |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |

## Annexure 7b: Phone Call Sheet



A1 fx Sl.no

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **Sl.no** | **Date** | **Name** | **Registration No.** | **Reason For Call** | **Phone Call done by** | Phone Call Brief |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |

## Annexure 8: Content of an Individual Case File

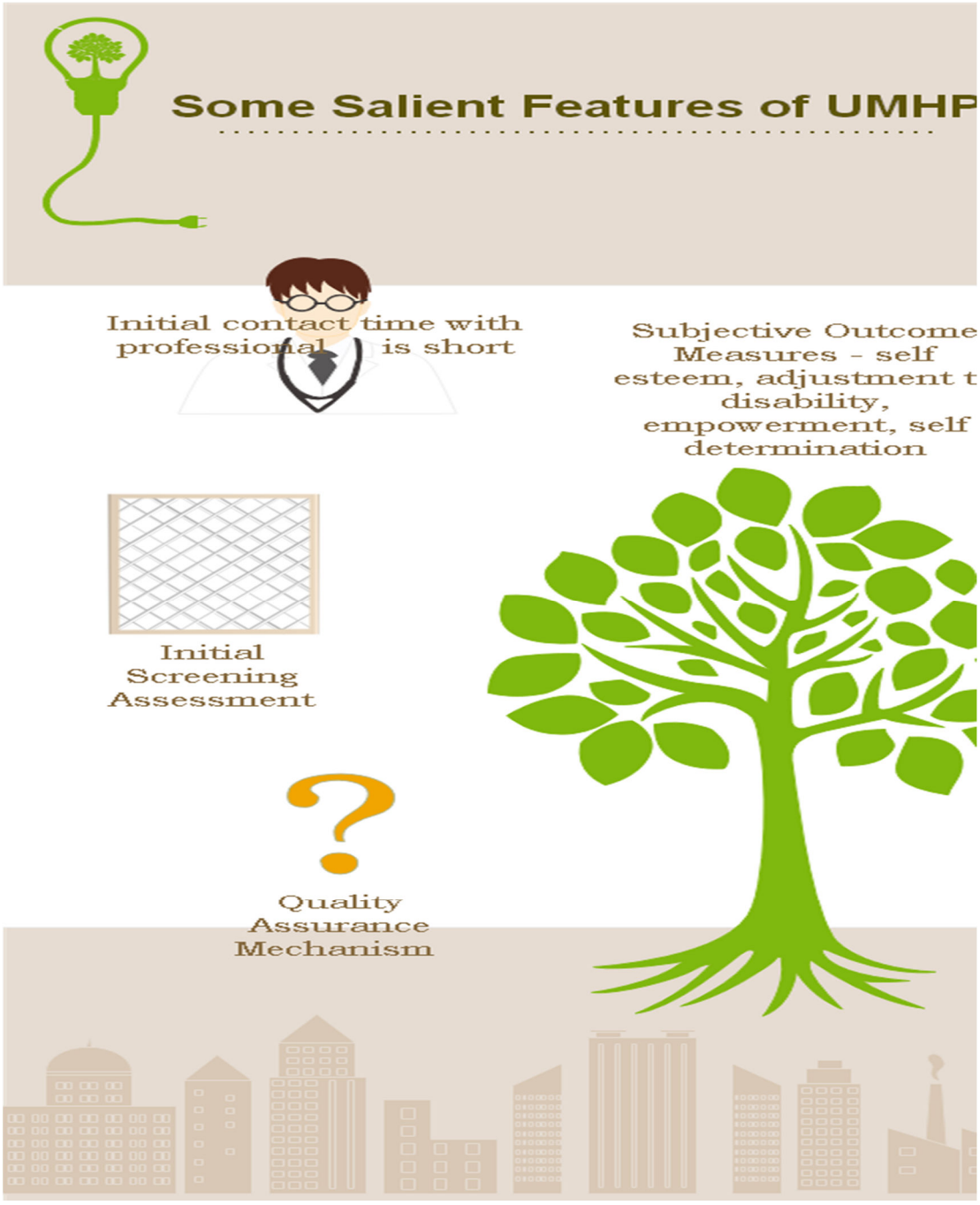
| | |
|---|---|
| 1. | Prescriptions arranged serially by date, latest on top |
| 2. | Intake Case Sheet (with MSE) |
| 3. | GHQ-12 |
| 4. | Doctor's Observations – longitudinal observations, prescription, and follow-up dates |
| 5. | CGI |
| 6. | Post-Intervention Scale Scoring Sheet in this order:<br>• GAF<br>• FBS<br>• IDEAS |
| 7. | Counseling Report |
| 8. | GAF Scale |
| 9. | IDEAS |
| 10. | FBS |
| 11. | Suicide Behavior Questionnaire – Revised (SBQ-R) |

Annexure 9: Different Registers & Cards kept in MHC

| | |
|---|---|
| **1** | **Daily Register:**<br>• Name<br>• File No.<br>• Contact Details<br>• Purpose of Visit: Follow-Up / Community / Door to Door<br>• Action Taken<br>• Remarks (Follow-Up date) |
| **2** | **Log Register:**<br>• Daily work report by each team member<br>• Meetings Minutes<br>• Summary statistics of daily work |
| **3** | **Home Visit Register**<br>• Identification<br>• Revisit<br>• Home Visit<br>• Awareness – Door to Door<br>• Visit NGO<br>• Employment Visit |
| **4** | **Referral Register**<br>• For Diagnosis<br>• For Psychometric |

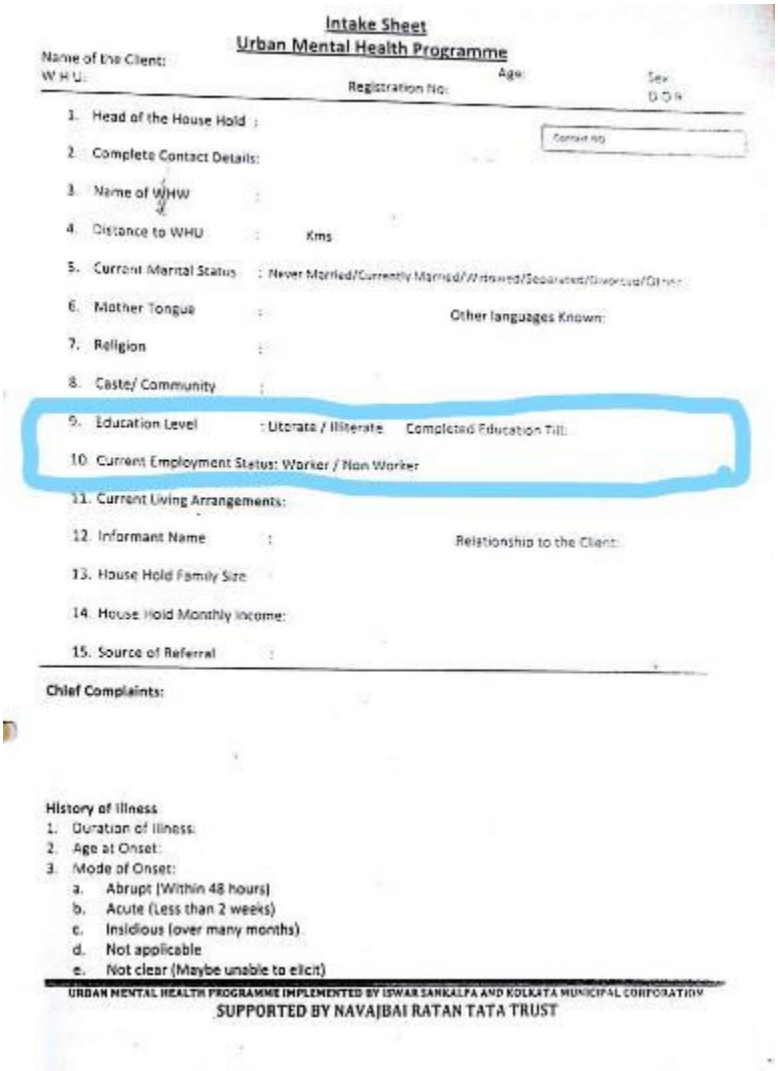
| | |
|---|---|
| **5** | **Copy of recording of Medicines distributed to clients given by Medical Representative**<br>• A ledger page for each medicine |
| **6** | **Medicine Copy**<br>• Distribution of Medicines per client from PHF funds |
| **7** | **Receipt of medicines from Medical Representative** |
| **8** | **Receipt Book for donation in kind** |
| | |
| | **Cards:** |
| **1** | **Home Visit Card** |
| **2** | **Attendance Sheet for Group Meeting** |

Annexure 10: Salient Features of UMHP



## Annexure 11: Case Intake Form

Highlighted section of case intake form to focus on person's level of skills[10]



**Intake Sheet**
**Urban Mental Health Programme**

Name of the Client:
W H U:
Registration No:
Age:
Sex
D O R

1. Head of the House Hold :
2. Complete Contact Details:
3. Name of WHW :
4. Distance to WHU : Kms
5. Current Marital Status : Never Married/Currently Married/Widowed/Separated/Divorced/Other
6. Mother Tongue : Other languages Known:
7. Religion :
8. Caste/ Community :
9. Education Level : Literate / Illiterate Completed Education Till:
10. Current Employment Status: Worker / Non Worker
11. Current Living Arrangements:
12. Informant Name : Relationship to the Client:
13. House Hold Family Size
14. House Hold Monthly Income:
15. Source of Referral :

**Chief Complaints:**

**History of Illness**
1. Duration of Illness:
2. Age at Onset:
3. Mode of Onset:
   a. Abrupt (Within 48 hours)
   b. Acute (Less than 2 weeks)
   c. Insidious (over many months)
   d. Not applicable
   e. Not clear (Maybe unable to elicit)

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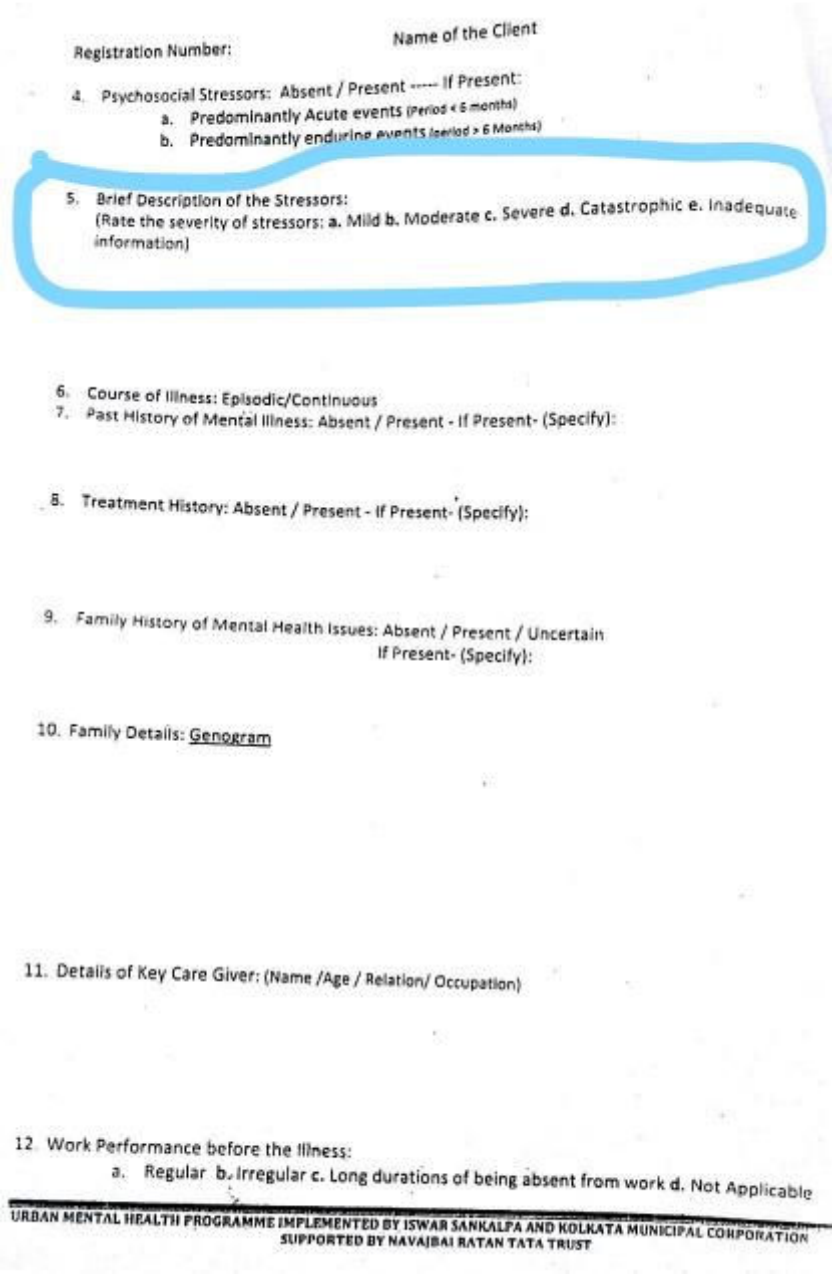
SUPPORTED BY NAVAJBAI RATAN TATA TRUST

[10] A person's level of skills is actually a better predictor of rehabilitation outcome than diagnostic variables (Anthony, Cohen, Farkas, & Gagne, 2001)

In above annexure, level of pre-existing skills of the client should be determined by a recording of skills prior to illness and present status. The later question on current and past work performance should also be brought to one place to make a meaningful conclusion on SKILLS of the person as predictor of recovery



Registration Number: Name of the Client

4. Psychosocial Stressors: Absent / Present ----- If Present:
   a. Predominantly Acute events (Period < 6 months)
   b. Predominantly enduring events (period > 6 Months)

5. Brief Description of the Stressors:
(Rate the severity of stressors: a. Mild b. Moderate c. Severe d. Catastrophic e. Inadequate information)

6. Course of Illness: Episodic/Continuous
7. Past History of Mental Illness: Absent / Present - If Present- (Specify):

8. Treatment History: Absent / Present - If Present- (Specify):

9. Family History of Mental Health Issues: Absent / Present / Uncertain
If Present- (Specify):

10. Family Details: Genogram

11. Details of Key Care Giver: (Name /Age / Relation/ Occupation)

12. Work Performance before the Illness:
   a. Regular b. Irregular c. Long durations of being absent from work d. Not Applicable

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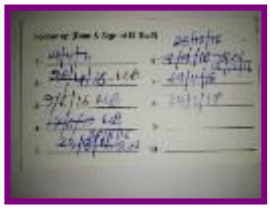
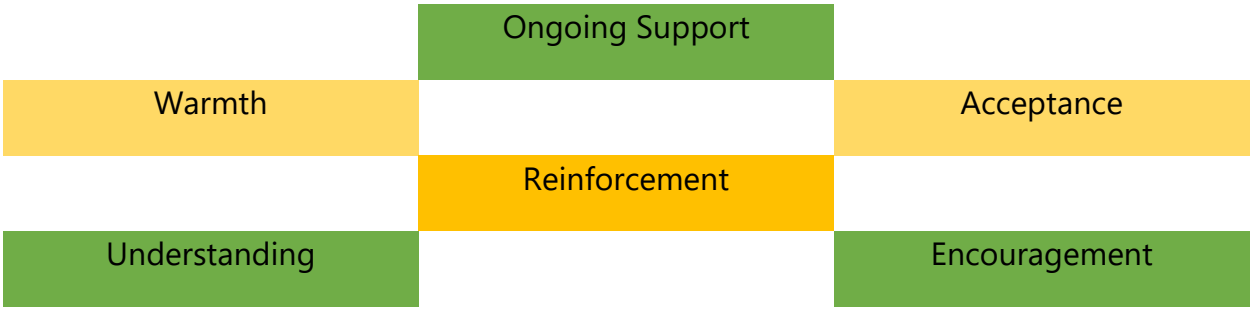
SUPPORTED BY NAVAJBAI RATAN TATA TRUST

The aim of the colored section is to record "Coping Strategy" of the client in line with stressors. It is important to record this information at baseline and regularly since building coping strategies would be a goal in treatment process

Annexure 12: Registration Card



Annexure 13: Support Elements of UMHP



## Annexure 14: Phases of treatment in depression[11]

**Table 9 -- Phases of Depression Treatment**

| Phase | Duration | Goal |
|---|---|---|
| **Acute** | About 3 months | To achieve complete recovery from signs and symptoms of acute depressive episode (i.e., remission). |
| **Continuation** | 4-6 months | To prevent relapse as patient's depressive symptoms continue to decline and his or her functionality improves. |
| **Maintenance** | 3 months or longer, depending on patient's needs | To prevent recurrence of a new depressive episode. |

Adapted from Alaxopoulos et al, 2001[9]

**Table 10 -- Most Common Psychosocial Interventions for Depression**

| Intervention | Preferred Techniques |
|---|---|
| **Psychotherapy** | • Cognitive-behavioral therapy<br>• Interpersonal therapy<br>• Problem-solving therapy<br>• Supportive therapy |
| **Psychosocial intervention** | • Bereavement groups<br>• Family counseling<br>• Participation in social events<br>• Psychoeducation |

Adapted from Alaxopoulos et al, 2001[9]

[11] http://www.michigan.gov/documents/mdch/bhs_CPG_Depression_Tables_9-10_206519_7.pdf

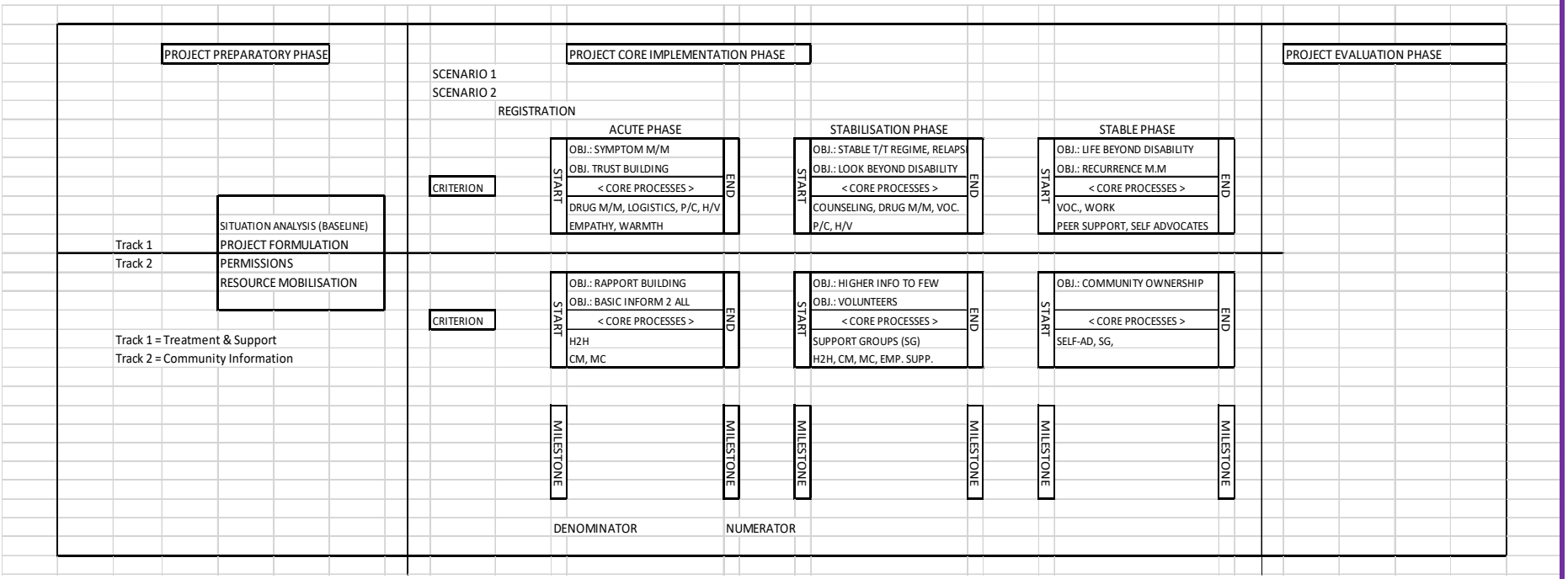
**Phases of treatment in Schizophrenia**

The treatment is divided into three phases:

| | | |
|---|---|---|
| Acute Psychosis in Schizophrenia | • Ensuring the safety of the client and the caregiver. Evaluating and treating precipitating factors.<br>• Rapidly resolving the client's psychotic symptoms.<br>• Establishing an effective and well-tolerated medication regimen.<br>• Beginning transitional phase to maintenance treatment.[12] | |
| Stabilization Phase | Relapse Prevention | |
| Stable Phase | Remission | |

[12] http://www.psychiatrictimes.com/articles/pharmacotherapy-acute-schizophrenia

## Annexure 15: UMHP FRAMEWORK



Annexure 16: Results or Changes expected in Stable Phase

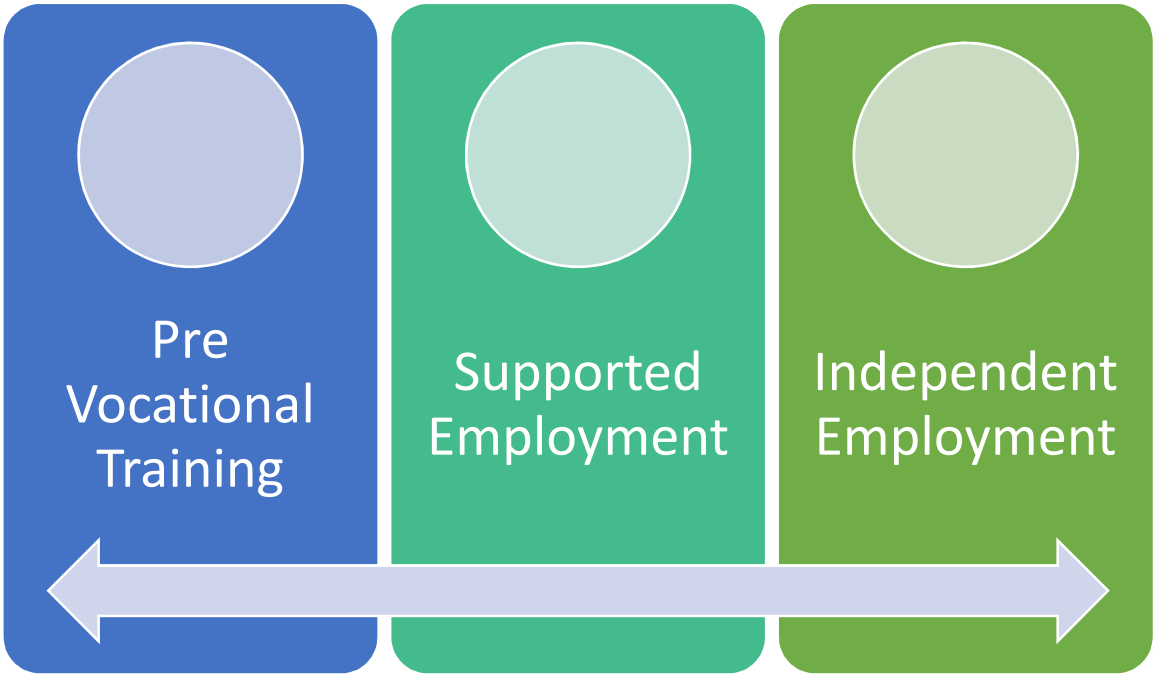
| S.N | Domain 1 | Domain 2 | Observation |
|---|---|---|---|
| 1 | Treatment | Peer Groups / Support Groups | Symptoms are managed well |
| 2 | Treatment | Peer Groups / Support Groups | Understands medicines and their effects on body |
| 3 | Treatment | Peer Groups / Support Groups | Crisis management plan in place |
| 4 | Treatment | Peer Groups / Support Groups | Has reasonable provider relationship |
| 5 | Treatment | Peer Groups / Support Groups | Feels that treatment is a resource that should be used for Recovery |
| 6 | Treatment | | Manages physical health well (management of illness or exercise ) |
| 7 | Treatment | | No substance abuse or takes treatment for abuse |
| 8 | Counseling | Support Group | Sense of self and identity |
| 8 | Counseling | Support Group | Acceptance of the illness |
| 9 | Counseling | Support Group | Hope |
| 10 | Counseling | Support Group | Coping with effects of past trauma (physical / sexual) |
| 11 | Counseling | Support Group | Active Coping Skills |
| 12 | Counseling | Support Group | Meaningful & Satisfying roles in community |
| 13 | Counseling | Support Group | Does not feel that one is alone in how one feels |

| | | | |
|---|---|---|---|
| 14 | Counseling | Support Group | Self-Efficiency and taking charge to change one's situation |
| 15 | Counseling | Support Group | Some satisfying relationships |
| 16 | Counseling | Support Group | Understands cost benefit analysis of actions |
| 17 | Counseling | Support Group | Is able to understand what is happening around him / her |
| 18 | Counseling | Support Group | Has an explanatory framework for his / her illness |
| | | | |
| 19 | Support Group | Self-Advocate | Cope with prejudice and discrimination |
| 20 | Support Group | | Has reasonable peer relationships |
| 21 | Self-Advocate | Support Group | Develops Personal advocacy skills |
| | | | |
| 22 | Vocational Training | Support Group | Acquires skills (educational or job) that gets the client a job |
| 23 | Vocational Training | Support Group | Is involved in work |
| 24 | Vocational Training | Support Group | Has some earnings from work |
| 25 | Vocational Training | Support Group | Has sense of self-respect ( related to livelihood) |

Annexure 17a: Screen Chronic Physical Health Conditions in person with MI

- Alcohol Abuse
- Asthma
- Primary Hypo/Hypertension
- Nicotine Dependence
- Obesity
- Anemia
- COPD
- Diabetes
- Chronic Skin Ulcer
- Migraine
- Fluid Electrolyte Acid-Base
- Hypercholesterolemia
- Persistent Cognitive and Gait
- Delirium, Encephalopathy
- Other

Annexure 17b: Employment Cycle in UMHP



Annexure 18: Checklist to see if the client is coping with work

| S.No. | Item | Yes / No |
|---|---|---|
| | **For the Client** | |
| 1. | Is the client interacting with others | |
| 2. | Is the client learning the job | |
| 3. | Is the client maintain work stamina / pace of work | |
| 4. | Is the client managing symptoms / tolerating stress | |
| 5. | Has there been an improvement in the self-esteem of the client? | |
| 6. | Has there been an improvement in the financial situation of the client? | |
| 7. | Is the client working full time or half time? | |
| | **For the Employer** | |
| 8. | Is the employer treating the client fairly as others | |
| 9. | Is the employer paying the client as per work performed at par with others | |
| 10. | Is the employer exploiting the client in any way | |
| 11. | Is the employer agreeable and has made changes to accommodate the client at work | |

Annexure 19: UMHP Clinic Manager's Checklist

| Serial No | Item | Check |
|---|---|---|
| 1 | Is the clinic space ready to function today? | |
| 2 | Is the working area for staff comfortable | |
| 3 | Is the waiting area for clients comfortable | |
| 4 | Does the client have privacy when speaking to counselor and doctor? | |
| 5 | Are all forms meant to record different information properly stacked for use? | |
| 6 | Are the medicines in order as per requirement? | |
| 7 | Are the files easily retrievable? | |
| 8 | Are there new files for use? | |
| 9 | Are there enough handout material to be given to caregivers | |
| 10 | Are there Registration Cards? | |
| 11 | Are all staff trained for the job especially crisis intervention | |
| 12 | Are all staff trained to follow protocol adopted for clinic | |
| 13 | Do I have the clinic summary form to understand what happened in the clinic today | |
| 14 | Are there more than one staff trained for a job - registration desk, scales administration, etc. | |
| 15 | How do we handle clinic if clinical staff does not come, do I have replacements? | |
| 16 | Have I filled in the summary sheet of the clinic work today? | |

| | | |
|---|---|---|
| 17 | Have I scheduled the review meeting of clinic performance for this month? | |
| 18 | Did we have a meaningful discussion on our achievement as a clinic in the last meeting? | |
| 19 | Is the electronic database up to date? | |
| 20 | are all papers that provide legal validity to this clinic in place and updated? | |
| 21 | Do I have adequate petty cash and are all accounts settled? | |

## Annexure 20: Personal Health Planner Sheet

The change I would like to make is: _____

The steps I will take to achieve this goal are:

_____

_____

The things that could make it difficult to achieve my goal are:

_____

My plans for overcoming these barriers are:

_____

_____

My confidence in being able to make this change is, on a 1 to 10 scale: _____

Signature

My goals should be S.M.A.R.T.:

- Specific
- Measurable
- Action-oriented
- Realistic
- Time-limited

Annexure 21: Purpose of Support Group

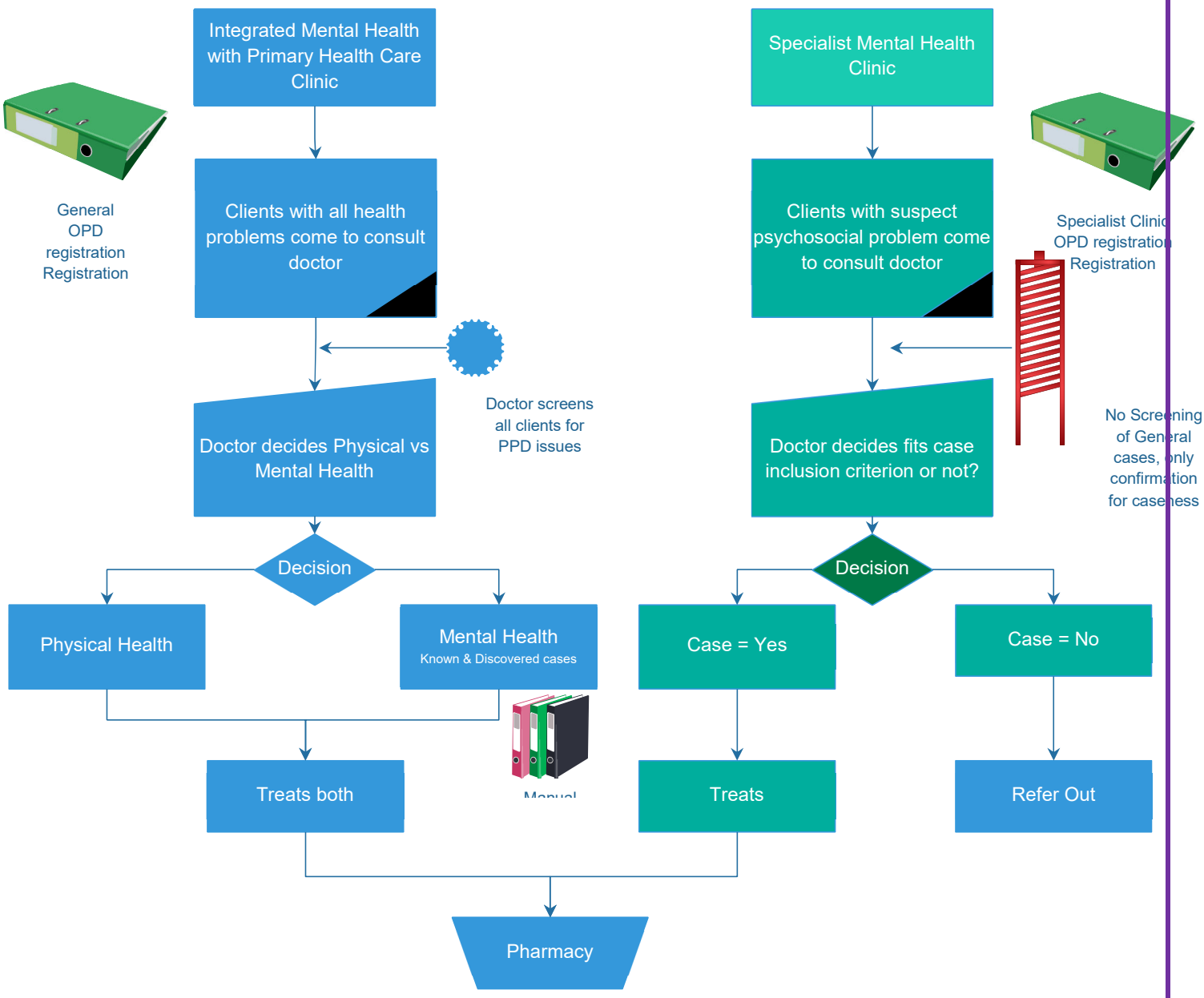
- Meet together to discuss personal experiences dissipating the feeling that "I am alone" with this problem
- Identify common problems
- Share Ideas to resolve these problems
- Provide Emotional support to each other in the group and even outside

Annexure 22: Inserts!

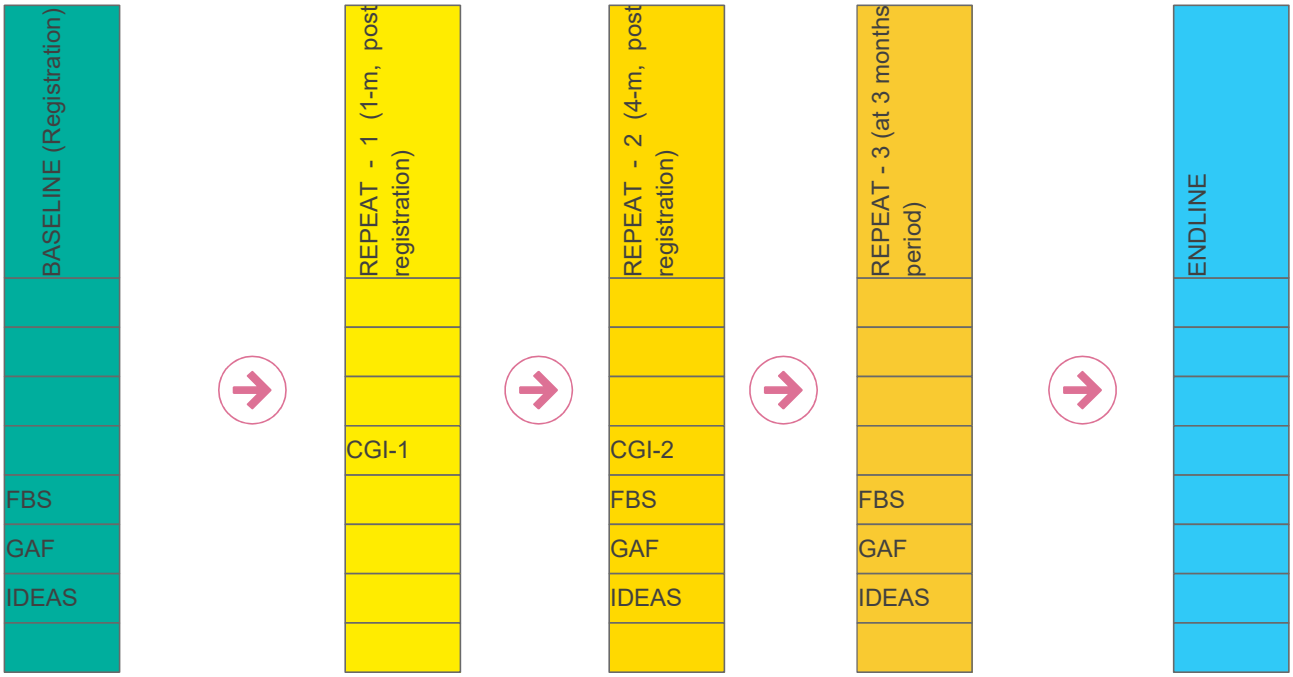
When does the client **accept** Medicine?

When does the client stop describing him/herself as a client and start referring self as an individual?

## Annexure 23: General Mental Health vs. Specialist Mental Health Service



Annexure 24: Measuring progress of client



Annexure 25: Unique File Number

UNIQUE FILE NUMBER

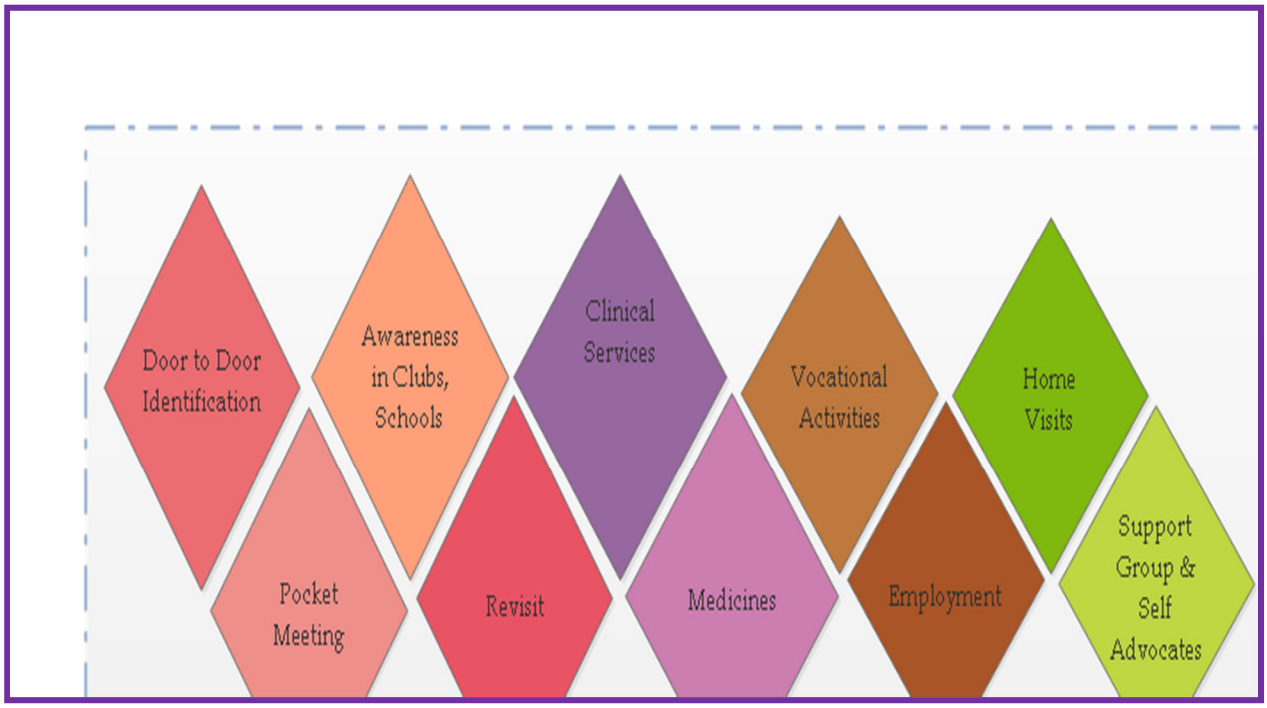
*Annexure 26: Original Design vs. Modified Design of UMHP*

*Table: Comparison between Original & Modified Design of UMHP*

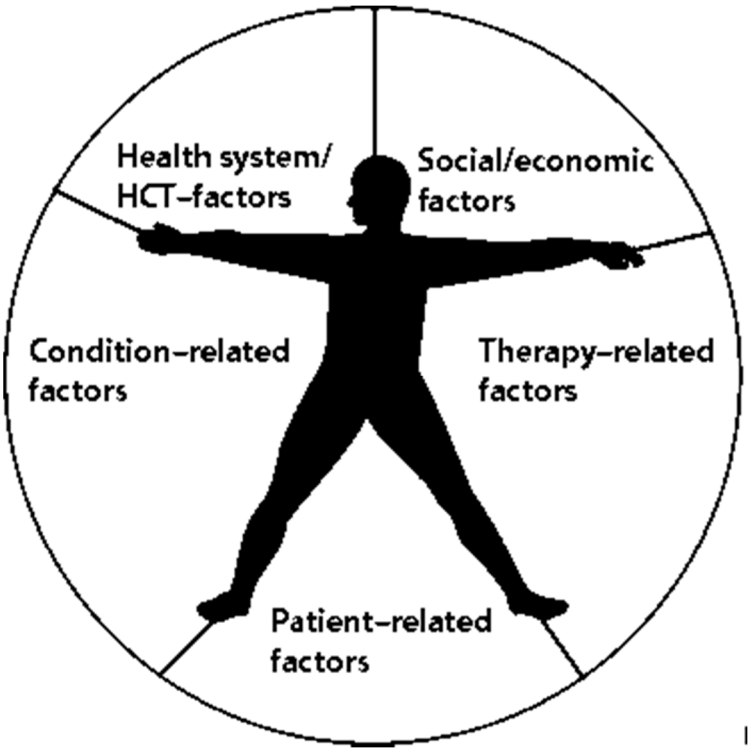
| *Activity* | **Original Design (Integrated Mental health services with general health services)** | **Modified Design (Specialist Mental Health services)** |
|---|---|---|
| *Track 1 (Clinic)* | | |
| *Mental health clinic* | No separate clinic although counseling staff would be available who would screen clients and refer to Primary health care doctors for treatment, care and support | Separate clinic, separate registration, separate mental health staff |
| *Who does the assessment and drug treatment for clients with psychosocial disability?* | Existing primary health care Doctors of Urban Ward Health Unit | Psychiatrist appointed by UMHP |
| *Where do clients register?* | Registration counter common for all clients | Separate registration for clients of this service who do not register in the general OPD registration |

| | | |
|---|---|---|
| *Who supplies medicines?* | Urban WHU Pharmacy provides medicines | Medicines provided by KMC + UMHP (limited extent) |
| *Who provides counseling services* | No provision | Counselor provides counseling services |
| *Who conducts support activities* | No provision | Support groups, Self-Advocates, Vocational Activities |
| *Track 2 (Community Work)* | | |
| *Who undertakes Community awareness on mental health and screening of person to identify those with psychosocial disability and refer them to clinic* | Ward Health Workers | UMHP staff |

Annexure 27: Different Elements of UMHP



Annexure 28: The five dimensions of adherence (WHO)[13]




[13] http://apps.who.int/medicinedocs/en/d/Js4883e/7.2.html#Js4883e.7.2.1

| Annexure 29a: Factors Reported To Affect Adherence | | |
|---|---|---|
| 1. SOCIAL AND ECONOMIC DIMENSION | 2. HEALTH CARE SYSTEM DIMENSION | 3. CONDITION RELATED DIMENSION |
| Limited English language proficiency | Provider-client relationship | Chronic conditions |
| Low health literacy | Provider communication skills (contributing to lack of client knowledge or understanding of the treatment regimen) | Lack of symptoms |
| Lack of family or social support network | Disparity between the health beliefs of the health care provider and those of the client | Severity of symptoms |
| Unstable living conditions; homelessness | Lack of positive reinforcement from the healthcare provider | Depression |
| Burdensome schedule | Weak capacity of the system to educate clients and provide follow-up | Psychotic disorders |
| Limited access to healthcare facilities | Lack of knowledge on adherence and of effective interventions for improving i | Developmental disability |
| Lack of healthcare insurance | Client information materials are written at too high literacy level | |
| Inability or difficulty accessing pharmacy | Restricted formularies; changing medications covered on formularies | |

| | | |
|---|---|---|
| Medication cost | High drug costs, copayments, or both | |
| Cultural and lay beliefs about illness and treatment | Poor access or missed appointments | |
| Elder abuse | Long wait times | |
| | Lack of continuity of care | |
| 4. THERAPY-RELATED DIMENSION | 5. CLIENT-RELATED DIMENSION | |
| Complexity of medication regimen (number of daily doses; number of concurrent medications) | Physical Factors | Confidence in ability to follow treatment regimen |
| Treatment requires mastery of certain techniques (injections, inhalers) | Visual impairment | Motivation |
| Duration of therapy | Hearing impairment | Fear of possible adverse effects |
| Frequent changes in medication regimen | Cognitive impairment | Fear of dependence |
| Lack of immediate benefit of therapy | Impaired mobility or dexterity | Feeling stigmatized by the disease |
| Medications with social stigma attached to use | Swallowing problems | Frustration with health care providers |

| | | |
|---|---|---|
| Actual or perceived unpleasant side effects<br><br>Treatment interferes with lifestyle or requires significant behavioral changes | Psychological/Behavioral Factors<br><br>Knowledge about disease<br><br>Perceived risk/susceptibility to disease<br><br>Understanding reason medication is needed<br><br>Expectations or attitudes toward treatment<br><br>Perceived benefit of treatment | Psychosocial stress, anxiety, anger<br><br>Alcohol or substance abuse |

*Sources: Miller et al., 1997; Nichols-English and Poirier, 2000; Vermiere et al., 2001; World Health Organisation, 2003; Krueger et al., 2005; Osterberg and Blaschke 2005*

Annexure 29b: Modified telephone call sheet

| | |
|---|---|
| 1. | Serial Number |
| 2. | Date of the call |
| 3. | Name of the client |
| 4. | Registration Number of the client |
| 5. | Is this a scheduled call or an emergency call? |
| 6. | Category of treatment to which the client belongs |
| 7. | What was the Reason For Call? |
| 8. | Who did the Phone Call? |
| 9. | Was the phone call received (Yes / No)? |
| 10. | Mention in brief the transaction of the Phone Cal (text) |
| 11. | In the Assessment of the caller, was the client (i) Better; (ii) Worse or (iii) No Change) |
| 12. | Did you share with the client the date of the next call? |
| 13. | Schedule the date of the next call |
| 14. | Did you give the client a target that you would follow up in the next call? |

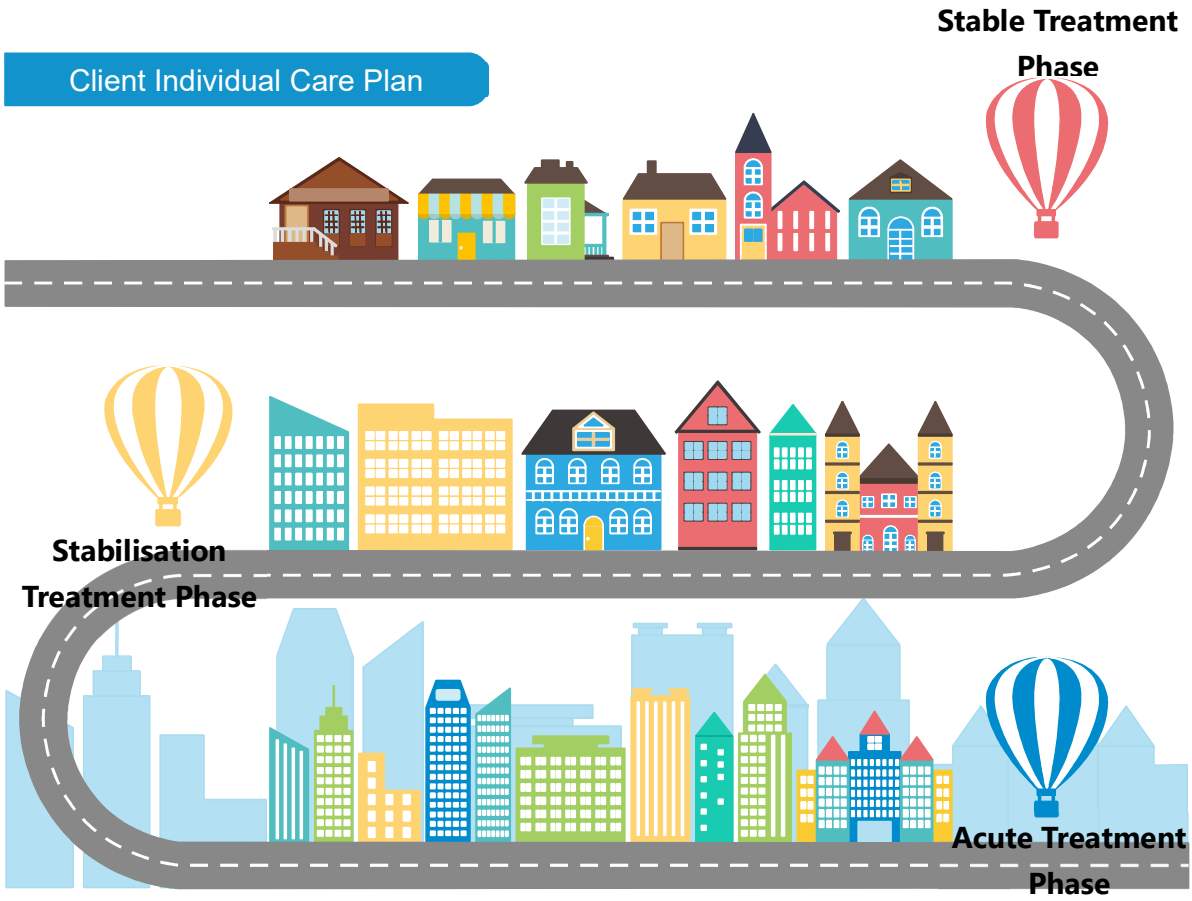
Grey fields are modified fields

Annexure 30: Sample Client Report Card

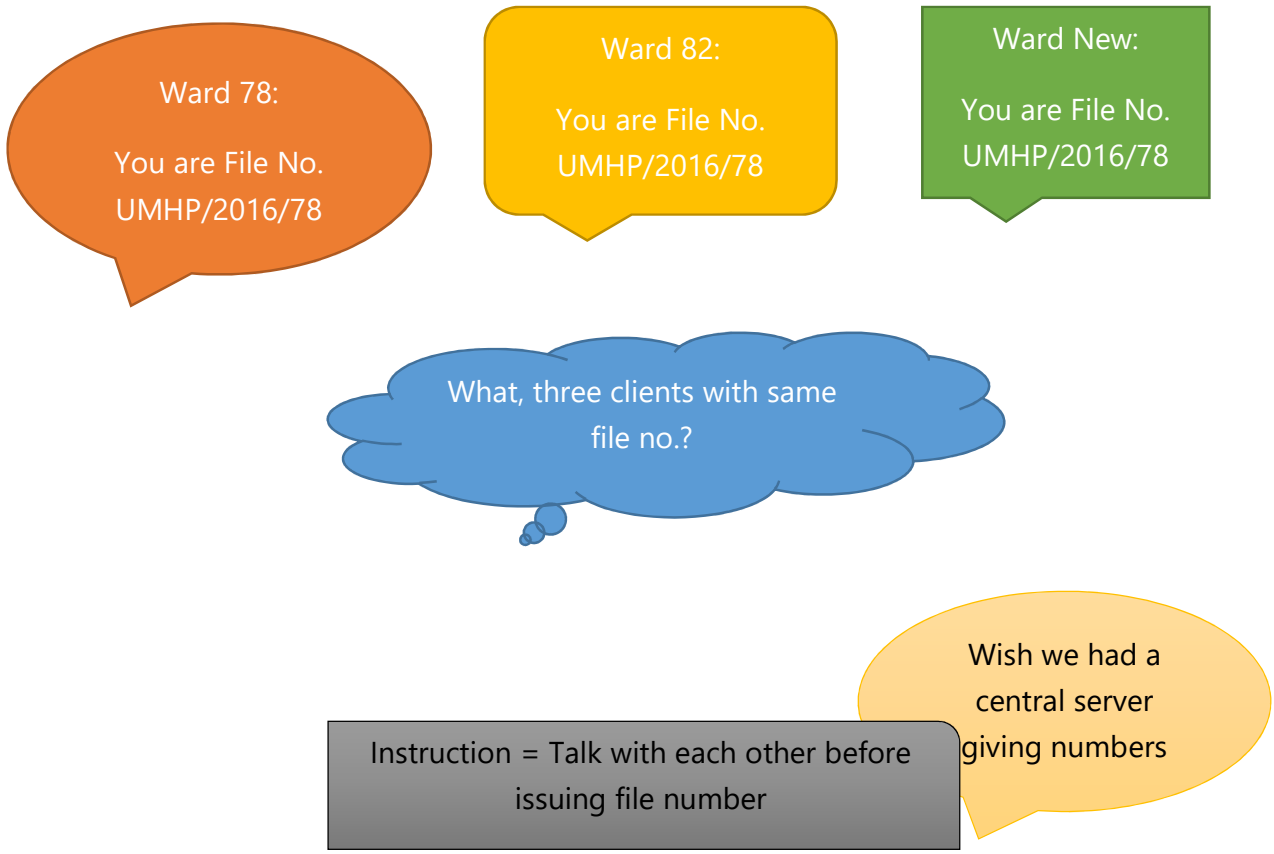
Age: 63 Sex: Male MR# 7554

| | Goal | | Nov 2010 | May 2009 |
|---|---|---|---|---|
| Weight | | | 235 | 240 |
| B/P | Less than 130/80 Best 120/80 | | 125/80 | 148/88 |
| **Tests** | | | | |
| HbA1c (sugar for 3 months) | Less than 7 Best if 6 | | 6.5 | 8.5 |
| LDL (lousy cholesterol) | Less than 100 Best if 70 | | 170 | 165 |
| HDL (happy cholesterol) | Greater than 40 | | 37 | 35 |
| Triglycerides (a bad fatty substance) | Less than 150 | | 150 | 250 |
| **Medication** | | | | |
| Aspirin (prevents heart attacks) | Take daily | | Yes | Yes |
| **Important Yearly Activities** | **Goal** | **Status** | **Next Test Due** | **Most Recent Test** |
| Eye Check (to prevent blindness) | 1 time a year | Overdue | 5/22/2010 | 5/22/2009 |
| Foot Check (to check for sores and numbness | 1 time a year | Completed | 5/22/2011 | 5/22/2010 |
| Urine Micro Albumin (to check for kidney failure | 1 time a year | Overdue | 5/22/2010 | 5/22/2009 |
| Flu Shot (to prevent flu) | 1 time a year | Completed | 11/22/2011 | 11/22/2010 |
| Pneumovax(to prevent special pneumonia) | Once in lifetime 2 times if first given before age 65 | Overdue | | |
| Smoking is dangerous to your health and increases the complications of diabetes. | Please stop smoking. | | Current Smoker | Current Smoker |

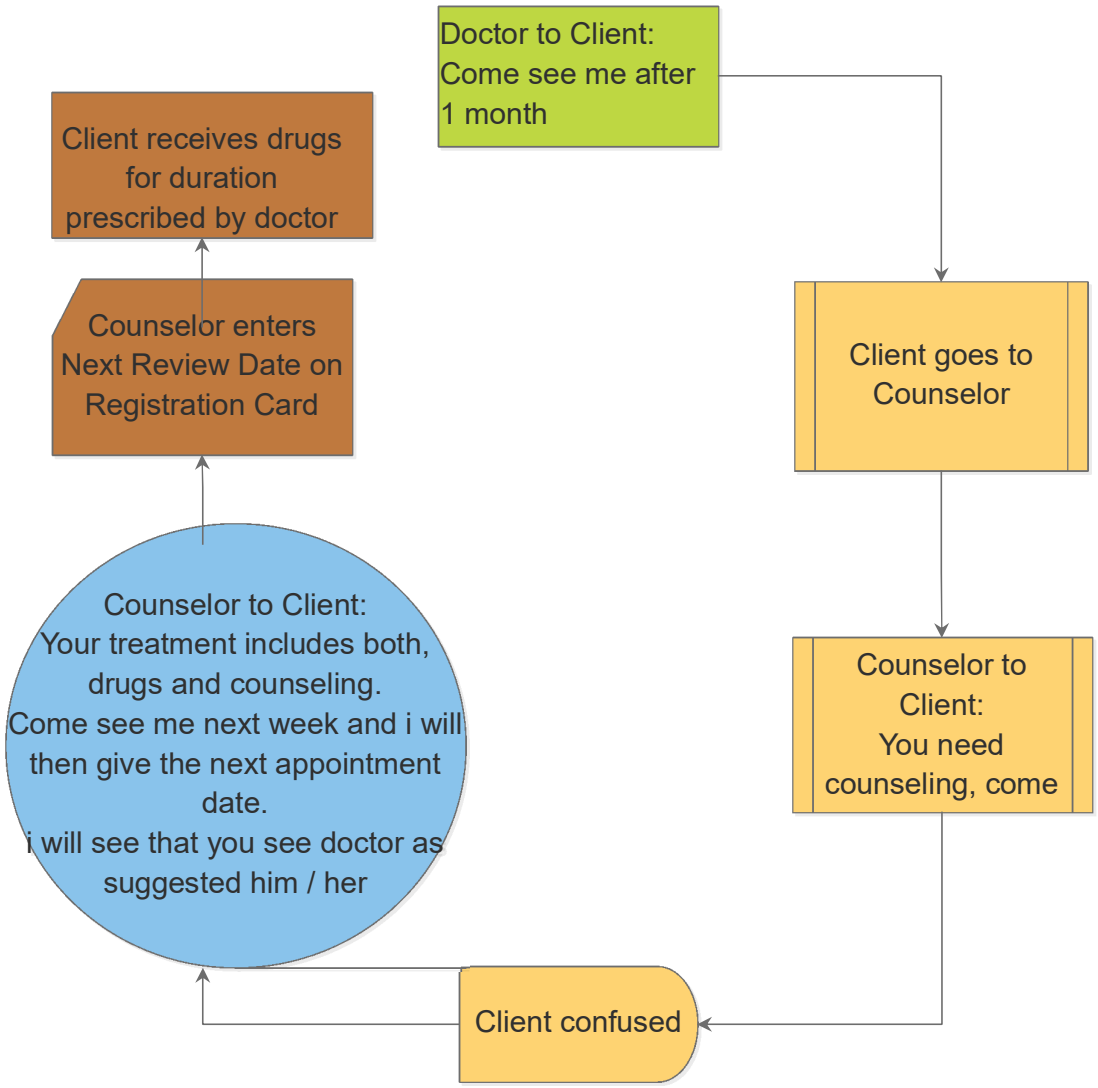
Annexure 31: Client Individual Care Plan



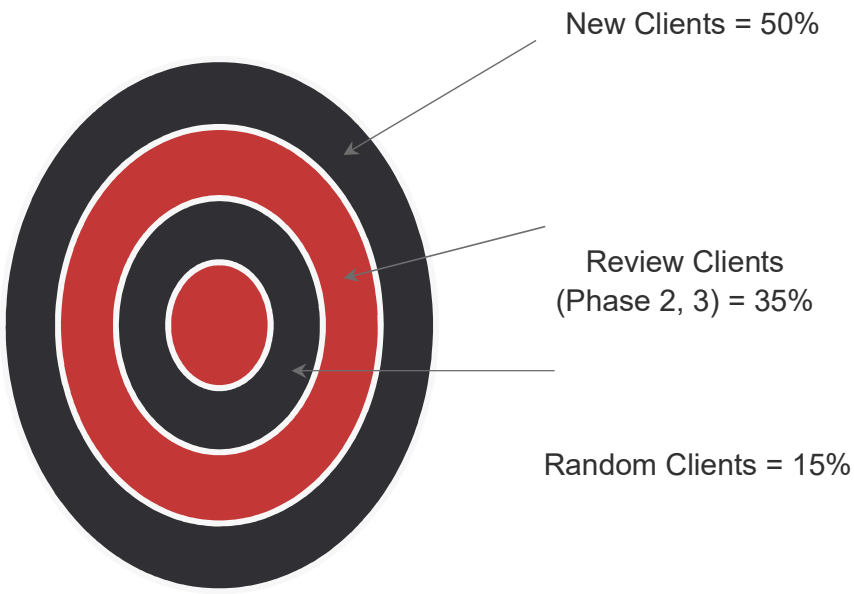
Annexure 32: Unique File Number in different locations of UMHP



Annexure 33: Next Review Date



Annexure 34: Clinic Client Profile

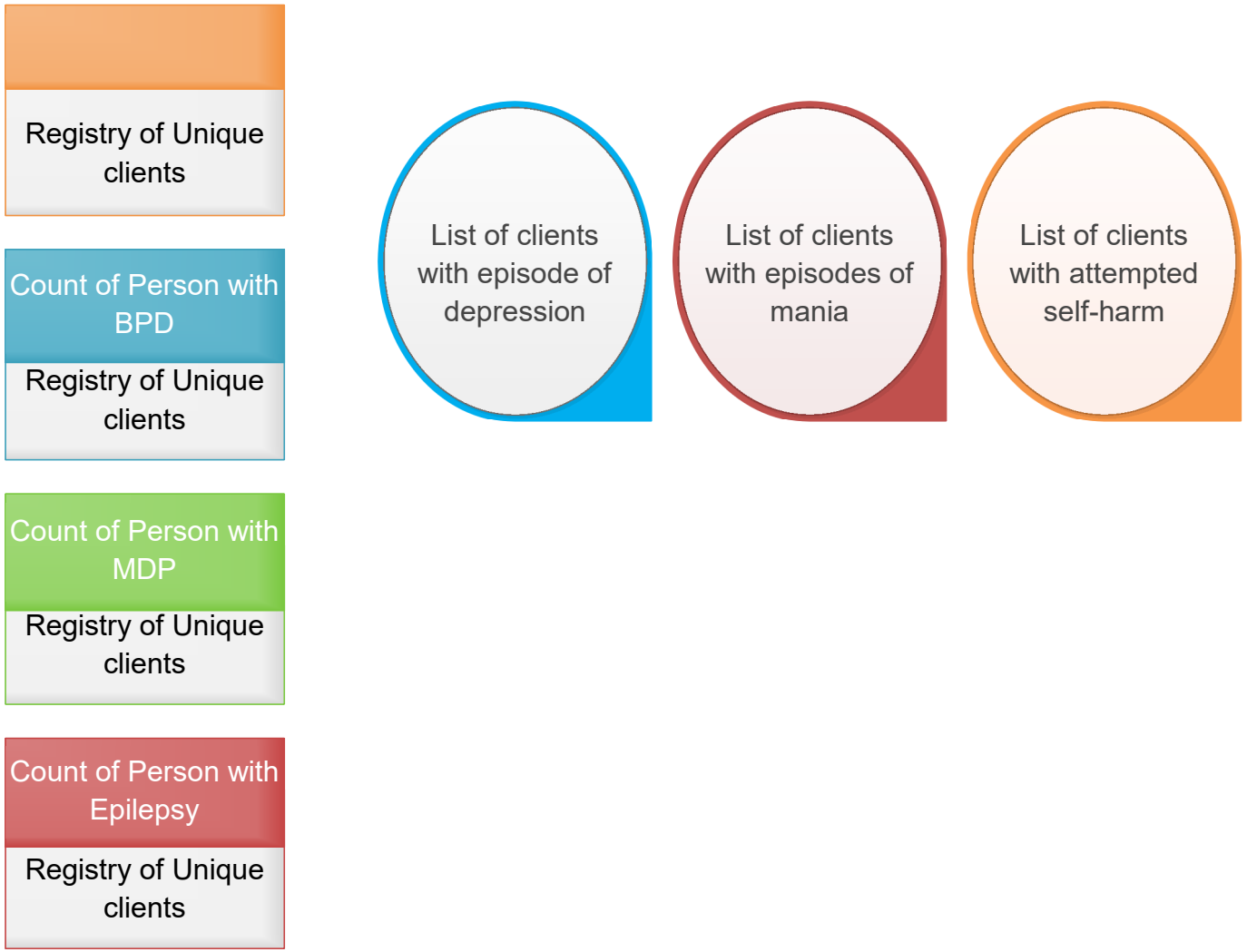


Annexure 35: Importance of Client History

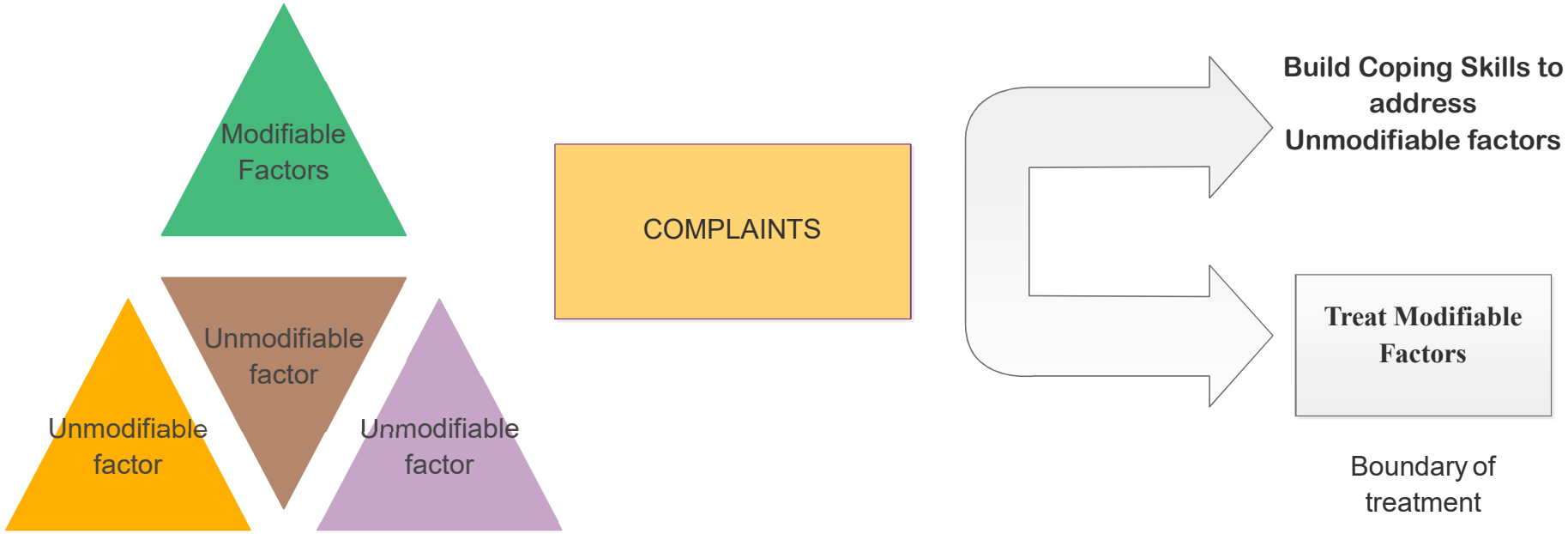
Annexure 36: Different sources of Information, tally

| Information collected from clients registered in OPD | Information from baseline report |
|---|---|
| Mean age of client | Mean age of client |
| Most clients have duration of untreated psychosis (DUP) > 1 year – does it mean we are identifying early enough? | What is the mean DUP in baseline? |
| Most clients coming to OPD have positive symptoms – we need to revisit our IEC material and focus on negative symptoms in psychosis which appear in prodromal phase and will aid early identification | What is the level of community awareness on negative symptoms of psychosis |

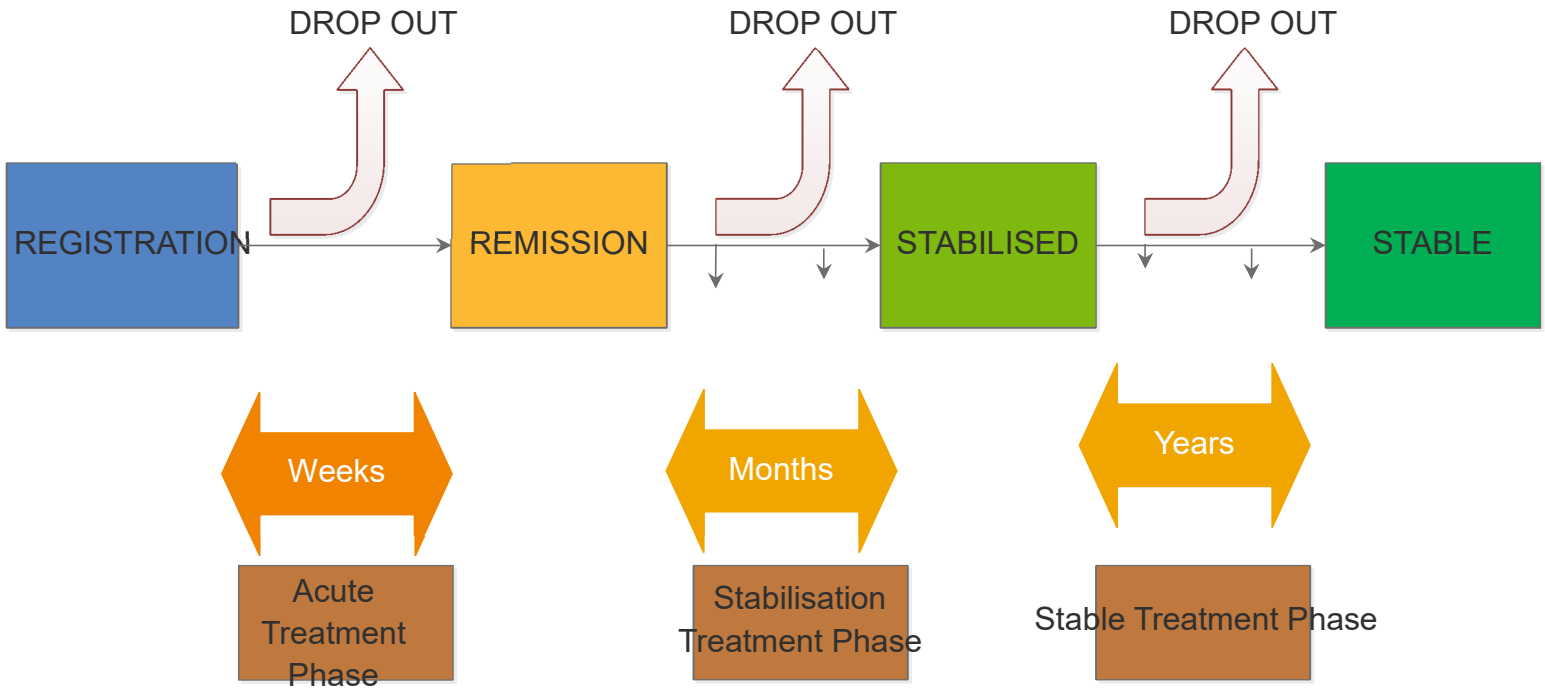
Annexure 37: Two types of registries that should be maintained by UMHP



Annexure 38: Approach of UMHP

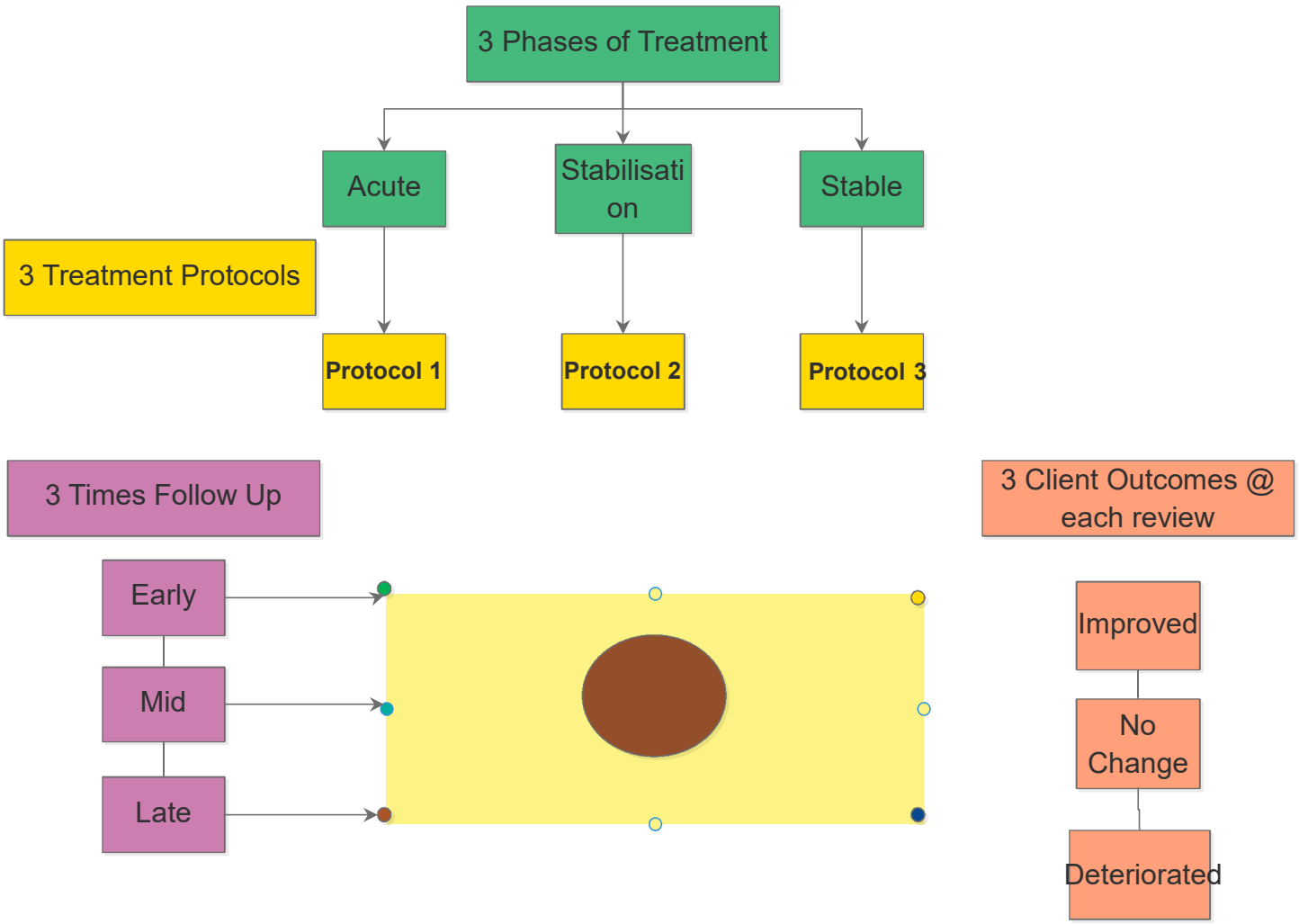


## Annexure 39: Phases of treatment




*Small vertical arrows on horizontal line represent review points

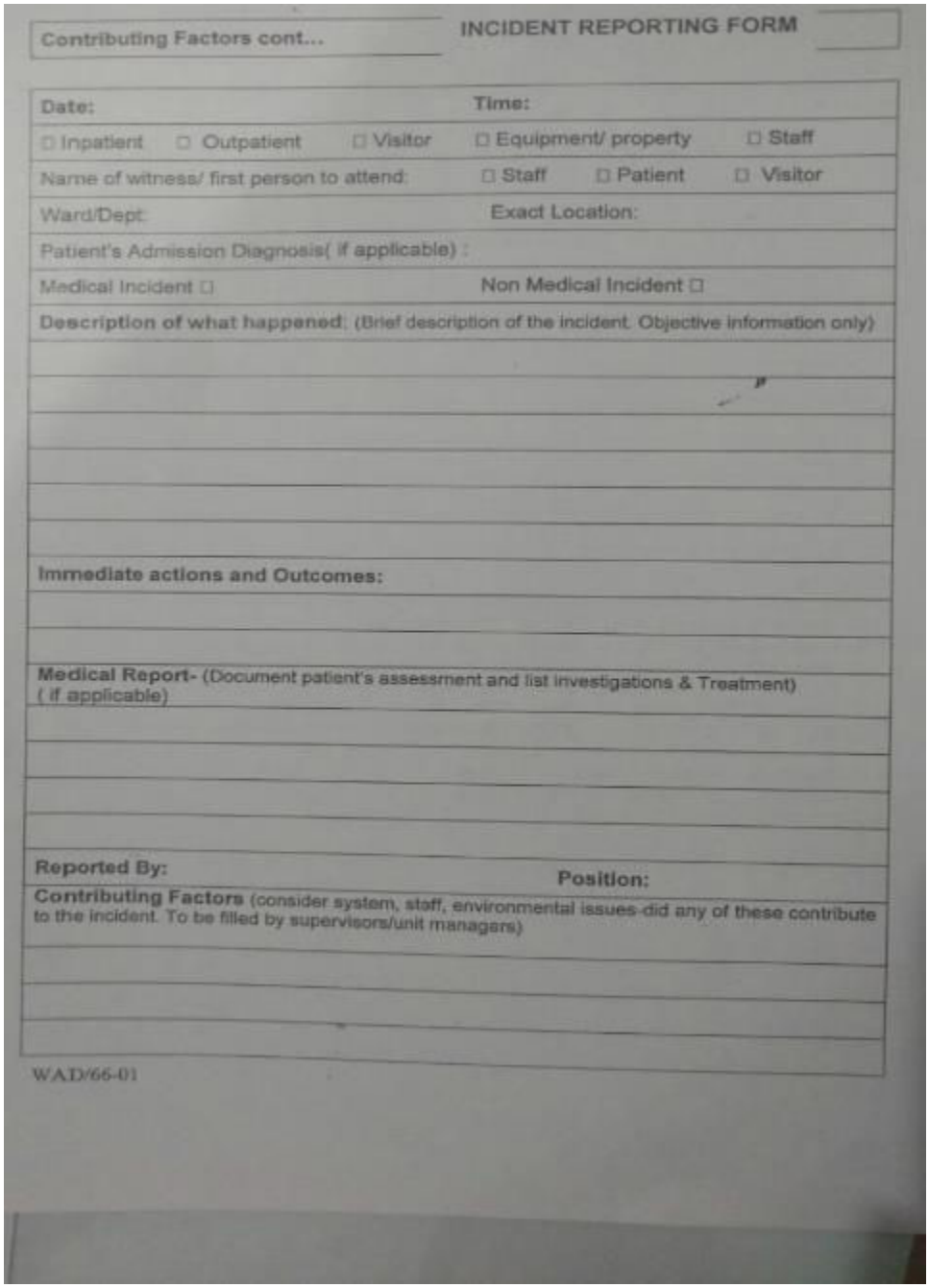
Annexure 40: Rule of 3



Annexure 41: Suggested longitudinal Data Collection for each client

| The Date Table | | | | | | | |
|---|---|---|---|---|---|---|---|
| **S.No.** | Client File No | Registration | End Point Achieved | Start Point | End Point | Start Point | Last Update |
| | | | Acute Treatment Phase | Stabilisation Treatment Phase | Stabilisation Treatment Phase | Stable Treatment Phase | |
| **1** | | Date | Date | Date | Date | Date | Date |
| **2** | | | | | | | |
| **3** | | | | | | | |

Annexure 42: Incident Reporting Form (Sample)



Contributing Factors cont...

INCIDENT REPORTING FORM

| | | | | |
|---|---|---|---|---|
| Date: | | | Time: | |
| ☐ Inpatient | ☐ Outpatient | ☐ Visitor | ☐ Equipment/ property | ☐ Staff |
| Name of witness/ first person to attend: | | | ☐ Staff ☐ Patient | ☐ Visitor |
| Ward/Dept: | | | Exact Location: | |
| Patient's Admission Diagnosis( if applicable) : | | | | |
| Medical Incident ☐ | | | Non Medical Incident ☐ | |
| **Description of what happened**: (Brief description of the incident. Objective information only) | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Immediate actions and Outcomes:** | | | | |
| | | | | |
| | | | | |
| **Medical Report-** (Document patient's assessment and list investigations & Treatment) ( if applicable) | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Reported By:** | | | **Position:** | |
| **Contributing Factors** (consider system, staff, environmental issues did any of these contribute to the incident. To be filled by supervisors/unit managers) | | | | |
| | | | | |
| | | | | |
| | | | | |

WAD/66-01

**Prevention** (Ideas of how this could have been prevented. To be filled by supervisors/unit managers)

| Name | Designation | Date/Time |
|---|---|---|

(To be filled by supervisors/unit managers)

**Department Head** (Ensure the form is adequately completed by your staff. Document what steps have been taken to prevent reoccurrence)

**Outcome:**

- ☐ **Category A**: Circumstances or events that have the capacity to cause error
- ☐ **Category B**: An error that did not reach the individual
- ☐ **Category C**: An error that reached the individual but did not cause harm
- ☐ **Category D**: An error that reached the individual and required monitoring or intervention to confirm that it resulted in no harm to the patient
- ☐ **Category E**: Temporary harm to the individual and required intervention
- ☐ **Category F**: Temporary harm to the individual and required initial or prolonged hospitalization
- ☐ **Category G**: Permanent harm to individual
- ☐ **Category H**: Intervention required to sustain life
- ☐ **Category I**: Death of individual

**Kindly submit the form to Quality office within 48 hrs of Occurrence**

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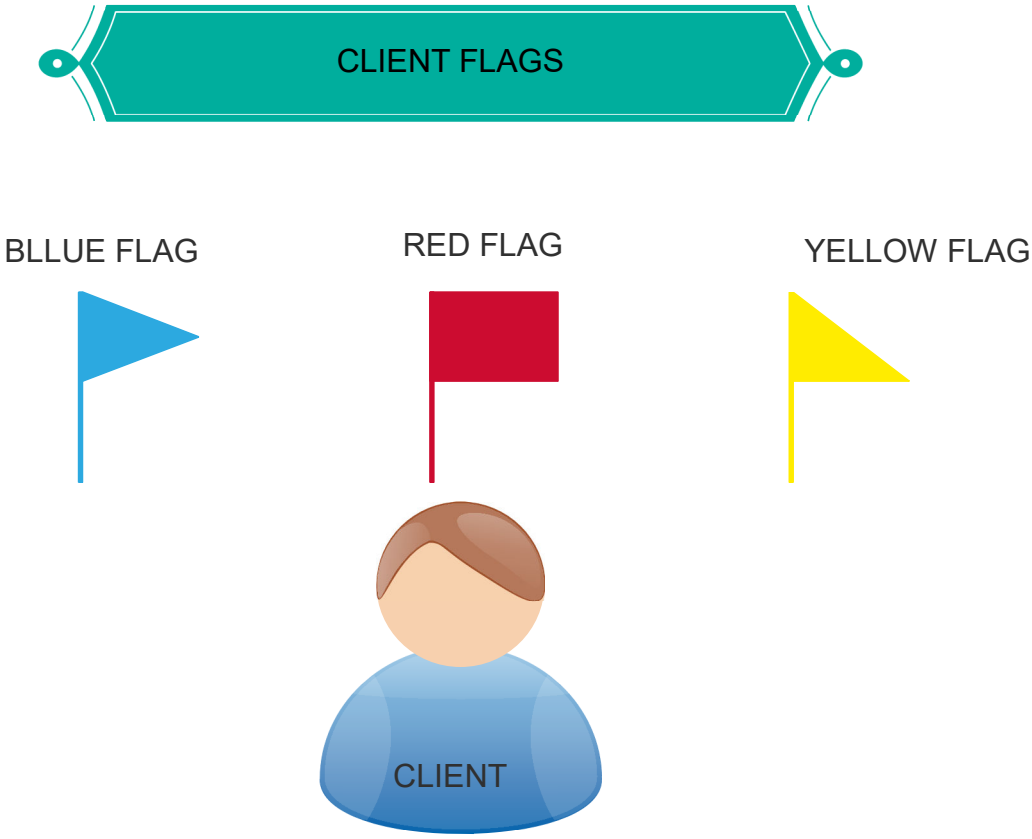
Annexure 43: Client Flags



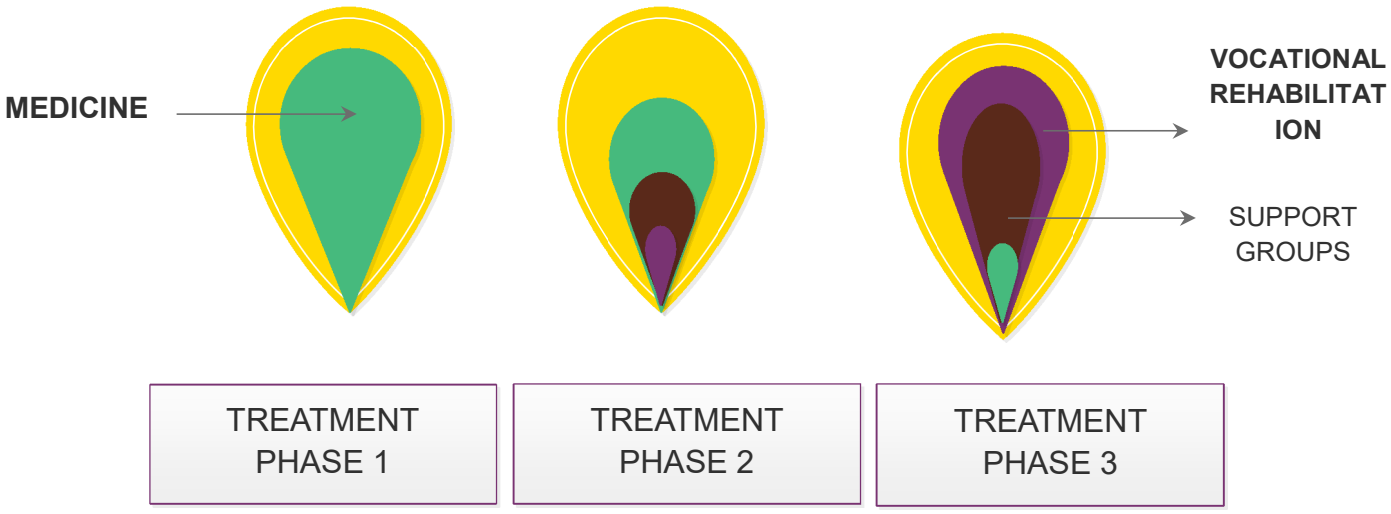

| BLUE FLAG | Treatment Phase | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|---|
| RED FLAG | Risk Stratification of Client | High | Medium | No |
| YELLOW FLAG | Has Client received Home visit? | Yes | | No |

Annexure 44: Clinic Performance Review Meeting

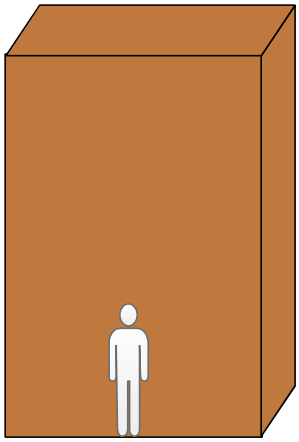
CLINIC PERFORMANCE REVIEW MEETING

Annexure 45: Different treatment phases, weightage of each element

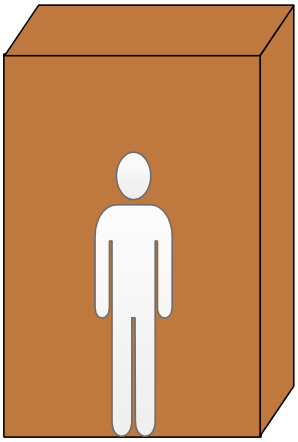
Importance of different treatment elements in different treatment phases



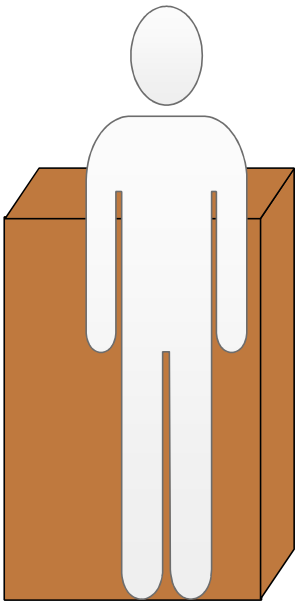
Annexure 46: Client Perspective in each treatment phase



ACUTE TREATMENT PHASE

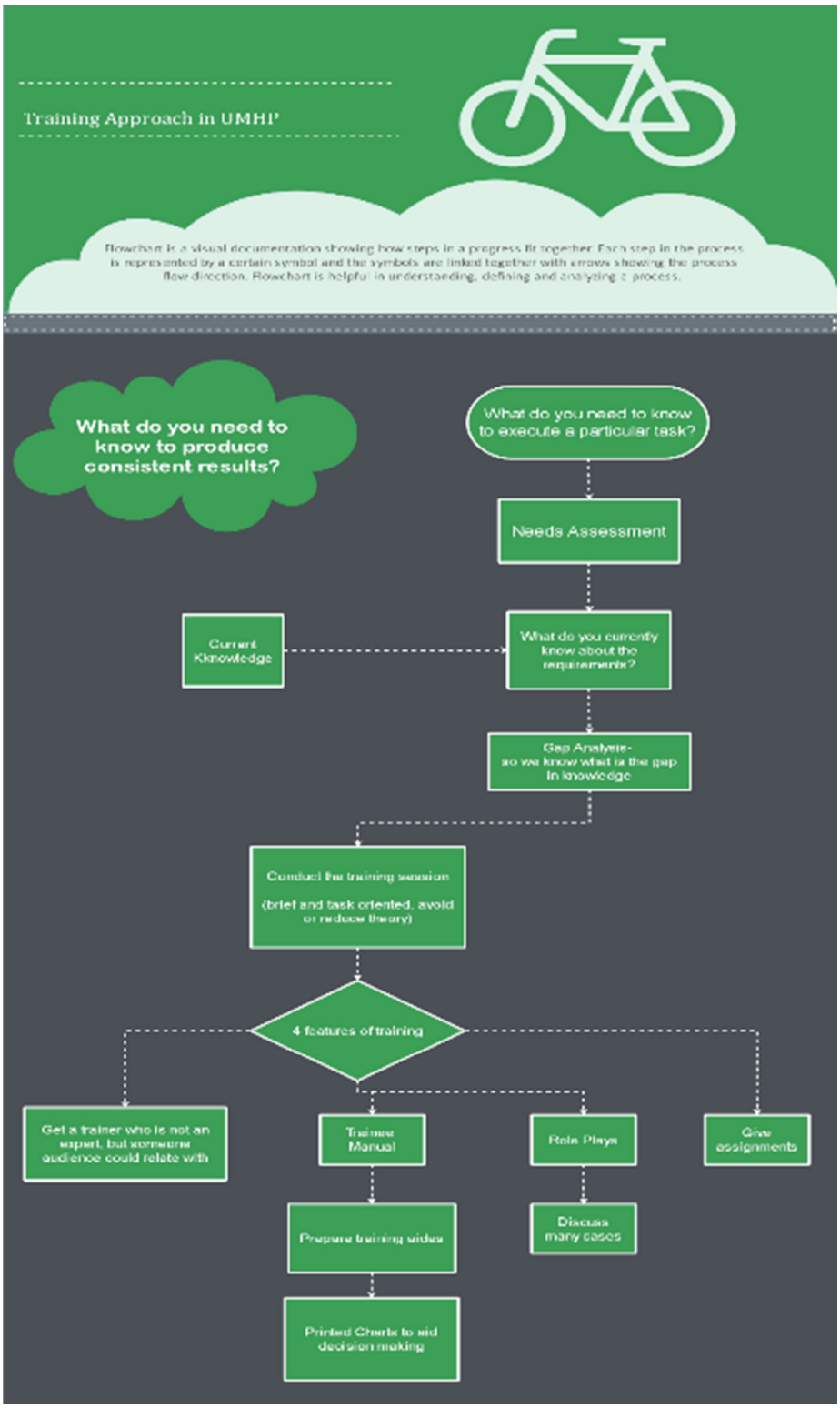


STABILISATION TREATMENT PHASE

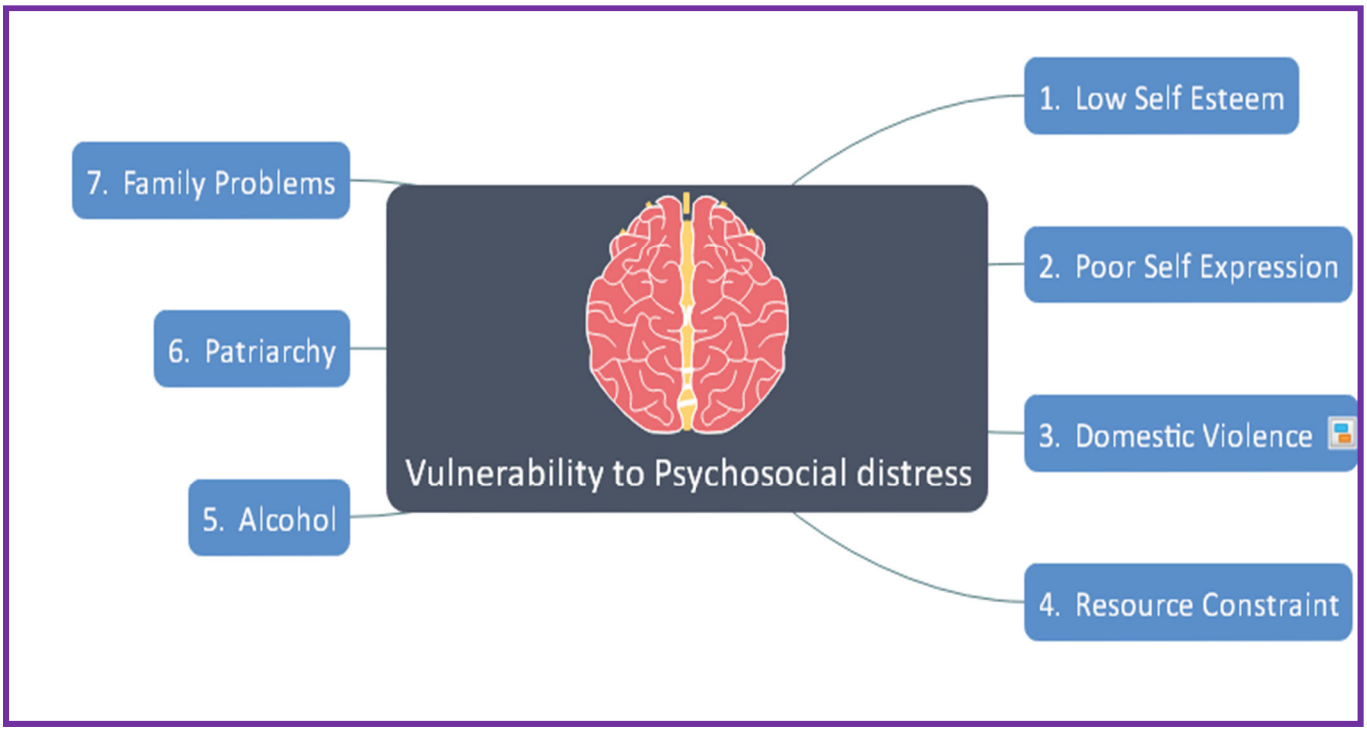


STABLE TREATMENT PHASE

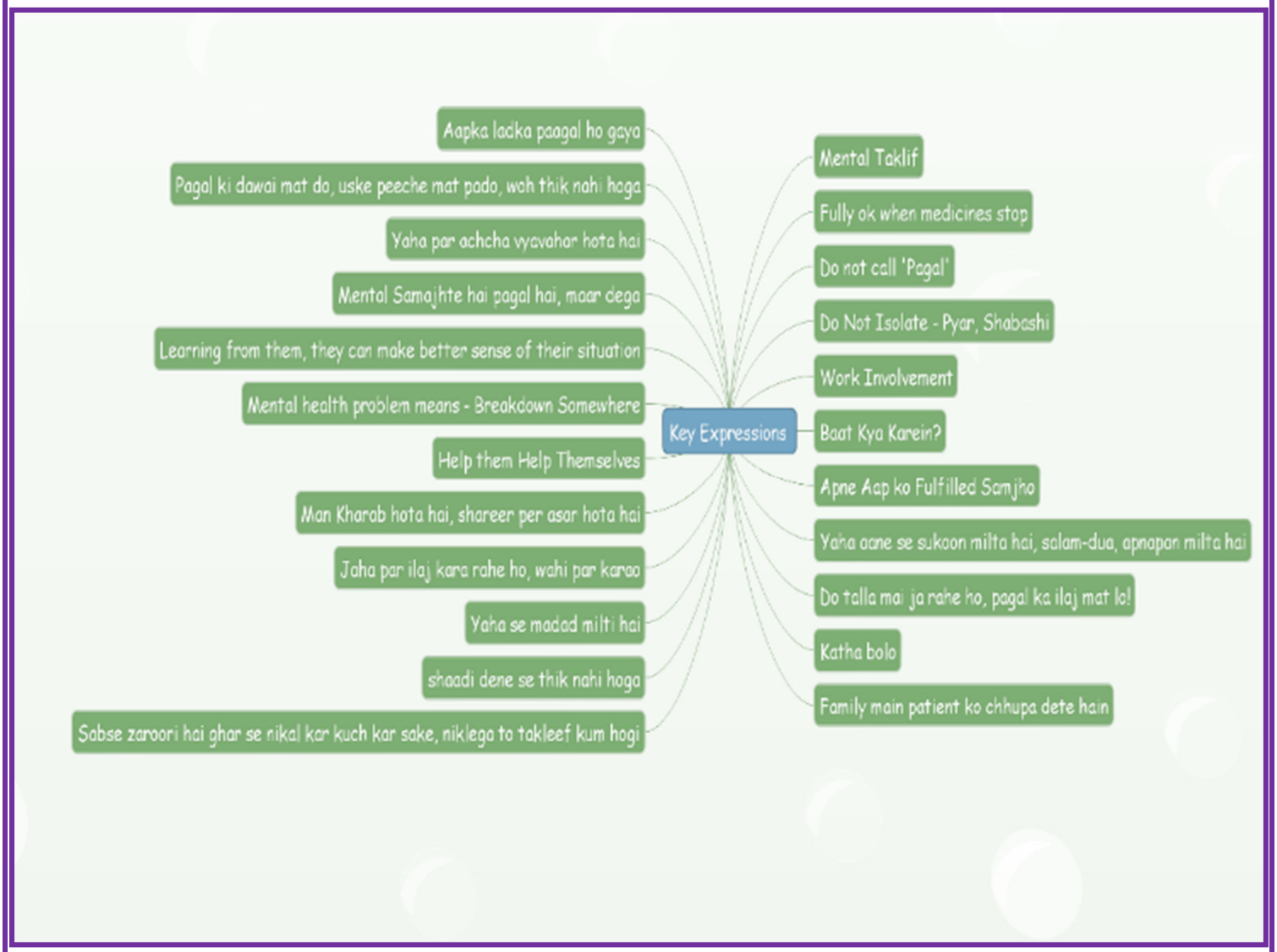
Annexure 47: Approach to training in UMHP



Annexure 48: Vulnerability to Psychosocial distress

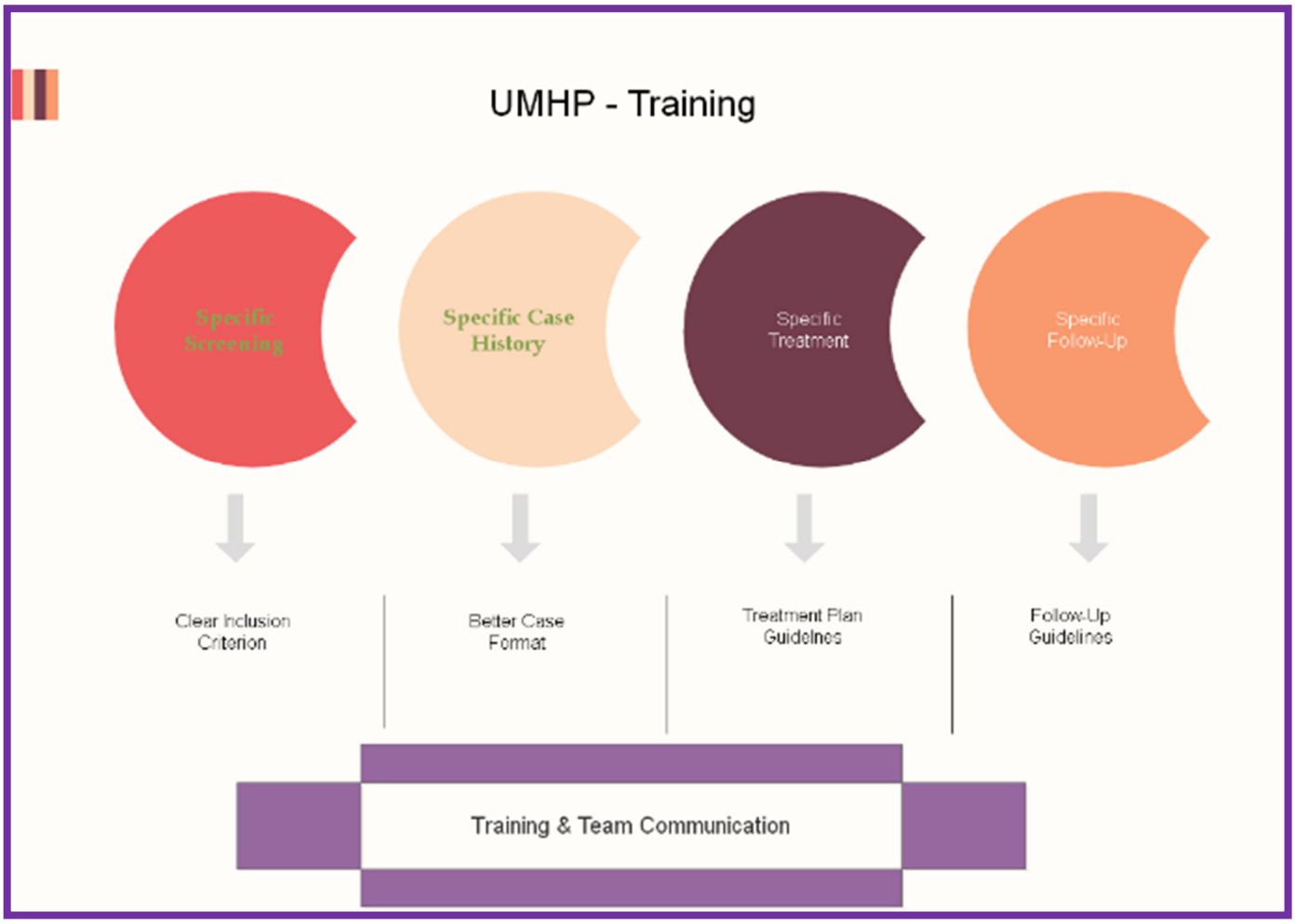


Annexure 49: Expressions of clients in describing their experiences



Annexure 50: Client files occupy maximum space in a clinic

Annexure 51: UMHP Training design



Annexure 52: Support Group Meetings

Annexure 53: Vocational Products made by clients of UMHP

Annexure 54: MIS of UMHP

| S.No. | Name of sheet | Type | What does it record | Frequency |
|---|---|---|---|---|
| **1** | 1A – Door to Door Soft Copy | Recording sheet | Records basic information of client | Event based |
| **2** | Potential Client List | Report | Open ended report | Event based |
| **3** | Master Sheet | Report | Open ended report | Event based |
| **4** | Scoring Sheet | Report | Open ended report | Event based |
| **5** | Home Visit Sheet | Recording sheet | Observation and Treatment planning by doctor | Event based |
| **6** | Phone Call Sheet | Recording sheet | Observation & Treatment Planning by Coordinator | Event based |
| **7** | Point of Contact Sheet | Material Request | Request for Emergency Medicines | Need Based |
| **8** | Counseling Report | Material Request | | Need Based |
| **9** | Employment Opportunity Sheet | Material Request | | Need Based |
| **10** | Vocational Training Sheet | Recording sheet | Individual Prescription and M,D and E drugs | Monthly |

| | | | | |
|---|---|---|---|---|
| **11** | Employment Engagement | Checklist | Tracks medicines consumed by clients over 5 days | Weekly |
| **12** | Awareness Events | Checklist | Tracks medicines consumed by clients over 7 days | Weekly |
| **13** | Networking Details | Material Request | Weekly medicines issued to IS staff and to CG | Weekly |
| **14** | Referral Register | Material Distributed | Weekly medicines issued to IS staff and to CG | Weekly |
| **15** | Support Group Involvement | Checklist | A sheet for each area for all clients, records daily attendance | Daily |
| **16** | Self-Advocate | Collection of sheets already discussed | | |
| **17** | Case Intake Form | Tracking Sheet | Monthly tracking of caregiver | Monthly |

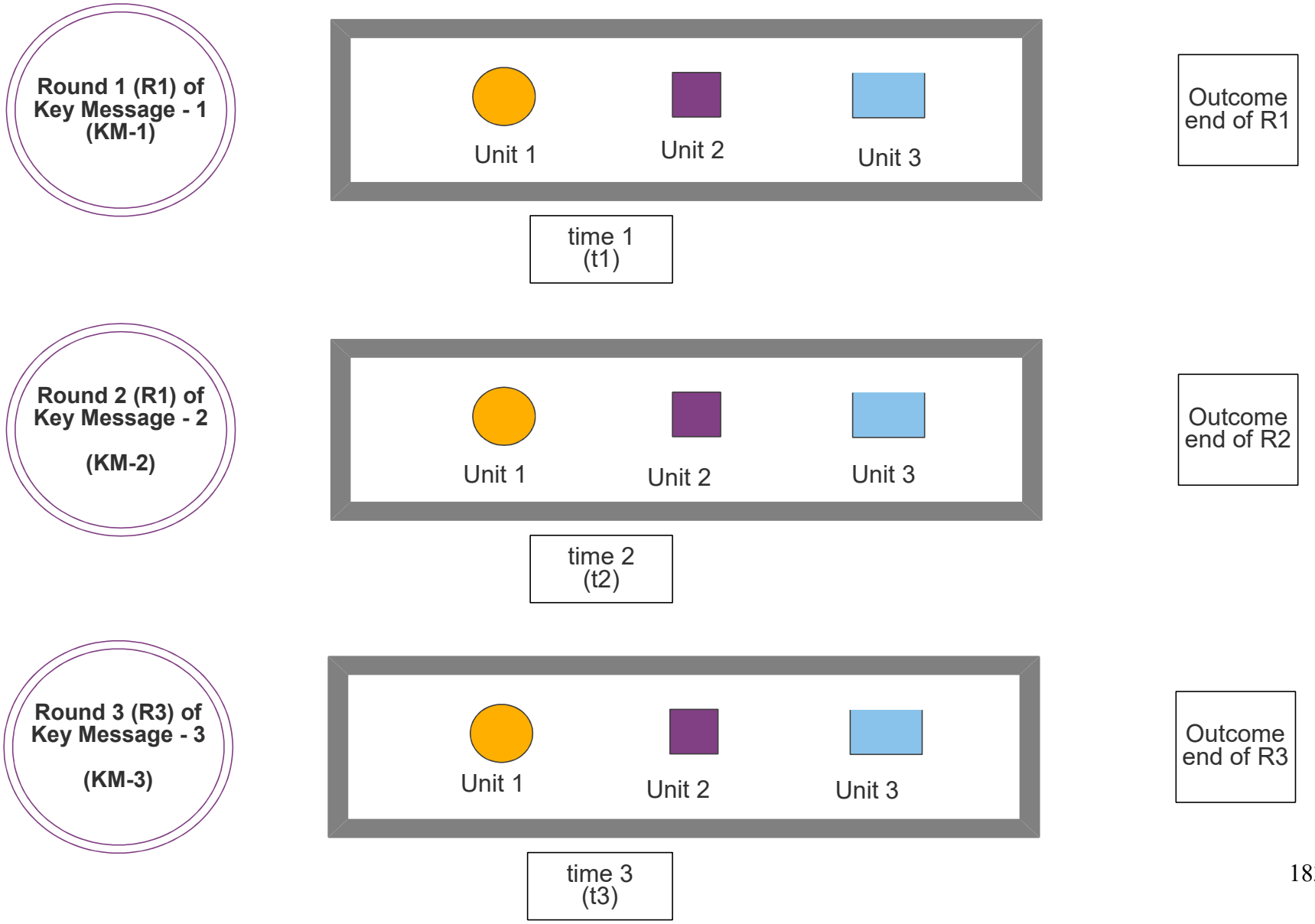
**Suggestions on MIS**

1. Please number all formats and all fields within format
2. On top of each format, please specify the purpose of the sheet / report / instrument
3. Please also mention how information required would be used, this would enable person filling information think on what he/she is recording
4. Date of filling the record should be mandatory in all formats

5. Please place the formats that are in series with the current format, the previous order and subsequent order such that linkages can be established between formats

6. It should be clear who should be filling in data and who is checking or commenting on it

Annexure 55: Outcome for track 2 of UMHP



Annexure 56: Forms, Manuals, Policies and other items required in UMHP

| | Forms | | |
|---|---|---|---|
| 1 | Mental Health Clinic Checklist | Create | Should be used during Observation, Regular Service periods |
| 2 | Incidence Reporting Form | Create | Template enclosed |
| 3 | Phone call follow up form to capture the three main enquiries | Modify | Current form is information of an event, this has to be modified as suggested |
| 4 | Home visit form needs to be developed | Modify | Current form is information of an event, this has to be modified as suggested |
| 5 | Crisis Intervention Form | Create | |
| 6 | Interview Schedule for clients who drop out of Stabilisation phase of treatment | | |
| | | | |
| | Manuals | | |
| 1 | Training for staff on crisis management at home of the client | | Suicide prevention modules for different cadre is available from: http://www.who.int/mental_health/resources/preventingsuicide/en/ |

| | | | |
|---|---|---|---|
| | | | mhGAP version 2.0 also has a module on suicide |
| 2 | Psychoeducation for client and caregivers | | Specially related to what the illness is; what adjustments in life are required and how to deal with side effects.<br><br>How to understand Needs of the client and the family – what is troubling them and what they want out of the treatment? |
| 3 | Family Intervention Manual | | |
| 4 | Treatment protocol | | WHO's publication – "Pharmacological treatment of mental disorders in Primary Health Care" is a good source for brief description of mental illness and their treatment (source: http://apps.who.int/iris/bitstream/10665/44095/1/9789241547697_eng.pdf)<br><br>Another resource is the WHO's mhGAP Intervention 2.0 (download: http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/) |
| 5 | Crisis Intervention manual | | See Resource mentioned in point 1 above +<br><br>A good resource is the "Crisis Intervention Manual" from page 9 onwards. Download it from: |

| | | | |
|---|---|---|---|
| | | | http://www.losmedanos.edu/PDFs/crisisinterventionmanual.pdf |
| 6 | Support Group Activity Book | | Group Intervention Therapy for depression by WHO (http://www.who.int/mental_health/publications/disorders_prevention_promotion/en/) |
| 7 | Non-adherence to treatment - most common reasons and solutions for them | | Management of side effects and other factors that determine adherence. A good resource to understand and plan for adherence can be accessed from: http://www.medscape.org/viewarticle/732805 |
| 8 | Prevention & Promotion in Mental Health | | Good resources are available here: http://www.who.int/mental_health/publications/disorders_prevention_promotion/en/ |
| | | | |
| | Policy | | |
| 1 | Client participation in treatment planning | | |
| 2 | Framework for client participation in treatment planning | | |
| | | | |

| | | | |
|---|---|---|---|
| | Hand outs | | |
| 1 | On each illness with focus on Early signs and early identification | | These can be developed in local language after referring resource on this site:<br><br>http://www.who.int/mental_health/management/en/ |
| 2 | A collection of audio and video files that provide a message to members of Support Group in line with the objective | | |
| | | | |
| | Auto Reports from MIS | | |
| 1 | Number of clients in each phase of treatment | | |
| 2 | Number of clients in each phase of treatment who received phone call (weekly report) | | |
| | | | |
| | Lists / Data bases | | |
| 1 | List of all clients, phase wise of treatment | | |
| 2 | Schedule of all calls to be made to Phase 1 clients | | A telephone helpline would be of great benefit |
| | | | |
| | Flags | | |
| 1 | High risk clients | | |

| | | | |
|---|---|---|---|
| 2 | Crisis events (Incidence reporting) | | Format enclosed |
| | | | |
| | Protocols | | |
| 1 | Clinical protocol | | |
| 2 | Division of all diagnostic conditions into three phases | | |
| 3 | Protocol for making ambulance available to the client for admission | | |
| 4 | Protocol for handling clients in acute stage of illness including measures to calm the client, protect staff and inform security in case required | | |
| 5 | Phone call follow up for Phase 1 clients | | |
| 6 | Protocol for the social worker or volunteer to handle crisis at home in high risk cases | | |

**Definition for Adherence**[14]:

Experts agree that percentage of total medicines not taken as preferred method for defining adherence cut off with 80% or more medicines taken as appropriate cut off for adherence in for schizophrenia and bipolar disorders.

The most important factors responsible for non-adherence include:

1. Poor insight and lack of illness awareness

2. Distress associated with specific side effects or general fear of side effects

3. Inadequate efficacy with persistent symptoms

4. Believing medications are no longer needed

Recommended Reading: http://www.medscape.org/viewarticle/732805

[14] The expert consensus guideline series: adherence problems in patients with serious and persistent mental illness.

J Clin Psychiatry. 2009; 70 Suppl 4:1-46; quiz 47-8 (ISSN: 1555-2101)

Velligan DI; Weiden PJ; Sajatovic M; Scott J; Carpenter D; Ross R; Docherty JP;

Annexure 57: Flash Card for the KMC health worker

# Flash Card for KMC Health Worker

| What is my function? | Competencies required for function | Resource & Toolkit | My own learning |
|---|---|---|---|
| 1. Identify mental disorders<br>2. Provide basic medication and psychosocial interventions<br>3. Referrals to general / specialist mental health services<br>4. Family and community psycho-education (Patient Information)<br>5. Crisis intervention<br>6. Prevention of mental disorders and mental health promotion<br>7. Filling data & Administrative tasks<br>8. Advocacy | 1. Diagnosis and treatment of mental disorders<br>2. Counselling, support and psycho-education<br>3. Referral<br>4. Crisis intervention<br>5. Survey and filling data forms<br>6. Mental health promotion and prevention of disorders<br>7. Advocacy | Information leaflets on mental health<br>Patient Information leaflets<br>Handy Flashcards for staff (salient points)<br>List of Emergency phone numbers to be contacted in distress | Workbook to note the main points<br>Participate in case discussion |